[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Nic Twaddle**
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

I have concerns with the proposal as I suggest that the decision to increase OHT's scope will lead to a decrease in the available workforce to provide treatment to NZ's children. I am also concerned that we are simply following suit to comply with other countries. I believe we need to act in our own interests based on our own data. I discuss both of these issues with the proposal in further detail below.

The proposal states a flexible workforce increasing OHT scope of practice will increase access to primary oral health care. Will it

really? This is a valiant intention but what about the unintended consequences? What about ensuring that we retain a high standard of care for our children? No where in the proposal is there a discussion about how this change in scope might affect New Zealand's children through the loss of high quality OHT's who decide they want to go and work in an adult scope.

How will the DHB's retain their OHT staff to treat the countries children when OHT's will have the ability to go and work in private should they choose to do so? What will be the increase in cost to the DHB's to try and retain these OHT's? What if OHT's decide even if pay rates are equal with working in adult scope in private that they just prefer to work with adults rather than kids? What is the cost of the increase in decay in our children who then progress through life with worse oral health and become the high needs patients of the future with unmet treatment needs?

These are the children that are currently flooding our hospitals for general admissions because of untreated dental decay. To quote the study by R Whyman et al.

"The total rate of admission to hospital for dental care has increased from 0.76 per 1,000 population in 1990 to 3.01 per 1,000 population in 2009 and admissions with a primary dental diagnosis have increased from a rate of 0.67 per 1,000 population in 1990 to 2.32 per 1,000 population in 2009.
Children aged 8 years or under had the highest rates of admission to hospital for dental care and significantly more children aged 3 and 4 years required admission for dental treatment than any other age group. Increases in the rate of admission occurred for all age groups over the period 1900-2009.
Admission rates were highest for people of Maori and Pacific ethnicity and lowest among people of Asian and NZ European ethnicity After taking the age structure of the population into account disparities in the rate of admission between ethnicities remain. Rates of admission for dental care have increased most for Maori and Pacific people and in the period 2005-2009 Maori and Pacific people were hospitalised for dental care at rates almost twice as high as for NZ European people"

Admissions to New Zealand public hospitals for dental care: a 20 year review
RA Whyman, EK Mahoney, J Stanley - 2012 - Ministry of Health

So we have a rising tide of decay that is so badly progressed that in the 19 years to 2009 our rates of hospital admissions for treatment increased by nearly four times that of 1990.

A very recent study widely publicised found
"The University of Auckland study involving 27,333 children aged 5 from Northland and Auckland, found 40.9 per cent of the children had caries, with more than three teeth affected by decay in 20 per cent."

That means if the figures are to be believed that 5400 5 year old children had at least 3 decayed teeth. That suggests to me that if anything we need more OHT's treating children not OHT's treating adults.

I suggest that if the proposal goes ahead you will see a decrease in OHT's wanting to work with children, a decrease in prevention where it is most needed among our children, an increase in unmet dental treatment amongst children leading to an increase in admissions of children to hospital. Ultimately costing the country more money and leading to an increase in suffering in our children, most of whom will go on to have life long poor oral health.

The focus of change should be on prevention of disease at the earliest stages not at the treatment of disease at the bottom of the cliff. There is more dental disease in the community than will ever be treated no matter how you change the workforce because in the end someone still has to pay, be it the patient or the government. What we need is to prevent decay in our children. If they develop good habits while they are young in terms of diet and oral hygiene then we may see a reduced burden of disease for life.

Regarding International Educational Benchmarks;

Is there any evidence to show that changes in other countries have improved outcomes or increased access to quality care. As a dentist my understanding is that dentistry in Australia is significantly more expensive than it is in New Zealand.

The proposal simply talks about the fact that there are "international educational benchmarks" and that other universities in Australia are offering adult scope programs. That in of itself does not provide reason to change the programs here in New Zealand. There needs to be evidence that this change to OHT’s scope will have a tangible improvement in overall oral health and most importantly

that there is no reduction in oral health of our children.

The proposal then suggests that universities here are "developing postgraduate programmes that will allow oral health graduates to upskill and
provide restorative treatment to patients 18 years and older. One of the New Zealand institutions has indicated it intends to incorporate this aspect into their undergraduate oral health programme in the future."

Since when was the dental workforce dictated by what a university would like to offer? The fact that a university would like to offer this program to their students is not a reason to change the OHT scope of practice. That is putting the horse before the cart and quite frankly the fact that it is openly stated that the universities are already developing the programs required for the increased scope of practice suggests to me that this consultation process is actually for show, to tick a box and that this is not actually a consultation at all.

There is not even a presentation of baseline data in this proposal as to the current state of affairs. There is nothing incorporated in the proposal to suggest there will be monitoring of data and changes and that if the impact on the dental health of our children is adversely affected then the decision will be reversed.

Frankly this proposal simply raises many unanswered questions and looks like a rash decision that may have severe unintended consequences.

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.

Any adult scope treatment (If this goes ahead) should be completed under the guidance of a dentist who is responsible for treatment planning and then assigning elements of a larger treatment plan to the OHT.

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 appears to be a major change with minimal consideration and minimal evidence of it's likely benefits. I urge you to consider the impact on the oral health of our children when making this decision.