[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Jono Yeow**
City/town	[redacted]
Email	[redacted]

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

Dentistry, as with most other surgical fields, increases in complexity as age of the patient increases. The differences of just the general physical health and oral health of a seventeen-year-old compared to a sixty-year-old for example, are worlds apart.

This is not a question of, "can an oral health therapist place a good filling in a tooth"; of course OHT's are very competent within their scope. Rather, the issue is that doing restorative treatment on a tooth is performing surgery on a human being, and implanting a medical device into that person. A course of treatment has to start with a diagnosis, which is very different in a young person, compared to diagnosing a problem which has been half a century in the making. Then the problem and treatment has to be presented to the patient to obtain informed consent, which is impossible to perform well if the whole range of common options are not made available at the time of appointment, or if the practitioner cannot perform most of the options for the particular problem.

As treatment begins, other aspects of the patient's health begin to interlink: multiple medications, complex medical issues, interactions of drugs used, can turn a simple dental procedure into a catastrophic medical event which can have long-lasting or permanent consequences. This is especially an issue for the elderly, and poor of our population, who are more likely to struggle with both complex medical issues and also good informed decisions with regards to treatment.

Can OHT's learn to navigate these more complex diagnoses, treatment planning steps, medical interactions and implications for long-term care and health, carry out restorations in a way that results in a good long-term outcome for the whole patient, not just the tooth? Absolutely, with enough additional study and mentoring and supervised practice. The path required is to train in dentistry, and any attempt to shorten, or reduce content or level of education in this regard can only result in poorer care at every step of the patient experience, and therefore poorer outcomes.

This leads to the next concern, that the proposed change in scope will not result in better access or lower treatment costs. There is no evidence that the proposed change will in fact deliver better access or lower treatment costs, and this scope is present in other countries. There are social implications of suggesting that the poorer or elderly of our communities should see lower-qualified OHT's as a way to address difficulty of accessing care, as this will only result in wider inequalities in our society, and is a dangerous and unethical stance to take. The Dental Council's stated purpose is "to protect the health and safety of the public of New Zealand." It cannot achieve this by lowering standards of care, but instead must advocate for the public and demand continually higher standards of care in dentistry. The access and costs of this, if they cannot be borne by the public that they are there to serve, must then be funded by subsidies, or taxation of the products sold in our country that so obviously result in the problems that require dental treatment (sugar), with the similar logical reason that alcohol, tobacco, and any other harmful product is taxed. Models of care that spread risk such as insurances or other means must be explored and implemented, rather than blind hope that deregulating and lowering standards of care will result in any kind of meaningful solution The fact is that overheads and compliance costs to provide safe and effective services are constant, irrespective of the degree that the provider holds.

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**