[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Johnson Kwong**
Company/organisation	[redacted]
City/town	[redacted]
Email	[redacted]

Q2 Your submission is in the capacity as

Other (please specify):
Oral Health Student

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 do not believe that removal of the exclusion to restorative treatment in patients 18 years and older will benefit the intended target audience. The proposed change will result in complication that will be detrimental to the health of New Zealand but may not be seen immediately.
The cost of dental care has been shown to be the largest deterrent from seeking dental care. There is no evidence to suggest that removal of the age restriction will increase accessibility. The majority of the expenses are due to overhead costs (dental materials, staffing, licensing, dental equipment, etc) which remain unchanged regardless of the practitioner providing the treatment. This proposed change affects only the labour costs which are unlikely to have significant impact on the final cost of treatment. There is also no clear evidence that the reduction in labour cost will be passed on to the patient nor is there any planned regulation to ensure affordability is achieved from such changes. Additionally, higher wages are expected with the extended responsibilities and training which further decreases the differences between the claimed cost reduction of OHTs compared with dentists.
Competition is the driving factor in cost-reduction however to my knowledge there is not a shortage of dentists but rather a surplus especially considering the vast number of dental schools in Australia with high numbers of graduates each year. Removal of the age restriction introduces more competition in a market where the supply is already saturated. The proposed change will however provide an incentive for OHTs to migrate away from the dental therapy field towards restorative work on adults. It is to my understanding that DHBs are already lacking resources both in staffing and funding. During adolescent clinics at the dental school, we have been suggested to avoid recalls less than 12 months unless absolutely necessary as there is no funding. The proposed change will incentivize further loss of staff from areas which are already compromising the health of its patients. Currently, there are insufficient resources to book children in for their appropriate recalls, the very field which the oral therapy scope was initially introduced for. I believe that we OHTs, should be focusing on improving areas within our own scope before trying to expand into areas which is already covered. It is undeniable that children with poorer oral health are more likely to develop into adults with poorer oral health. Therefore, it is illogical to remove upstream resources and move them downstream. Improved dental care for children will reduce the need for restorative treatment in adults.
Public perception of OHTs, dentists, therapists, hygienists and other dental specialties has often been confused and used interchangeably. The proposed change will create further confusion on which dental practitioners are qualified to provide the required treatment. Greater accessibility will aid in the screening phases, however, complicated issues may result in redundant appointments, unnecessary treatment and/or delaying treatment. Furthermore, the lack of complete knowledge of all treatment options or complicated medical conditions reduces the quality of care for the patient. This also becomes an issue with the patient providing informed consent by not being provided all possible options. While we should be aiming for accessibility for everyone, this should not come at the expense of quality of care especially when regarding health.
As a final year BOH student, I feel that the current Bachelor of Oral Health course does not provide sufficient training to deal with complicated cases compared with the BDS course (pathology, pharmacology, dental materials, etc). Differences may be attributed to BDS having higher entry requirements, background knowledge and/or are generally more academically inclined. While further training may reduce the gap in knowledge, the gap is much larger than the two-year difference between the courses. The BOH course focuses heavily on areas such as scaling, child management and oral health advice which only make up a small part of the BDS curriculum. While there are areas of overlap, we OHTs focus in different areas in the dental field and make up part of the dental team to care for the patient overall. It seems that the complexity of treating aged adult dentition is not fully recognized and show signs of the ‘Dunning-Kruger Effect’.

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.

I agree with OHTs extended scope to diagnose caries.

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

It seems that the push for such proposal is not in the best interest of the patient and indicates agenda bias. Accessibility and affordability are being used as a mask while potential increased financial gain and/or perceived power from an expanded scope is clouding our judgement. The implementation of this proposal will have lasting non-reversible effects and should be decided with evidence-based research rather than a political agenda.