Page 2: Your demographics

Q1 Your details

Name	**Priyena**
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

I have tried to but have genuinely failed to understand how the proposal is meant to help alleviate issues being described. There is definitely an alarming and sad situation where most adults in New Zealand hold off going to see the dentist due to the anticipated cost of

definitely an alarming and sad situation where most adults in New Zealand hold off going to see the dentist due to the anticipated cost of treatment. Financial hurdle is a significant barrier to getting access to proper oral health care and I whole heartedly agree that we should work to find substantial solutions to minimise if not eradicate such inequality.

However, the proposal fails to highlight in which specific ways it will help achieve that, how is the removal of the 18 year old age limit on OHT's for restorative work going to make oral health care accessible to more people at a lower cost? Fillings in Australia don't differ significantly in the cost range to treatment provided in New Zealand. How are we going to regulate that treatment provided by oral health therapists would be cheaper than those provided by dentists, assuming it would be cheaper to see the OHT because they've studied for 3 years with an easier entry requirement into their course as opposed to a dentist that has studied for 5 years and has endured severe competition to make it into the cut-off for BDS? How do we ensure that the general public will understand the fundamental differences between a dentist and a OHT with increased scope? Is competition amongst oral health professionals meant to reduce costs? If so, by what anticipated margin, and will that be enough to encourage low income adults in deprived communities in New Zealand to get dental check-ups done more often, to seek treatment sooner rather than later, to not wait for an occlusal filling to turn into an extraction? How do we know these theories will work? Furthermore, countries such as Australia, Netherlands and the UK were used as examples, but I struggled to find evidence that supported that access to dental services to adults in those countries have improved as a direct result of the increased scope of OHT's. In fact, according to the National Oral Health plan, only one in three Australians said they keep up to date with their dental visits and more than 63,000 Australians are admitted in hospitals each year for dental conditions that can be prevented. A new report from the Grattan Institute found that 2 million Australians avoid seeking dental help still. There is plenty of data that states that equal oral health care for all is still an issue an Australia despite the supposed plethora of health professionals available to provide service. In 2016, the Australian Bureau of Statistics found that the country had 846 oral cancer deaths and that 25% of the population was living with untreated tooth decay. Do we really need to follow the ways of our colleagues across the ditch even if there isn't enough evidence to support that proper oral health care is being provided to rural communities and deprived low income populations just so graduates can be free to migrate to and from for equivalent job prospects? Perhaps it is an initiative that can be explored later, but there are other more viable ways in which we can reduce disparities in the populace and allow fair distribution of dental services. Why not subsidize oral health care for communities, or increase free dental services to the age of 21, organise initiatives to make it attractive for adults to seek help sooner rather than later and to see dentists as there aren't any shortage of such health professionals at this stage. Creating more labour/ work force for treatment is not the issue, it's accessibility to seek that help and I would argue there are more effective ways to achieve this then increasing the OHT scope.

There are also more significant issues at play. There is a difference between doing restorative treatment on an 18 year old vs an 80 year or a 60 year old. Perhaps we can consider moving the age limit for complimentary treatment to 21 years of age, however the general adult population often has more issues at stake then just active caries in the mouth. The older the population gets, there increasing complexity in treatment planning, consideration of medical issues and patient management as well. What happens if a filling results in an unforeseen pulp exposure in a clinical situation? What happens if a restoration ends up being too deep and subgingival requiring some form of gingivectomy or crown lengthening? What happens if a crack is discovered in the tooth and it's best chance at survival is a crown? What happens if clinical scenarios end up turning sour and the health professional is not trained well enough to manage issues beyond their scope? Let's say, the patient gets referred off to a dentist for further management. Who pays for the cost of the consultation and for the treatment that needs to be done then? I don't see how clinical scenarios like this will help make the financial burden easier on the patient, I only see the distress it will put them through. There's a lot more that goes into just doing restorative work for adults; treatment planning and getting informed consent is a big pillar before dentists commence doing any simple or complex series of work on a patient. Isolating complicated to simple treatment in practice is complex, and I agree that using age as a marker (18 years old at this stage) to protect oral health therapists from ending up in medicolegal situations is an effective measure of both protecting them and the patient. We should give everyone a fair chance of getting a detailed and thorough dental examination. How is it possible for a health professional to provide that when they are competent in certain aspects of the field but not all. The mouth is not a clear cut environment, it's dynamic and everchanging, the person behind it is just as complicated, and treatment plans should have the best chances of reflecting that as not all issues can be solved with restorative work.

I am also deeply worried about the large unmet need for dental care for children. DHB's struggle to retain dental therapists as it's more lucrative to work in the private sector as a hygienist. It saddens me to think the increased scope would discourage professionals from wanting to treat children and move onto adult scope of practice thus exacerbating the issue at hand. We need to address this disparity first. We need to support oral health therapists in tackling rampant caries and chronic pain issues associated with oral sources in

first. We need to support oral health therapists in tackling rampant caries and chronic pain issues associated with oral sources in children. We should make job prospects for treating children more encouraging and more rewarding. We should work to retain them in these fields so that our younger population doesn't continue to struggle as it is. The waitlist for GA treatment for children in hospitals is incredibly painful for parents to endure and it shouldn't have to be this way. It makes more sense to confront these pressing matters first, instead of making it worse by the extension of attracting therapists into adult restorative scope.

In conclusion, I implore authorities making these decisions to assess issues at stake and potential solutions with objectivity and put the public, the individuals taking the brunt of these changes ie the patients, and their interests first before going ahead with or declining this proposal. None the less, thank you for allowing a fair expression of our opinions on this matter.

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**