Page 2: Your demographics

Q1 Your details

Name	**Sylvia Lee**
Company/organisation	
City/town	
Email	

Q2 Your submission is in the capacity as — **dentist or dental specialist**

Page 3: The proposal

Q3 Do you agree or disagree with the proposal to remove the 18-year age limit for restorative activities from the OHT scope of practice including: accredited, gazetted programmes allowing oral health therapists to perform restorative treatment on patients 18 years and older an exclusion, such as "Restorative treatment on patients 18 years and older", being placed on oral health therapists' scopes of practice until they complete an accredited adult restorative programme which will allow them to apply to have the exclusion removed (noting that the activities registered oral health therapists can currently perform within their scope of practice remain unchanged). — **Strongly disagree**

Page 4: Your support

Q4 Please describe why you support the proposal — **Respondent skipped this question**

Page 5: Your concerns

Q5 Please describe your specific concern/s with the proposal

It does not take into consideration that adult scope of dental care is much more comprehensive than simply "drilling and filling" simple cavities, ESPECIALLY in the lower decile and geriatric populations (for whom I presume this change is scope is being proposed to accommodate for). The general public do not understand this and therefore the treating clinician requires extensive training in the management of medical comorbidities, drug interactions, emergency care, physiologic, endodontic, periodontic, surgical, prosthodontic, orthodontic knowledge to deliver effective and safe treatment outcomes before ever "picking up the drill" to do irreversible work on adult teeth. This ability of the treatment provider is necessary for the patient to receive appropriate care with informed consent - ensuring that the patients understand ALL the treatment options within the branches of dentistry as mentioned, risks and benefits, long and short term consequences locally and systemically. OHTs do not have this training and for there to be any kind of provision of training to this extent, they may as well be doing the BDS degree to become a dentist. The logical reason behind the age restriction to the OHT scope is because that is what the training and experience of this profession is suited to accommodate for- under 18 population do not have complex medical and dental risks and complications associated with treatment relative to the older population above that age, and to think there is "no difference between a tooth in an 18year old and a 18 year old and 1 day" is demonstrating lack of knowledge and appreciation for the systemic and permanent effects of treating the adult patient base.

I cannot begin to understand how treatment cost would be "cheaper" and more "accessible" by an OHT without compromising on treatment time, quality of work, cross infection standards, and material costs. What would be the difference (besides in training as mentioned above) be? How would the dental council allow this difference whilst still upholding the patients right to informed consent and equality in the quality of healthcare across all demographics?

The rationale behind this proposal is largely mistaken to think New Zealanders suffer from dental problems because there is a shortage of able providers. That is quite the contrary with the increased influx of overseas dentists and graduates domestically. New Zealanders suffer untreated dental problems because there is inadequate government funding to access the already present, qualified and abundant workforce.

What about the most vulnerable and underserviced population in our country that OHTs are the main treatment providers trained to serve- the children? There is a minimum 6month wait period for a child to be treated in the public hospital and to say the current practicing school dental nurses within the DHB are being swamped with the needs of our children would be an understatement. They are overstretched and heavily burdened already, and to disperse this workforce to an even wider age gap would be detrimental to the dental health and wellbeing of our paediatric population especially in the more deprived communities who are in desperate need of more preventative care. The outcome of when this generation become adults would be even more burdensome to the healthcare system and costly (financially to say the least) for the adult patient. The result will be a more dentally unhealthy and under treated adult population in the coming years.

New Zealand following the current OHT scope in Australia or the UK is unrealistic as we have a completely privatised dental health model with regards to funding that do not align. There is no evidence that the purpose of those countries changing their OHT scope is being fulfilled. Why are we trying to follow?

First do no harm - If providing for the most vulnerable, underserviced, low decile and remote communities with quality dental care whilst upholding their ethical rights is the objective of the council, this proposal is a step in the wrong direction.

Page 6: Details about OHT scope, qualifications and competencies

Q6 Do you have any specific feedback on the proposed amendments to the OHT scope of practice, prescribed qualifications or competencies as set out in appendices 1 & 2?	**No**

Page 7: Specific comments on the proposal

Q7 Please provide us specific comments related to the OHT scope, qualifications and competencies.	**Respondent skipped this question**

Page 8: Anything else

Q8 Do you have any further comments on the proposal?	**No**

Page 10: Last thoughts

Q9 Please provide us your feedback	**Respondent skipped this question**