Page 2: About your submission

Q1

First name

NZ Society

Q2

Last name

Periodontology

Q4 **New Zealand**

Are you primarily based in New Zealand or overseas?

Q5

Company/organisation name

New Zealand Society Of Periodontology

Q6 **Professional body**

In what capacity are you making this submission?

Page 3: About your submission

Q7 **Respondent skipped this question**

What is your profession?

Q8

Respondent skipped this question

Please enter your Dental Council Person ID, if applicable

Page 4: Proposed registration pathways

Q9

Yes

Do you believe the proposed changes will help reduce barriers to registration for suitably trained overseas practitioners?

Q10

Please tell us why:

Yes, we believe it will reduce the barriers to registration by adding a number of other pathways that are significantly less resource intensive than the current individual assessment pathway that is often utilised by overseas specialists. Whether lowering the barriers does lead to more overseas trained dentists and specialists working in New Zealand is less certain, as there are many factors that can act as a barrier to emigration. However, we do not necessarily believe that lowering barriers to registration is an entirely good thing. We wish to iterate that the solution to workforce shortages cannot be to lower standards for entry to practice. It is imperative to recognise that once regulatory standards are diluted, they are extraordinarily difficult to restore, and we make note that the DCNZ has not outlined any mechanism of review of their proposal and its downstream effects on workforce and public safety.

Page 5: Introduction of the proposed 'Competent authority - registration' pathway

Q11

Partially support

Do you support the introduction of the 'Competent authority - registration' pathway?Click to learn more about the proposed pathway

Q12

Please tell us why:

Partially support. The currently listed registration authorities (UK, Ireland, Australia, Canada, USA) can be presumed to have rigorous assessment pathways for registration. We do have the following concerns

- If any of these authorities loosen their requirements in the future, how adept can DCNZ be in responding to this to prevent potentially low quality candidates applying?
- What are the mechanisms for further authorities being added? Would this undergo consultation with stakeholders or is it decided internally by DCNZ? How susceptible to political pressure and interference is this process?
- What fraud checks are undertaken when the clinician applies for registration? Are their documents trusted or is there verification with the original regulatory body undertaken?
- This is not a reciprocal registration pathway, so New Zealand dentists who wish to have overseas work experience or training are disadvantaged. We acknowledge this is not within the remit of concern for the NZDC, but is a factor affecting dentist and specialist support of the proposals.

“The proposed period of clinical practice required before applying for registration under the Competent authority - registration and Comparable health system pathways is based on the Medical Council of New Zealand (MCNZ) pathways that have been operating for a number of years”. We think care should be taken when using the Medical Council as a benchmark. Medicine is very different to dentistry as most of their new registrants are working in hospital system which is far more hierarchical than private practice dentistry and has much more clinical oversight and supervision built in. A right touch risk-based approach should recognise this and allow for an increased length of supervision for dentists and specialists as it is likely to be less intensely supervised (a dental clinician will be working in a room alone with one chairside assistant only) with less safeguarding and follow-up. It must also be recognised that for many dental procedures, poor clinical outcomes and patient consequences may not become apparent for quite some time. For this reason, we would strongly encourage the DCNZ to extend the supervisory period to at least twelve months for dentists and specialists registering via the ‘competent authority pathway’.

Further to the requirements about the period of time that the clinician must have worked before applying for this pathway. Having only worked two of the past five years for specialists does not seem enough. The justification used is that “The clinical practice requirements are shorter for dental specialists than for the other scopes of practice. This reflects the specialist additional training completed and the transparency of specialist referral practice”. We disagree that this is the case. How do we know their speciality training has been carried out to the appropriate degree? Bad specialists can survive and indeed decide to move countries. There is nothing stopping them advertising directly to patients even if referrals from GDPs dry up, and they will still be able to call themselves a specialist even if their work is not of acceptable quality. This is not in the best interests of public safety as the public does not have sufficient skills to be able to judge a registered specialist’s work appropriately and would trust someone who can call themselves a registered specialist even if it turns out the work is not being completed to New Zealand standards. This can ultimately undermine the public trust in our profession.

The other glaring issue seems to be the lack of mechanism to revoke the registration of a clinician who has registered via this pathway should safety, competency, or conduct issues arise. We quote the Q&A provided which says “If the supervisor is not in a position to advise that the practitioner is competent and safe to practise independently then the supervision period would extend; the supervision conditions cannot be removed until the practitioner has satisfactorily completed the supervision period. If the supervisory relationship was to breakdown, the practitioner would need to stand down from practice until a new arrangement was found.” We have several comments on this

- There doesn’t sound like there is a way to “fail” out of the programme. If someone clearly isn’t suitable the DCNZ has to keep supporting them to the detriment of long-term public safety
- We assume the DCNZ would need to use their current regulatory tools to address these concerns e.g. disciplinary hearings. Evidence shows that these are extremely resource intensive (note the increased disciplinary levy in 2025) and take a long time (years) to get an outcome. The DCNZ has demonstrated it has no enforcement mechanisms for dentists who might continue to practice even if they have been through the disciplinary process. This can severely undermine the public trust in the profession to the detriment of all.
- There is no auditing mechanism built into the proposal of the supervisor or the registering clinician. We believe that the DCNZ should be able to carry out random audits of the work of the clinician and of the supervision being carried out. Supervisors can be financially incentivised to gloss over clinical deficiencies if it means they can staff their clinic and turn more profit. By introducing a random audit mechanism, it creates more honesty within the system with the long term goal of protecting public safety

a random audit mechanism, it creates more honesty within the system with the long-term goal of protecting public safety.

- We strongly support the use of a Provisional Registration and a two strikes policy whereby if two supervisors both decline to support the ongoing registration of the candidate, that their registration can be withdrawn. This allows for the breakdown of one supervisor relationship (that might not be the fault of the registering clinician) and reduces the risk of the candidate being taken advantage of, but also still provides some disciplinary teeth and a method of enforcement to protect public safety if competency or conduct is not up to standard

Further to the guidelines, we feel there should be some written protocols in place to review these new registration pathways in a certain length of time (e.g. five years) to assess

o Number of clinicians who gained registration but then received validated complaints. If this is excessive compared to the registered clinicians who registered via other pathways then it might need to be rethought.

o Supervisor validity. E.g. are there supervisors who are overly represented as being associated with clinicians who later received complaints

o Are the New Zealand trained workforce and local graduates being disadvantaged by an influx of overseas trained dentists?

We want to specifically address one of the “competent authorities” as defined in this document. The UK is currently experiencing systemic collapse in its dental sector with specific regards to NHS dentistry.

Evidence shows:

- 13 million people in England cannot access NHS dentistry

https://www.bda.org/media-centre/13-million-unable-to-access-nhs-dentistry/

- 97% of new patients are unable to find NHS care

https://dentistry.co.uk/2024/10/11/almost-all-new-patients-unable-to-access-nhs-dental-care/

NHS contracts often work to incentivise speed rather than quality. Preventive and periodontal care are deprioritised because the system simply does not fund them adequately. Regulation is also under strain. The UK regulator (GDC) has failed Professional Standards Authority benchmarks and faces significant backlogs in fitness-to-practise cases:

https://www.professionalstandards.org.uk/news-and-blog/latest-news/detail/2023/11/15/psa-publishes-performance-review-of-the-gdc

Dentists from these systems may be competent individuals, but we are concerned that they might be conditioned by a structurally broken environment. It is unsafe to assume equivalence with New Zealand’s prevention-focused, high-trust model.

We also note that the DCNZ has specified that candidates entering by both the competent authority or comparable health systems will have to undertake a “Dental practice in NZ” course that includes a cultural safety module. We question the extent to which Cultural safety can be adequately taught online to people with no background in Aotearoa’s indigenous culture. New Zealand healthcare delivery and dentistry is grounded in Te Tiriti obligations, Māori health frameworks, and equity-based care. But cultural safety is not only theoretical. It might not be attained through the delivery of short modules or brief supervision. Flooding the system with clinicians unfamiliar with Māori and Pacific health frameworks risks worsening existing inequities.

Page 6: Introduction of the proposed 'Comparable health system' pathway

Q13

Do you support the introduction of the 'Comparable health system' pathway for dentists?Click to learn more about the proposed pathway

Partially support

Q14

Please tell us why:

We recognise that the Dental Council proposes that this pathway is only open for general dentists and not for dental specialists. We raise similar concerns as with the competent authority pathway in that further clarification and regulatory tools are needed to affirm the safety of the New Zealand public. Mechanisms need to be in place to audit and revise this system if it turns out to be not fit for practice and compromises public safety. There also needs to be clarification on whether other countries will be added to the current list and whether political interference from within New Zealand can influence this. Given that there is no current mechanism of removing a country from this pathway, prudence should be shown in adding any country to the list if there is a real risk their registration pathways might be open to manipulation and change that would not necessarily be in the best interests of New Zealand.

Further consideration should be given to the idea that Comparable health systems ≠ comparable dental standards. Council itself acknowledges a global dearth of oral-health data, yet still assumes equivalence based on population health indicators: https://data.who.int/indicators/i/C25EFD6/9F88C44 This methodology has its flaws. General health outcomes do not measure dental training quality, clinical exposure, or regulatory enforcement. Countries proposed as “comparable” including Greece, Portugal, Italy, Korea and Israel face well-documented issues such as commercialised education, variable training standards, graduate unemployment, and inconsistent regulatory enforcement.

Page 7: Introduction of the proposed 'Teaching and research' pathway

Q15

Do you support the introduction of the 'Teaching and research' pathway?Click to learn more about the proposed pathway

Partially support

Q16

Please tell us why:

Partially support. We agree that there needs to be a pathway to encourage academic staff to apply for positions in our teaching institutions. This will help with staff recruitment which can be a real issue. We seek clarification on the statement in the document saying that they cannot undertake any individual clinical practice (manage patients in any location)” and "management of patients is not permitted in any location" Further clarification is needed as to whether this applies to work within the University or only to external work e.g. in private practice. The NZSP thinks it is important to acknowledge that the person registered under this pathway will need to be able to carry out clinical work particularly the supervision of DClinDent students within the faculty. These staff will often be in a situation where they might have to manage patients on behalf of students and it would be too limiting if this were specifically excluded. We agree that someone who is specifically registered under this pathway should be excluded from external clinical work outside of the faculty.

We also request that it be clarified further under what recognised overseas oral health registering or licensing body this applies to. Is it the same as the previously outlined bodies for the competent authority and comparable health systems or is it open to every single recognised overseas health registering body e.g. India and Russia.

We see no reason why a clinician who does register via the teaching and research pathway cannot later pursue registration via the individual assessment pathway if this is important to them.

We would ask the dental council to consider the implications in the long term of a clinician registered under this pathway. For example, can they become Head of Department? There are no guidelines given in the current consultation documents as to who is carrying out the permanent supervision. E.g. should it be specified that the supervisor must be from within the same speciality?

Page 9: Proposed removal of requirement for a medical degree for oral medicine specialist registration

Q17

Do you support removing the requirement for a medical degree for oral medicine specialist registration in New Zealand, subject to the relevant medical training and clinical experiences being embedded into the specialist training programme?Click to learn more about the proposed changes.

Oppose

Q18

Please tell us why:

We think the best people to comment and make decisions about a speciality is the speciality itself and hence more consultation and followup on the matter should be done in conjunction with existing oral medicine specialists. In general, we are against the lowering of standards of any profession, which would include removing medicine from Oral Medicine training.

Page 10: Proposed removal of requirement to register in dental technology before registering in CDT

Q19

Do you support removing the requirement to register in dental technology before registering in clinical dental technology?Click to learn more about the proposed changes.

Support

Q20

Please tell us why:

This move aligns us with other regulatory bodies.

Page 11: Proposed changes to the New Zealand registration examination requirements

Q21

Do you support the proposed changes to the New Zealand registration examination requirements?Click to learn more about the proposed changes.

Support

Q22

Please tell us why:

Respondent skipped this question

Page 12: Proposed administrative changes to the prescribed qualifications

Q23

All scopes

Do you have feedback on the proposed administrative changes to prescribed qualifications for any of the scopes of practice, as reflected in the draft Gazette notices?

Q24

Please tell us your feedback. When discussing multiple scopes, please indicate clearly which scope of practice you are referring to in your comment.

No comment

Page 13: Proposed fees for the new registration pathways

Q25

Yes

Do you find the proposed fees for the new registration pathways reasonable?Proposed fee notice

Q26

Please tell us why or why not?

Yes, we believe the Dental Council should make sure that the costs of delivering these registration pathways is met by the newly registering clinician. If modifications are made as we recommend (increased supervisory period, formal random auditing) then increases to the proposed costs would need to be factored in, which we also support.

Page 14: Thank you for your time

Q27

Is there any additional feedback you would like to share on the consultation?

We also ask that the DCNZ take a close look at their justification for opening up the registration pathways as specifically outlined on page 10 of their consultation document. Essentially it boils down to increasing the number of clinicians who can register to work in New Zealand, without compromising the health of the New Zealand public which they are legislatively beholden to protect.

Our concern is simple: New Zealand cannot safely absorb a large influx of overseas dentists. International experience consistently shows that when dental markets open too widely, standards fall, the profession destabilises, and patient outcomes suffer.

We would point out that the current issue is not necessarily one of undersupply, but rather a maldistribution. Increasing the number of dentists does not mean underserved communities will suddenly receive care. Dentists are not compelled to practise in rural or high-need areas. They cluster where private practice is most financially viable e.g. major cities and affluent suburbs, exactly as they already do.
Dental Council workforce data confirms this clearly:
• 64.4 dentists and specialists per 100,000 adults (2022)
• up from 45.2 per 100,000 in 2016,
• with extreme geographic clustering for example, Dunedin has approximately 120 per 100,000, while rural regions remain far lower.
Source:
https://dcnz.org.nz/assets/Uploads/Publications/workforce-analysis/Workforce-Analysis-2020-2022.pdf
This demonstrates that New Zealand does not have a supply problem, it has a distribution problem. It is unlikely that flooding the register will drive dentists into rural communities, it will simply oversupply metropolitan areas and intensify competition where dentists already concentrate.

Overseas influx drives oversaturation. Markets such as Dubai, Qatar, Malaysia and parts of Europe (e.g. Germany) demonstrate a clear pattern. Their dental sectors were not destabilised by domestic graduate numbers; they were overwhelmed by rapid inflows of overseas-trained dentists seeking access to higher-income systems.
As these dentists entered already limited markets, competition intensified. Clinics were forced to undercut one another on price, appointment times shortened, and financial pressure pushed practitioners toward high-volume models. Over time, dentistry shifted away from therapeutic, prevention-focused care toward volume-driven treatment. The result was a measurable decline in quality, an increase in complaints, and a progressive loss of public trust. When markets oversaturate, clinicians are forced to compete on price rather than quality, and patient care inevitably suffers. New Zealand, despite its different population size, is not immune to this mechanism. New Zealand must take extreme care and responsibility to avoid this scenario and the collapse of patient trust.

We believe that this current proposal to decrease barriers to registration is being misrepresented as a dental workforce issue. In reality, it is an economic problem. The cost of delivering dentistry in New Zealand continues to rise due to increasing cost of materials, equipment, compliance requirements, indemnity insurance, overheads, and staffing. Increasing dentist numbers does not reduce these costs. Instead, oversupply compresses margins. When margins collapse, clinicians are forced to shorten appointments, reduce preventive care, and operate on volume rather than quality.
Health-economics literature is clear: price competition in oversupplied healthcare markets erodes non-price quality factors such as time, thoroughness and prevention.

We are concerned that an eventual oversupply of dentists can push unsafe practice. International evidence shows that when income is threatened, dentists start to practise beyond their scope, retain cases they should refer, and attempt complex procedures to protect revenue. This directly increases complications, complaints, and patient harm. The professional culture shifts from safety to survival.

DCNZ lacks capacity to absorb this influx:
Estimates suggest the potential pool of overseas dentists eligible under these pathways could exceed 400,000 practitioners from the 27 listed countries. New Zealand may not be equipped, either administratively or logistically, to safely manage an influx of this scale. This raises serious concerns around regulatory capacity, supervision, complaint management, and workforce planning.

DCNZ's own reports confirm there are rising competence notifications, an increasing case complexity, and we know that additional

DCNZ's own reports confirm there are rising competence notifications, an increasing case complexity, and we know that additional disciplinary levies have been imposed to fund investigations.
Source:
https://dcnz.org.nz/assets/Uploads/Publications/Annual-reports/2024-25-Dental-Council-Annual-Report.pdf

We are concerned that the Council does not have the administrative capacity to safely manage a surge of overseas registrants. Increased inflow will mean more complaints, more investigations, greater supervisory burden, and higher levies for all dentists. This might be financially unsustainable for the profession.

Bottom line
New Zealand does not need more dentists it requires the right dentists.
Every system that lowered barriers too far UAE, Qatar, Malaysia, the NHS, parts of Europe has experienced:

- oversupply,
- falling standards,
- rising complaints,
- professional destabilisation.

Opening these pathways will:

- not fix rural access,
- not reduce costs,
- not help patients,
- will crash the market,
- will lower standards,
- will increase levies,
- will displace NZ graduates,
- will compromise patient safety.

We emphasise, this is not anti-overseas dentists and specialists. It is pro-patient, pro-standard, and pro-sustainability. Competence and not convenience must drive registration.