## Page 2: Your demographics

**Q1** Your details

| | |
|---|---|
| Name | **Lye Funn Ng** |
| 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

If the aim of increasing the age limit of OHTs scope of practice is to reduce cost for all of the general public, then I see a few issues with this objective.
1) not all OHTs work for DHBs which involves funded dental treatment. Even if all future OHTs (under this new proposed ruling) are somehow covered by DHBs, this would mean increased budgeting to the dental scheme from all DHBs - and considering how budgets are like locally and globally, I see this as an extremely challenging and unlikely outcome.

2) If they end up being private paying OHTs, then yes they may charge a bit more compared to publicly funded OHTs, and currently less so than dentists. That is the appeal, I can see that. However, with increased scope of practice, I also anticipate (and hope) there will be increased regulations and accreditations and standards of practice needing upkeep - which will translate to higher overhead costs; and eventually the costs will rise in time to come, whilst it doesn't seem obvious at this time.

3) There is only so much that the OHTs are able to diagnose and treat with this new proposed scope. In cases of cracked teeth, endodontic involvement, oral pathology and oral surgery, OHTs are not trained with the basic knowledge that dentists do in order to fully diagnose and treat patients sufficiently. If a patient is seen by an OHT, and whose case turns out to be too difficult, only to be referred to dentists - would this not result in redundant costs in terms of fees, time and energy for all parties involved including the patients?

Then there is the other matter of the quality of work, and extent of their expertise. Currently the restorative work by OHTs that I see are of adequate quality on average, and those are acceptable as these are deciduous dentition with short tooth lifespans. However for permanent dentition, I worry that the level of skills and understanding and clinical knowledge, even with vague "additional and further training" proposed, would not be enough to maintain permanent dentition in the long run, for the patients' overall and longterm benefit.

OHTs are currently already stretched thin and this shows in long wait times for children to be seen by them, backlog of recalls, especially in rural settings where the mobile buses come by only every so often. Increasing the scope of practice would involve taking on more patients on their current plates - and I worry this will impact more negatively on children in the general population.

Instead of all, that I believe the DHBs and Dental Regulatory Bodies should ensure increased fundings to undertake schemes which will benefit children's dental health from the upstream (preventative) rather than downstream (treatment). Such as vigorous dental involvement from the very start, working hand-in-hand with Plunket nurses for education to parents; better access and higher dental recall frequencies for all children, making all school zones water only, and hopefully, sugar free as well; to name some suggestions.

I also am in support of increasing full (or part) fundings from government for dental healthcare to adults, and special funding considerations to the subpopulations of special needs, geriatrics, etc.

## 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?

**Yes**

## Page 7: Specific comments on the proposal

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

Should OHTs wish to treat adults, then they should be further trained another 2-3 years, in a strict and vigorous accreditation programme like what dentists go through.

## Page 8: Anything else

**Q8** Do you have any further comments on the proposal? **Yes**

## Page 10: Last thoughts

**Q9** Please provide us your feedback

This proposal feels like it came out of nowhere from a few negative media backlash to the cost of dentistry. Why wasn't dentistry as a whole profession properly consulted to provide a broader outcome? Medical GPs costs a lot too - but their costs are not passed onto the general public 100% because a large proportion is covered by the government as seen as necessary healthcare. Shouldn't NZ start viewing dentistry as a necessity healthcare and start funding dental costs too? Increasing the OHTs scope of age limit is not going to help reduce costs of dentistry for the majority of the public. Good dental education and awareness schemes, nationally funded oral healthcare for all ages will be a better shot at that objective.