

FREQUENTLY ASKED QUESTIONS: ORAL HEALTH IN NEW ZEALAND

What is the oral health status of New Zealand?

There are two measures of oral health in New Zealand:

- The percentage of five-year-olds that are free of dental decay ('caries free')
- The average number of disease, missing, and filled teeth of children in their final year of primary schooling (known as DMFT).

In 2004, less than 52 percent of five-year-olds were free of decay. Underlying this are major inequalities in oral health between groups. In some areas, less than 25 percent of five-year-olds are free of decay. Children of Maori or Pacific ethnicity, who are from low-income backgrounds, or who live in rural or non-fluoridated areas all have poorer oral health relative to other groups.

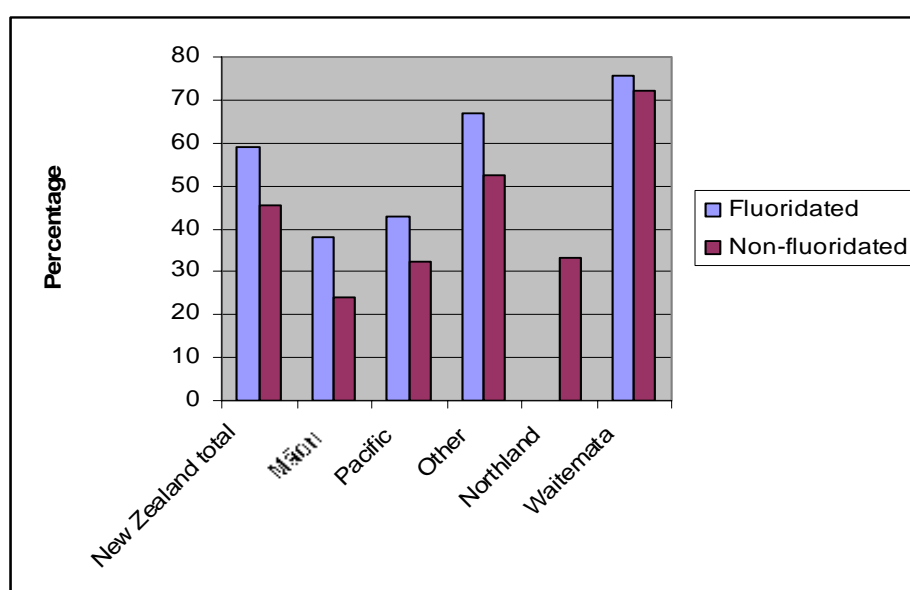


Figure 1: Percentage of children caries free at age five by fluoridation status (2004)

What about other age groups?

There is currently no routinely collected national data on the oral health status of adolescents, adults, or older adults. However, research suggests that oral health at age five predicts oral health in adulthood.

To obtain further information on these groups, the Ministry of Health recently commissioned a New Zealand Oral Health Survey.

Who funds oral health services in New Zealand?

Oral health services are a mix of publicly and privately funded care, depending on age group and socio-economic status.

Publicly funded oral health care is available for 4 groups:

- Children from birth to Year Eight
- Adolescents from Year Nine to age 18
- Low-income adults

- Special Needs and Medically Compromised Patients

Oral health care for most adults is performed by private dentists, on a user-pays basis.

How much public funding is currently spent on oral health services?

Approximately \$100 million per annum.

How does New Zealand compare with other countries?

New Zealand's child oral health statistics currently compare unfavourably with Australia and the United Kingdom, where similar oral health systems exist. This is particularly apparent when inequalities associated with ethnicity and/or fluoridation status are taken into account.

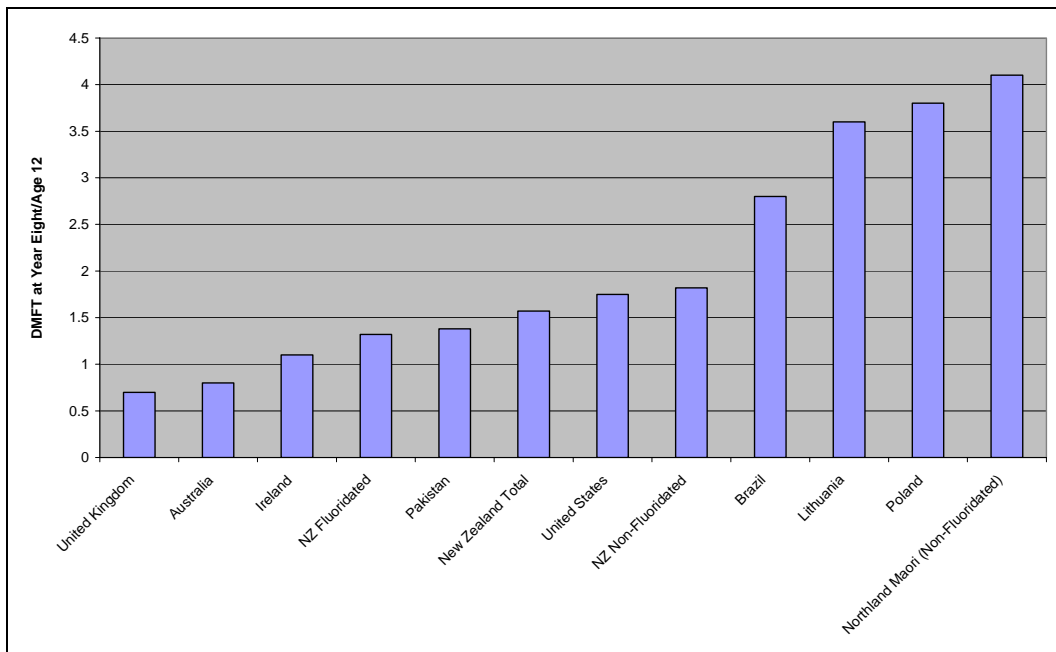


Figure 2: DMFT at Year 8/Age 12 by Country (WHO, 2004)

What is being done to improve this situation?

The Government has responded to this challenge with a new vision for oral health in New Zealand. This vision is described in *Good Oral Health for All, for Life: The Strategic Vision for Oral Health in New Zealand*.

The first step in realising the vision will be a major re-orientation of child and adolescent oral health services.

FREQUENTLY ASKED QUESTIONS: GOOD ORAL HEALTH FOR ALL, FOR LIFE

What is the strategic vision?

The strategic vision for oral health is 'good oral health for all, for life'. This means creating an environment that promotes good oral health, and providing services that set New Zealanders on the path of good oral health from an early age.

Why do we need a strategic vision?

It has become increasingly apparent that publicly funded oral health services are no longer meeting the needs of many New Zealanders. Previous gains in child oral health plateaued during the 1990s and have now begun to decline. Inequalities are increasingly evident. Recent reviews of the School Dental Service and Māori Child Oral Health Services describe a sector in need of strategic direction, rebranding, and major re-configuration at the operational level if services are to be effective in providing quality oral health care¹.

The Government has made improving oral health a priority. However, to date oral health policy has lacked consistent direction. A strategic vision will provide this direction over the next 10 years.

How will the vision be realised?

Seven key actions are necessary to realise this vision:

- Re-orientation of child and adolescent oral health care to community-based services
- Reduction of inequalities in oral health outcomes and access to oral health services
- Greater focus on oral health promotion
- Building of better linkages with primary care services
- Development of the oral health workforce
- Development of oral health policy
- Greater research, monitoring, and evaluation

What will happen first?

The first priority is re-orientating child and adolescent oral health services. This is because these services provide the cornerstone of publicly funded oral health care in New Zealand, and are critical for establishing a foundation of good oral health for life.

Child and adolescent services will be re-orientated away from the traditional school-based, treatment-focused approach, to a community-based service characterised by prevention and early intervention, and strong links with primary care.

Is there new funding?

Budget 2006 included a commitment to increase funding for child and adolescent oral health services by \$40.8 million over the next four years. This is in addition to the Government's earlier commitment to \$100 million over five years to upgrade oral health facilities.

¹ The final reports of these reviews are available at www.moh.govt.nz/oral_health.

FREQUENTLY ASKED QUESTIONS: COMMUNITY ORAL HEALTH SERVICES

What are 'Community Oral Health Services'?

Community Oral Health Services are re-orientated services that will be charged with promoting, maintaining, and restoring the oral health of New Zealanders from birth to age eighteen. They will replace the former School Dental Service.

What do Community Oral Health Services look like?

Community Oral Health Service facilities will be larger, better equipped, and more accessible than current school dental clinics. Facilities will vary but will include:

- Stand-alone clinics in metropolitan or rural areas
- Clinics co-located with a school, community health centre or other multi-purpose community-based centre
- Mobile clinics
- Hospital-based units

What services will be offered?

The primary focus of Community Oral Health Services will be oral health promotion, examination, and treatment for children from birth to Year Eight. Many facilities will also offer these services to adolescents.

Community Oral Health Services will have the potential to offer complementary services through co-location with other facilities, such as PHOs or Wellness Centres. Specialist oral health care, such as paediatric dentistry or special needs dentistry, may also be available – however, this will vary depending on the facility, available workforce, and may require payment.

Who will staff Community Oral Health Services?

Most facilities will be staffed by dental therapists, and dental assistants – just as the School Dental Service is now. However, in larger facilities community or general dentists will be employed to increase the capacity and capability of the facility.

Community Oral Health Services will also be a base for oral health promotion activities. Staff specialising in these activities will also be located in larger facilities.

Can adults be treated at Community Oral Health Services?

Services with part- or full-time access to a dentist may also offer oral health care to some adults. Again, this will be at the discretion of the service provider and may require a co-payment.

What does this mean for the School Dental Service?

School Dental Services will be replaced by Community Oral Health Services. However, some school dental clinics will be retained and refurbished and expanded to become Community Oral Health Services. New facilities might also be built on school sites, including high schools, where this best meets the needs of that community.

Will children miss out on oral health care?

No child will miss out on oral health services as part of this change. The objective of the Community Oral Health Service is to be more accessible for children and offer better care than the School Dental Service through:

- Greater visibility – parents and whānau will not have to work out where the dental therapist is located
- Services will be available for more hours of the day, during more days of the year
- Dental therapists will be supported by dental assistants – this improves efficiency in examination and treatment times, and also increases the number of clinical hours the dental therapist has available to work with patients
- Larger clinics that meet modern health and safety and infection control standards, and that are equipped for modern dentistry.

What does this mean for adolescent oral health care?

Most adolescent oral health care is currently provided by private dentists under the Adolescent and Special Dental Services Agreement. In some areas this will continue to be the case. However, in other areas adolescents will be able to attend a Community Oral Health Service. Care will be provided by dentists and dental therapists.

In this way, Community Oral Health Services will increase the availability of oral health care for adolescents currently living in regions where access to dentists willing to provide this service has been poor.

When will Community Oral Health Services be available?

District Health Boards will submit business plans to the Ministry of Health from November this year for funding to implement new services. The first new facilities will open their doors next year, but the major re-orientation of oral health services being called for by the government is expected to take several years to complete. All DHBs will be expected to have plans well progressed by mid-2007 with some expected to move much faster than that. In the meantime oral health services for children will continue to be available via existing school dental services.

Who can provide specific information about new services?

District Health Boards are responsible for planning and funding Community Oral Health Services. Contact individual DHBs for specific details on what will be happening in their region.

FREQUENTLY ASKED QUESTIONS: REDUCING INEQUALITIES IN ORAL HEALTH

Why focus on reducing inequalities?

The strategic vision for oral health is 'good oral health for all, for life'. There are currently major inequalities in oral health in New Zealand. Research has shown that inequalities in oral health during childhood can re-emerge in adulthood, even when socio-economic status is taken into account.

Therefore, we need to focus on eliminating inequalities in oral health amongst children, if we are to have good oral health for all, for life.

What inequalities currently exist in oral health?

The most dramatic and consistent inequalities in oral health status are between people living in fluoridated and non-fluoridated areas. People of Māori and Pacific ethnicity, who are from low socio-economic backgrounds, or who live in rural regions also have poor oral health, and poorer access to oral health services, relative to other groups.

How will we address this?

Reducing inequalities in oral health outcomes and access to oral health services is a key action area in *Good Oral Health for All, for Life: The Strategic Vision for Oral Health in New Zealand*.

Specific actions to reduce inequalities in oral health will include:

- Promoting oral health at the population level through a healthy environment e.g. access to fluorides, healthy eating strategies, and smoking reduction
- Improving access to services, particularly for children and adolescents, through the new Community Oral Health Services. Hard to reach areas will have access to services through mobile dental clinics and the mobile surgical bus.
- Supporting the development of Māori and Pacific oral health providers and workforce to ensure that services are both appropriate and appealing for these groups
- Developing oral health interventions that are designed and delivered in relevant ways e.g. 'brush-in' programmes at kōhanga reo
- Improving links with other health services that may already be in contact with high risk populations e.g. Tamariki Ora nurses.

FREQUENTLY ASKED QUESTIONS: FUNDING FOR COMMUNITY ORAL HEALTH SERVICES

What is happening next?

The Government has already prioritised funding for improved child and adolescent oral health services. This means that the money is not able to be used for other purposes. However, the funding is not automatically being distributed to DHBs. The Ministry of Health has developed Business Case Guidelines and DHBs are expected to use these to make an application for the additional funding.

What needs to go in the business cases?

DHB can present a comprehensive business case that covers the whole child and adolescent oral health spectrum, or they may want to start by focusing on a particular region or service area. Whichever approach they take, they will be expected to set out what their overall long-term plan is, so that it is clear how the parts will fit together.

The plans need to show how the DHB will:

- Increase the focus on prevention and early intervention
- Reduce inequalities for those with the greatest need
- Use the workforce in more efficient and effective ways
- Develop facilities that will keep up with changing demands.

How soon will DHBs be able to get started on their business cases?

DHBs can start on their business cases now, and some are already underway. The first round of applications will be considered at the end of November, and the Ministry will receive applications on a three-monthly cycle after that. The speed of decision-making will depend on the scope and detail of the plans. Final funding decisions will be made by the Ministers of Health and Finance. All DHBs are expected to have set out what their overall plans are by the end of June 2007.

Will other providers be able to access the funding?

DHBs are able to be flexible with how funding is used and are expected to work with their local communities and service providers to work out the best way of delivering services. This could lead to a variety of arrangements including funding services through the DHB Provider-arm (dental therapists and hospital dental services) contracting with private providers such as dentists, non-government agencies such as Maori oral health providers, or with primary health organisations and having linkages with other health providers such as WellChild/Tamariki Ora providers and health educators.

Who decides if a school clinic will stay open?

As part of the needs assessment process, DHBs will have to consider the suitability of current clinics for meeting current and future needs. DHBs and school boards will need to work closely together to identify sites that may be able to be upgraded or suitable for a new clinic or which may be unsuitable for longer term use.