

Good Oral Health for All, for Life

**The Strategic Vision for
Oral Health in New Zealand**

Citation: Ministry of Health. *Good Oral Health for All, for Life: The Strategic Vision for Oral Health in New Zealand*. Wellington: Ministry of Health.

Published in August 2006
by the Ministry of Health
PO Box 5013, Wellington, New Zealand
ISBN 0-478-30033-6 (Book)
ISBN 0-478-30034-4 (Web)
HP 4289

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz>



MANATŪ HAUORA

Foreword

New Zealand has reached a turning point for oral health. Several decades of dramatic improvements in the oral health of young people have begun to reverse. Inequalities in oral health and in access to oral health services have become increasingly evident, with Māori, Pacific, rural and low socioeconomic populations all showing progressively poorer oral health relative to other groups.

Recent reviews of the School Dental Service showed that services are often hampered by ageing equipment and buildings, and models of service delivery that are no longer meeting communities' needs. Secondary services are under pressure from larger case loads of patients requiring more complex treatment. Barriers to oral health facing older adults, who are increasingly keeping their own teeth, are also presenting a challenge at the other end of the age spectrum.

The future can be very different. The Ministry of Health has a vision:

Good oral health for all, for life.

The vision is for an environment that promotes oral health, whether through fluoridated water, a healthy diet, or publicly funded services staffed by a multidisciplinary workforce that actively addresses the needs of those at greatest risk of poor oral health. In this future, oral health is recognised as an important part of general good health. Links between oral health services and other health care ensure that oral health is promoted, improved, maintained and, where necessary, restored at the earliest opportunity.

Good oral health for all, for life, starts with promoting oral health for the youngest and most vulnerable members of our society. Ensuring that oral health services are accessible and responsive to the needs of children and their families and whānau is the first step in accomplishing that objective.

For this reason, the Government will be investing in a strengthened, community-based oral health service for young people. The new Community Oral Health Service will make oral health a more visible and integrated part of primary health care. Community dental services will be delivered by a range of providers, including District Health Boards, Māori and Pacific providers, primary health organisations and private dentists, and will draw on the skills of a wide range of health professionals.

To reinforce the Government's commitment to improving oral health services, the Ministry of Health has developed this strategic vision document. The document introduces readers to the new vision for oral health, and to the immediate steps needed to achieve this. It is intended to excite and inspire funders and planners, providers and communities as to the possibilities for improving oral health. It is also intended to spark debate.

This document is a beginning. Clive Wright, keynote speaker at the Oral Health Forum 2000, noted: 'if we do not have a vision of where we want to be, we have no idea of how to get there'. This document launches the vision. I look forward to your participation in this exciting period for oral health.



Hon Pete Hodgson
Minister of Health



Contents

Foreword	iii
Part I: The Strategic Vision for Oral Health	1
Why a Strategic Vision?	1
Defining Oral Health	2
Oral Health in New Zealand	2
The Oral Health Vision in Context.....	5
The Vision for Oral Health.....	7
Part II: Action Areas	9
Action Area 1: Re-orientate Child and Adolescent Oral Health Services	9
Action Area 2: Reduce Inequalities in Oral Health Outcomes and Access to Oral Health Services....	13
Action Area 3: Promote Oral Health	15
Action Area 4: Build Links with Primary Health Care	18
Action Area 5: Build the Oral Health Workforce	20
Action Area 6: Develop Oral Health Policy.....	24
Action Area 7: Research, Monitoring and Evaluation	27
Part III: The Way Forward.....	30
References.....	31
National Oral Health Steering Group	32

Part I: The Strategic Vision for Oral Health

Why a Strategic Vision?

The World Health Organization recognises oral health as an integral part of general health and a basic human right. The 2005 Liverpool Declaration called for countries to formulate policies for oral health as an essential part of their national health programmes. New Zealand supports this call for action.

Improving oral health is also one of the 13 health priorities specified in the New Zealand Health Strategy, and one of 12 priorities for Māori health. Yet, in recent times oral health policy has lacked a consistent direction. Oral health has also become disconnected from other health policy work.

This is about to change. The Government has now signalled a commitment to a major reinvestment in the oral health of young people. It is therefore timely to consider the overall strategic direction for oral health. This document sets out the strategic vision for oral health policy over the next 10 years. This vision is:

Good oral health for all, for life.

The vision is for high-quality oral health services that promote, improve, maintain and restore good oral health, and that are proactive in addressing the needs of those at greatest risk of poor oral health.

Realising this vision will require a significant re-orientation in the delivery of publicly funded oral health services. It will require a change in the way we understand oral health, and in the assumptions that underlie the delivery of oral health services. This document outlines the philosophy that underpins the new vision, and places oral health within the context of other health strategies, such as the Primary Health Care Strategy.

This document also outlines the seven key action areas that will be the focus of the Ministry's oral health policy work over the next 10 years. It explains the rationale for our initial focus on the oral health of young people, while also recognising the need for policy activity beyond this age group. It also highlights our overall objective of eliminating oral health inequalities.

Good Oral Health for All, for Life is a foundation. At this stage a strategic vision is preferable to a formal strategy so that the vision can evolve. This document aims to generate discussion around the future direction of oral health. Supporting documents will be produced at a later date providing more specific actions for realising the vision.

Defining Oral Health

Oral health is a difficult concept to define. The purely biological definition conceptualises oral health as the absence of disease – in particular, dental decay and periodontal disease. In contrast, the World Health Organization defines oral health as:

A natural, functional, acceptable dentition which enables an individual to eat, speak, and socialise without discomfort, pain or embarrassment, for a lifetime, and which contributes to general well being (WHO 1982).

This definition is more useful, because it highlights the physical, social, and psychological importance of oral health. The biological aspects of oral health require teeth to be maintained in their optimum state throughout an individual's life. However, the psychosocial aspects of oral health mean that the teeth and gums must look and function at a socially acceptable level if an individual is to thrive in society. The popularity of orthodontic treatment, cosmetic tooth whitening, and advancing rehabilitative dentistry illustrate how social constructs of oral health extend beyond the absence of oral disease. Embarrassment, pain, or self-consciousness resulting from missing, damaged, diseased or otherwise aesthetically unappealing teeth can have a profound impact on an individual's quality of life. Self-esteem, personal relationships and employment options can all be compromised by the real or perceived consequences of poor oral health.

Also, oral health conditions are caused by an interplay of social, behavioural, cultural and economic factors. Dental diseases have socio-behavioural risk factors in common with several other prominent non-communicable diseases, such as diabetes, cancer and cardiovascular disease. These common risk factors include socioeconomic deprivation, poor diet, tobacco use and age.

Hence, promoting oral health is not simply a matter of reducing caries levels. It is also about promoting the overall health of society and its individuals.

Promoting oral health is about promoting the health of society.

Oral Health in New Zealand

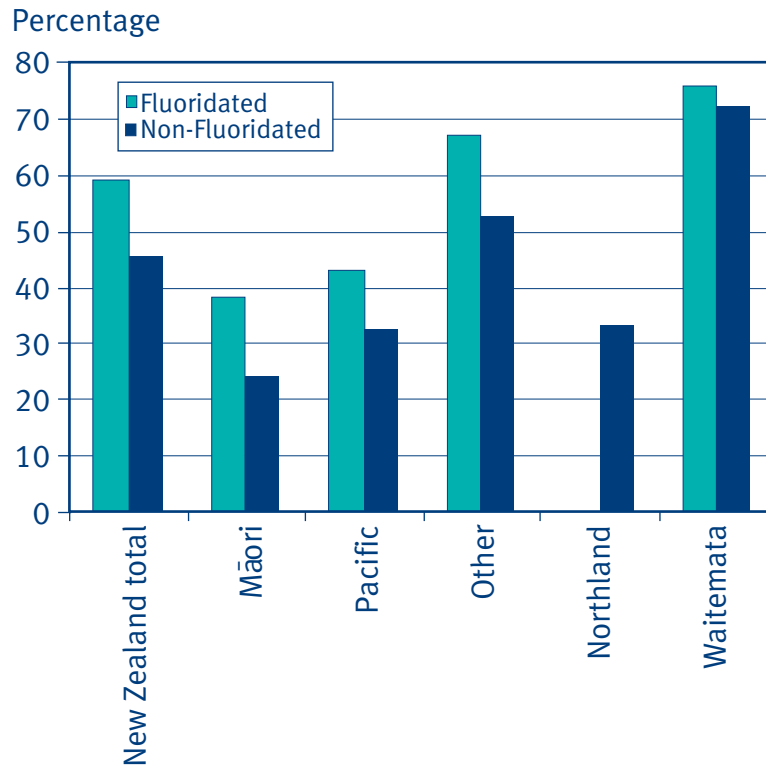
The oral health status of New Zealand is variable. The introduction of fluoride into toothpaste and some regional water supplies during the 1970s, combined with improving diagnostic technology, has seen the overall standard of oral health improve in the last 30 years. Advances in cosmetic dentistry and dental hygiene offer additional improvements for some people. People now have the opportunity to keep their natural teeth in better condition for longer. Declining rates of edentulousness add support to this.

Within this picture of health, however, there are disturbing trends in the patterns of child oral health. Dramatic declines in the prevalence and severity of child dental decay began to plateau in the mid-1990s, and have now begun to reverse. New Zealand's oral health statistics now compare unfavourably with similar countries, such as Australia and the United Kingdom.

Inequalities in oral health

Even more concerning is the pattern of inequalities that underlies child oral health statistics. The data shows that for many groups in New Zealand, the picture is less optimistic. In 2004, 52 percent of five-year-olds in New Zealand were caries free. However, as the chart below shows, this overall figure masks significant differences associated with ethnicity, region and water fluoridation status.

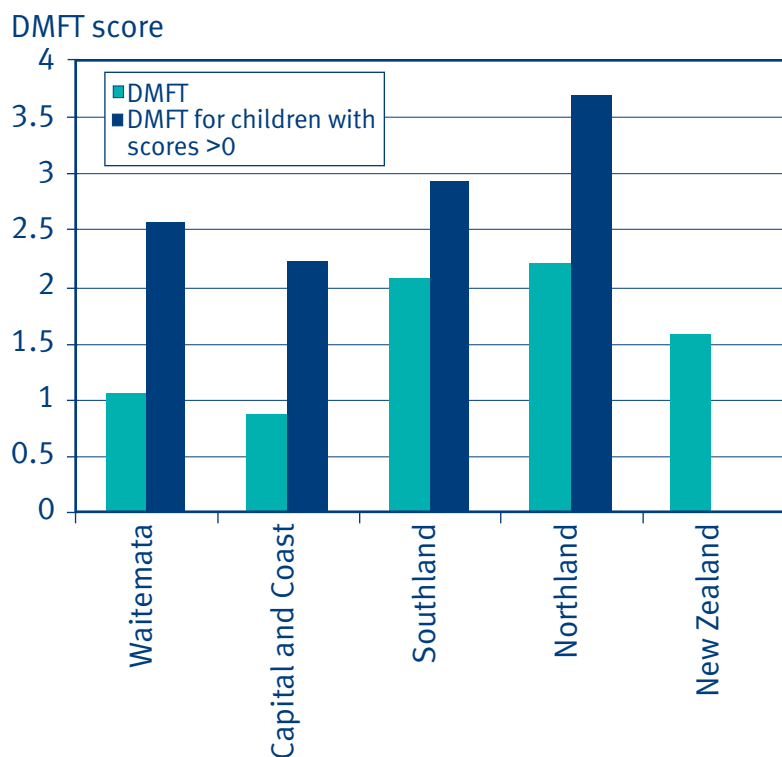
Figure 1: Percentage of children caries free at age five, 2004



Unfortunately, it appears that these inequalities – particularly between Māori and non-Māori – are worsening. Although oral health statistics have only been collected by ethnicity since 2002, a widening gap between the two groups is already becoming apparent.

The figures also mask the severity of disease faced by some groups. When children with a DMFT (decayed, missing and filled teeth) score of zero are removed from the overall pool, it becomes clear that there is a group of children for whom dental disease is severe. Figure 2 shows that even in regions with good oral health overall, there are pockets of children with disease at the level of regions traditionally characterised by poor oral health status. Indeed, in some areas the severity is at the level of developing or Eastern European countries.

Figure 2: Comparison of DMFT scores at year 8 in selected DHBS



Adolescent and adult oral health

The picture of oral health is less clear for adolescents and adults. The last National Oral Health Survey was conducted in 1988, when health services and dental technology were very different to what exist now. The change in child oral health statistics in the intervening period also suggests that much may have changed since this time. The oral health status of adolescents was not reported in the 1988 Survey.

What research has been undertaken suggests that inequalities in child oral health re-emerge following exit from school dental services. In particular, socioeconomic status and caries experience at age five are predictive of diseased or filled surfaces (DFS) and diseased surface (DS) scores at age 26. Research has also suggested that less than half of 26-year-olds are routine users of dental care. Individuals from groups most at risk of poor oral health are most likely to be irregular users of dental services.

There is little recent research on older adults or special needs groups in New Zealand. Predictive modelling has suggested declining edentulism and increasing decay rates among older (dentate) adults. However, there is no data on service utilisation by this group. Even less is known about the oral health and service experiences of patients with special needs, despite services for these patients being offered through the publicly funded oral health system.

Oral health
at age five
predicts oral
health at
age 26.

The Oral Health Vision in Context

The New Zealand Health Strategy provides an overarching framework for the health sector, and improving oral health is one of the 13 population health objectives identified in the Strategy. The strategic vision for oral health is guided by the principles of the New Zealand Health Strategy, the Primary Health Care Strategy, and the following population strategies:

- He Korowai Oranga: Māori Health Strategy
- Health of Older People Strategy
- New Zealand Disability Strategy
- Pacific Health and Disability Action Plan.

Other key documents that have influenced the vision are:

- *Reducing Inequalities in Health*
- *Healthy Eating – Healthy Action*
- *Improving Child Oral Health and Reducing Child Oral Health Inequalities*
- *The Recruitment and Retention of Dental Therapists*
- The Māori Child Oral Health and School Dental Service reviews.

The principles

The strategies listed above have informed the principles underpinning the new vision for oral health, as follows.

- Improving the oral health status of those currently disadvantaged is a priority – particularly Māori, Pacific peoples and other individuals from lower socioeconomic groups.
- Oral health is an integral part of general health and wellbeing throughout life.
- DHBs have the primary responsibility for ensuring high-quality oral health services are available.
- A strong preventive programme complements examination and treatment services.
- A robust and appropriately trained workforce provides a high-quality service.
- Evidence-based oral health services require comprehensive information collection and ongoing research.

Oral health and primary health care

A strong primary health care system is central to improving the health of New Zealanders and tackling inequalities. An effective primary health care system extends beyond curative care to offer services that promote, maintain, and restore health. Primary health care involves:

- early intervention and prevention for people at risk of poor health
- health promotion initiatives to assist people and communities to maintain and enhance their own wellbeing
- restorative services for people with health problems
- planning and monitoring actions to maintain and improve health outcomes.

Primary health care is the first level of contact that individuals, families and communities have with health services. Primary health services are community-based so that they are accessible to those in most need. 'Community-based' means that care can be delivered in a range of traditional and non-traditional settings, such as local health services, schools, marae, work places, community organisations and recreational venues.

Oral health care, particularly for young people, fits naturally into this framework. Community-based oral health services will promote, maintain and restore good oral health for young New Zealanders, and have the potential to extend their services to other groups at risk of poor oral health. These community-based oral health services should be considered a part of primary health care. For many young people, community dental services will be the first point of contact with oral health care.

Community-based oral health services will promote, maintain and restore oral health.

Oral health and young people

Oral health services for young people are the cornerstone of publicly funded oral health services in New Zealand. This is because promoting good oral health in young people has benefits over a lifetime. High levels of dental caries in childhood predict greater oral health disease levels in adulthood, even when other factors are controlled for.

The life-course approach offers an explanation for this. This approach argues that throughout life, adverse health episodes, environmental exposures and individual behaviours gradually accumulate to increase the risk of chronic disease and mortality. Biological events (eg, dental caries) and social experiences (eg, access to services) are particularly important in mediating disease risk.

The life-course approach is particularly relevant as we consider approaches to reduce inequalities. Research has shown that social differences in access to and uptake of oral health care in children under age five are associated with differences in caries levels in adulthood. Hence, by addressing inequalities in access to services for young children, we can positively influence their oral health status in later life.

Promoting good oral health in young people has lifetime benefits.

The Vision for Oral Health

The Ministry's vision is:

Good oral health for all, for life.

Over the next 10 years the Ministry will work with DHBs and other providers of oral health services towards:

- an environment that promotes good oral health
- oral health services that promote, improve, maintain and restore oral health throughout the life course
- publicly funded services that are accessible, appropriate, and proactively address the needs of those at greatest risk for poor oral health
- publicly funded oral health services that are part of the community.

This vision differs from current arrangements in the following ways.

Table 1: A comparison of current and future approaches

Now	Future
An emphasis on treatment	An emphasis on prevention and early intervention.
A division between oral health and general health	Oral health is integrated into general health frameworks.
DHBs provide services	There is a mix of service providers, including DHBs, PHOs, Māori and Pacific providers and non-governmental organisations (NGOs).
School-based dental services for children	Community-based dental services for children, with the potential to expand to adolescents and low-income adults.
Separate funding for child and adolescent oral health services	Funding that allows flexibility of service programme design.
An emphasis on primary school years	An emphasis on preschool and early primary school years.
Clinicians work in isolation	A team-based approach to oral health – dentists, dental therapists and dental assistants work together.
A small Māori and Pacific oral health workforce	A workforce more representative of ethnic diversity of New Zealand.
Pressure on secondary services	Greater capability at the primary care level, with secondary services focused on patients who cannot be managed by primary care.

Priority groups

Four key groups are the focus of the oral health vision:

- children and adolescents
- people of all ages with physical, intellectual, behavioural, or cognitive disabilities, or who are medically compromised
- people experiencing inequalities in outcome (eg, Māori, Pacific and low-income populations)
- older adults.

Action areas

There are seven key action areas through which the Ministry will work towards realising the vision:

- re-orientate child and adolescent oral health services
- reduce inequalities in oral health outcomes and access to oral health services
- promote oral health
- build links with primary care
- build the oral health workforce
- develop oral health policy
- research, monitoring, and evaluation.

Delivering the vision will require the skills and input of the Ministry of Health, DHBs, NGO oral health providers, the oral health workforce, the primary health care sector, and the community.

Part II: Action Areas

Action Area 1: Re-orientate Child and Adolescent Oral Health Services

The initial action to realise the new oral health vision is to re-orientate child and adolescent oral health services. As discussed earlier, improving oral health in childhood sets up individuals for good oral health later in life.¹

In 2005, the Government articulated a vision for child and adolescent oral health services. The vision was for a ‘community-based’ service providing ‘seamless’ care for young people from birth to 18 years of age. The service will also:

- treat health problems at an early stage of development
- emphasise illness prevention and promotion
- empower communities to participate in decisions about their oral health
- involve intersectoral collaboration, where possible
- have particular consideration for the needs of groups with inequitable oral health outcomes or access to services
- have a strong focus on maintaining good oral health in early childhood.

This vision supports the Government’s plans for a health sector characterised by strong primary care services.

Seamless services

A seamless service means that traditional distinctions between preschool, school and adolescent dental services will no longer exist. DHBs will have the flexibility to develop service models that best meet the needs of their individual communities. Planners will be encouraged to take a primary care approach to designing and funding oral health services, and to be innovative.

A seamless service does not necessarily mean a single clinical service providing care for all age groups. Rather, seamless care means ensuring young people have access to all the elements of primary oral health care, whether this is through Well Child services, school dental clinics, Māori or Pacific health providers, private dental practitioners, health promoters and educators, or primary health organisations (PHOs).

In some areas this may mean very little change. Services for children may continue to be delivered at school-based clinics while adolescent care may be provided by dentists contracted under the Adolescent and Special Dental Services Agreement. In other areas, services may look very different. Oral health services provided by Māori providers in Hawke’s Bay, or by PHOs in Waikato, are examples of models that are already breaking the traditional mould.

¹ This section introduces the philosophy of the underlying changes to child and adolescent oral health services, but should be read in conjunction with the other action areas.

Seamless care means access to all elements of primary oral health care.

The focus on preschool oral health

The Oral Health Toolkit recommends that children from Māori, Pacific and new migrant backgrounds, or children living in low decile areas, be enrolled in the School Dental Service at age one. Children in other groups should be enrolled before their third birthday. Unfortunately, enrolment data suggests that enrolment levels for children under five are less than 60 percent. In some areas this is much lower.

Outcomes in this age group are also not reassuring. In some areas of New Zealand, caries-free rates in children at age five are less than 35 percent. This is unacceptable given what we know about the link between early caries experience and oral health later in life. Clearly, intervention is occurring too late.

A fundamental part of increasing the preventive focus for oral health is improving outcomes for preschoolers. For this reason, the new vision encourages oral health activities to start at birth. The best way to achieve this is through greater linkages with providers of primary care. Oral health contacts with infants do not necessarily have to be conducted by oral health specialists, but could be performed by Well Child providers, practice nurses, Plunket, Māori or Pacific providers, or other services offering health care to caregivers and infants. The 15-month immunisation contact is an ideal opportunity to engage new parents in oral health. Anticipatory guidance on oral health issues and oral hygiene education should be provided to parents and whānau as a standard part of such contacts. Enrolment in community dental services could also be facilitated in this way.

Increasing the focus on preschool oral health is a key objective in re-orientating oral health services for young people. All DHBs will be required to demonstrate a strong commitment to preschool oral health, for both initial funding and ongoing monitoring purposes.

Community oral health services

The most visible element of re-orientated services will be the Community Oral Health Service (COHS), which will replace the School Dental Service, to reflect the greater role services will have for children, and potentially adolescents outside of the primary school age range. Community oral health services will also be a more recognisable part of the community than traditional school dental clinics.

Community oral health services will be delivered from a wide range of facilities, including:

- stand-alone community-based clinics in metropolitan or rural areas
- community-based clinics co-located with a school, community health centre or other multi-purpose community-based centre
- mobile units in an outreach location made available for dental care
- hospital-based units.

Children from birth to year 8 will continue to be the primary focus for care at community oral health services. However, depending on how DHBs choose to develop their service models, providers may also care for adolescents.

Fundamental is improving outcomes for preschoolers.

COHSs will be a recognisable part of the community.

In some locations the community dental clinic will be the base for outreach health promotion and community link services offered by the COHS itself, or by other health providers.

Treatment hubs could offer greater access to specialist care.

The COHS will continue to be publicly funded, but will not always be delivered by DHBs. Where appropriate, DHBs may consider utilising private dental practice providers, or investing in community-based facilities with other primary health care providers (eg, PHOs, or Māori or Pacific health providers). These options will be particularly attractive where a more community-appropriate provider is likely to achieve better oral health outcomes, where a traditional-style facility would be less productive, or where access to an appropriate workforce or service coverage would be better achieved in conjunction with another provider. For example, multidisciplinary treatment hubs could offer patients greater access to care beyond the scope of dental therapists, or additional specialist services, such as paediatric dentistry and orthodontics.

Continuity of care

Moving towards a community-based model of oral health care provides the opportunity for services to develop capabilities at the primary care level. Community-based oral health services will be delivered from a variety of facilities that fall into different levels on a hierarchy of care.² New guidelines for role delineation define four levels of service for oral health care and encourage more complex treatments to be performed at community sites. For example, Level Three services will provide examination and treatment services with the option of sedation services for patients with mild systemic disease.

Services with access to an on-site dentist, assisted by dental therapists and dental assistants, will allow the bulk of care for most young people to be delivered within the community. It will also reduce reliance on adolescent and special dental service contracting.

Level Four facilities, which include access to facilities for surgery under general anaesthesia, will continue to be delivered from hospital or specialist sites. However, increased capability at the community level will decrease the pressure on secondary-level services, leaving the latter to focus on more complex cases and patients (such as those with special needs, or who are medically compromised).

Reviewing programme design

Re-orientating child and adolescent oral health services goes beyond making changes to facility configurations and making linkages with other health providers. Meeting the new vision requires a fundamental shift in the way oral health care is delivered. Given the challenges evident in child oral health status, it is clear that a review of the assumptions on which oral health care is delivered is not only overdue, but is also vital if oral health outcomes are to be improved.

The new vision requires a shift in delivery of care.

² Detailed discussion of levels of care and the implications for service planning are available in the *Community Oral Health Facility Guidelines*.

The Ministry does not have all the answers. For this reason, a series of intersectoral advisory groups will be convened to review current guidelines, programmes and assumptions, evaluate current literature, and consider alternative models. The groups will either update current guidelines or identify directions for future research and policy work.

Initial issues that will be addressed include:

- age of first clinical contact
- recall timeframes
- intervention in mid- to late primary dentition
- preschool programmes
- prevention and oral health promotion.

Actions

To support the re-orientation of child and adolescent oral health services, the Ministry of Health will:

- obtain and roll out additional funding for child and adolescent oral health services
- support DHBs to develop business cases for re-orientated child and adolescent oral health services
- convene an Oral Health Steering Group to provide strategic leadership
- review, in collaboration with sector groups, service models and clinical guidelines.

DHBs will be expected to:

- plan and fund child and adolescent oral health services that meet the vision expressed in this document
- ensure that preschool programmes and services that target inequalities are the first priority for funding
- support Māori and Pacific providers to develop oral health solutions that meet the needs of these populations
- describe their progress and challenges in re-orientating child and adolescent oral health services as part of annual planning
- explore potential linkages for oral health services with primary care.

Action Area 2:

Reduce Inequalities in Oral Health Outcomes and Access to Oral Health Services

Inequalities in oral health arise from a variety of factors, including socioeconomic differences, poor nutrition, lack of access to water fluoridation and/or oral health services, and attitudes to oral health.

Re-orientating child and adolescent oral health services will play an important role in reducing inequalities in oral health outcomes. We know inequalities in child oral health exist, and we know that these are associated with inequalities in oral health in adulthood. It is reasonable, therefore, to expect that by reducing inequalities for children and young people, we can reduce the risk of oral disease and lessen the psychosocial impact of poor oral health on adults.

Some groups will require particular attention. Māori and Pacific oral health lags behind that of other population groups, for reasons that go beyond socioeconomic differences. Improving the oral health of these groups is a particular priority in realising the oral health vision. The Primary Health Care Strategy suggests that improvements for Māori will be achieved through Māori provider development as well as by improving the delivery of mainstream services for this group.

Māori provider development

Māori providers currently deliver contracts addressing oral health at all levels. Tamariki Ora nurses promote enrolment and attendance through stand-alone oral health educator and Adolescent Oral Health contracts, while community clinics often provide treatment services to tamariki and rangatahi, as well as to low-income adults.

The whānau ora approach is well suited to the oral health vision.

The Māori Child Oral Health Review found that many Māori providers of oral health services take a whānau ora approach to health care. The review reported that it is the kaupapa of these providers to treat any member of the whānau who needs to be seen. In this way, the whānau ora approach is well suited to the vision of community-based services and life-long oral health. Strengthening the link between Māori providers and other providers of general and oral health services will be key in delivering a seamless oral health service. DHBs should continue to contract with Māori providers and explore ways in which providers can develop their services for oral health.

DHBs will also be required to demonstrate the steps their own services are taking to ensure services meet the needs of the Māori population.

Pacific oral health

Pacific oral health status varies, but commonly lies between that of Māori and that of other groups.

Pacific providers are still a very small part of oral health services. However, active involvement of Pacific communities is necessary to ensure services are accessible to, and appropriate for, the people in this community.

A major impediment to the development of Pacific oral health services is the lack of a trained Pacific oral health workforce. The *Pacific Health and Disability Workforce Development Plan* recommended that a strategy be developed to increase the recruitment of Pacific dental therapists. However, given the team approach to delivering oral health that underlies the new vision, it is likely that a broader approach will be required. We need to develop strategies that will support the recruitment of Pacific people at all levels of the oral health workforce, including dentists, dental assistants and health promoters.

Water fluoridation

The most dramatic and consistent inequalities in oral health status are those between children in fluoridated and non-fluoridated areas. Key to supporting an environment that supports good oral health is promoting the use of fluoride. The Ministry's current policy recommends water fluoridation at 0.7 to 1.0 milligrams per litre of drinking water.

At a population level it is estimated that water fluoridation prevents between 58,000 and 267,000 decayed, missing, or filled teeth (DMFT) in New Zealand every year. The benefits are most pronounced for those most at risk of poor oral health. Unfortunately, there is a large proportion of New Zealand that continues to go unfluoridated. This contributes to the inequalities evident between some regions and some ethnic groups (a large proportion of the unfluoridated population are Māori).

Decisions on water fluoridation are currently the responsibility of local governments. However, reports suggest there is some community and local government support for a more direct role by the health sector in decision-making, and the Ministry would like to explore this further. In the meantime, DHBs are expected to continue to support and promote water fluoridation in their regions, wherever feasible.

Water
fluoridation
is key for oral
health.

Actions

- DHBs will be required to identify disadvantaged groups in their populations and to demonstrate that appropriate strategies are in place to address the oral health needs of those groups.
- DHBs will be encouraged to contract with Māori and Pacific providers delivering oral health services.
- Pacific communities will be encouraged to provide oral health services where that will meet the needs of their populations.
- Research into Pacific oral health issues should be encouraged, particularly where this relates to building the Pacific oral health workforce.
- DHBs should continue to support and promote water fluoridation in their regions wherever feasible.
- The Ministry will explore alternative decision-making responsibilities for water fluoridation.

Action Area 3: Promote Oral Health

Treatment services will be complemented by a strong promotion programme.

Good oral health is achieved through a combination of optimal biological, social, behavioural, environmental and economic factors. Restoring oral health through treatment is only one part of achieving good oral health. Improving and maintaining oral health through prevention and promotion is a more effective way to achieve good oral health in the long term. By becoming more proactive in promoting oral health, particularly in childhood, we can expect benefits across the life course as healthy environments and behaviours early in life decrease the risk of disease in later years.

A fundamental principle underlying the vision for oral health is that examination and treatment services will be complemented by a strong preventive and promotion programme. Re-orientating health services from a curative and clinical focus is also one of five key areas for action identified by the Ottawa Charter for Health Promotion (1986). A preventive-based approach will allow oral health services to address the range of factors that contribute to oral health, rather than focusing on the physical outcomes of oral diseases.

Oral health can be promoted at several levels, as follows.

Promoting a healthy environment

Oral health begins with a healthy environment. Factors that contribute to a healthy environment for oral health include fluoridated water, a healthy diet and smoke-free surroundings. Although individuals have some control over these factors, there are often underlying barriers that prevent individuals – particularly those most disadvantaged – from accessing a healthy environment. Social, cultural and political change is often necessary to achieve long-lasting environmental change. As a result, healthy environments need to be promoted at the population, and usually the governmental, level.

Healthy environments need to be promoted at the population level.

One strategy that is vital for promoting a healthy environment for oral health is the expansion of water fluoridation. This was discussed in the previous section, but it is worth re-emphasising that the Ministry strongly advocates fluoridation of reticulated water supplies as a way to promote the oral health of both children and adults. This is supported by international research. The Ministry is committed to improving oral health through water fluoridation wherever feasible. This may require change at a political level.

Promoting a healthy environment for oral health will also involve actions not solely directed at oral health. An environment that supports oral health is often the same as one that supports general health and wellbeing. Population-level health promotion actions with shared objectives to oral health should ensure that oral health messages are included in these activities. Actions to reduce diabetes, cardiovascular disease and cancer risk at the population level are particularly relevant for oral health. For example, *Healthy Eating – Healthy Action, Let's Beat Diabetes*, and smoke-free campaigns promote many of the same outcomes that will create an environment that supports oral health.

Promoting healthy behaviour

In addition to a healthy environment, behaviours that promote oral health should also be encouraged. Many actions that improve or maintain good oral health can be performed by individuals themselves. Intuitively, this implies that education and information will be critical for teaching healthy behaviours. However, there is still debate about how this can be successfully achieved. Many preventive and educative approaches have not only failed to produce long-term behaviour change, but have increased rather than decreased inequalities.³ Other programmes have anecdotal support but have yet to be systematically evaluated.

Good oral health behaviours must be promoted.

One initiative that has produced encouraging results is the ABCD programme, developed in the United States. The programme emphasises preventive care and a conservative approach to treatment, and has been successful in increasing access, prevention and dental services for high-risk children. Reports indicate that improvements in the oral health of participants remain evident up to four years later.

Although programmes promoting healthy behaviour should continue to be developed locally, evaluation and local piloting of international programmes, such as ABCD, may be a useful starting point for establishing evidence based oral health promotion programmes in New Zealand.

Oranga niho: promoting oral health for Māori

Promoting oral health for Māori is a priority in the oral health vision. Māori are over-represented in low socioeconomic and non-fluoridated populations – both risk factors for poor oral health. Actions that address Māori oral health are therefore a priority for publicly funded oral health services.

At the population level, ensuring Māori have access to fluoride – either through water supplies or topical fluorides – is crucial. At the more basic level, programmes need to be designed and delivered in ways that are relevant to Māori. The number of Māori-specific programmes, such as fluoride toothpaste brushing in kōhanga reo, is increasing. However, as with other programmes, systematic evaluation of the impacts of these initiatives on oral health status is important for the future.

Development of the Māori health workforce is also critical to ensuring programmes are delivered appropriately. DHBs should continue to contract with Tamariki Ora nurses, who play an important role in educating tamariki and whānau about oral health.

³ For a summary of recent evidence see Watt 2005.

Actions

- The Ministry will continue to advocate water fluoridation at all levels.
- The Ministry will consider ways to include oral health in general health promotion strategies that address similar risk factors, and will encourage DHBs to do the same.
- An advisory group will be established to review current evidence for health promotion programmes, and inform directions on specific oral health actions.
- The Ministry and DHBs will ensure that activities and resources to promote oral health are culturally appropriate (eg, resources should be available in a range of languages, and interventions delivered in relevant settings).
- The scope of the National Oral Health Promotion Co-ordinator will be expanded to provide national leadership on oral health promotion issues.
- Māori providers will be encouraged to develop and deliver evidence-based programmes that promote good oral health and behaviours.
- DHBs and providers will be encouraged to collaborate at the regional and national level to share programmes and resources that successfully promote oral health.

Action Area 4: Build Links with Primary Health Care

Primary health care services are services that improve, maintain and restore people's health. They are the first level of contact that individuals, families and communities have with health services. Traditionally, primary health care has been considered the sphere of the general 'medical' professions – particularly general practice and nursing. Oral health care has sat outside this.

Since the launch of the Primary Health Care Strategy, the primary health care environment in New Zealand has been changing. The Strategy recognised that previous isolated ways of working need to be replaced by new collaborative models, and that a broader approach to primary health care can contribute to reducing health inequalities and improving outcomes. The Strategy also argued that co-ordination of care between different services is important for a comprehensive disease prevention and management approach.

The development of the primary health sector is timely for the re-orientation of oral health services. The vision for publicly funded oral health care is for services that are accessible and appropriate for those at greatest risk for poor oral health. Key to realising this vision will be building links between the primary-level oral health sector and primary health care services. Primary health organisations (PHOs) are ideally positioned to promote oral health to their enrolled populations and wider communities. Three possible ways this can be achieved are:

- directly providing oral health services
- partnering with DHBs and/or private dental practitioners
- equipping PHO practitioners with the knowledge and resources to support prevention and early intervention for oral health.

PHOs are ideally positioned to promote oral health.

PHOs as providers of oral health services

The new vision sees oral health integrated into general health frameworks. It also sees publicly funded oral health services provided by a mix of providers, rather than just DHBs. PHOs, as key co-ordinators and providers of primary health care, should be encouraged and supported to develop oral health services – particularly where this will meet a certain population need, such as youth, Māori, Pacific or low-income adult oral health.

PHOs are particularly well positioned to provide services for populations most at risk of poor oral health. Services to Improve Access (SIA) funding is specifically aimed at reducing inequalities among populations with the worst health status. PHOs serving a population where more than 50 percent fall into deciles 9 and 10 of the New Zealand Deprivation Index can access this funding. PHOs are encouraged to develop and implement initiatives that will address oral health inequalities for these groups.

Collaborative or joint ventures should be supported.

PHO partnerships with DHBs and private dental practitioners

There are obvious benefits to be gained from PHOs, DHBs and private practitioners partnering to deliver oral health services. Collaborative ventures can offer patients easier access to a greater range of services, or reduce pressures on publicly funded oral health care. Joint initiatives should be supported where they are feasible, and where they will improve the quality of, or access to, oral health services for the priority groups.

Support for non-oral health practitioners

Integrating oral health into general health frameworks will require support and education for non-oral health practitioners, particularly those most frequently in contact with high-need groups. In many cases, primary health care practitioners will be best placed to identify individuals at high risk of developing poor oral health, or to refer an individual with pain or signs of oral disease on to a dental professional. This is particularly important for groups who might be otherwise reluctant to seek oral health care, such as adolescents, adults, or the whānau of very young children.

To support primary health care professionals to identify at-risk individuals and make appropriate referrals, PHOs should ensure that programmes such as Lift the Lip are widely available, and that professionals are encouraged to use them. As co-ordinators of primary health care, PHOs should also ensure that links are built between oral health and non-oral health practitioners in their region so that appropriate referral pathways are known and utilised.

Actions

- The Ministry of Health will develop a policy framework to encourage more explicit links between primary health care and oral health services.
- In planning oral health services, DHBs should consider the capacity and potential for development of the PHOs in their region.
- PHOs should consider:
 - how services in their region can contribute to meeting the oral health vision
 - purchasing resources, and training non-oral health primary care practitioners in prevention and early intervention practices (eg, Lift the Lip)
 - developing local initiatives that bring together ‘traditional’ primary health care practitioners and community oral health professionals
 - joint investment in oral health facilities with other providers
 - utilising Services to Improve Access (SIA) funding to fund initiatives aimed at reducing inequalities among populations with the worst oral health status.
- Regional Adolescent Co-ordination Services should work with PHOs to promote good oral health for adolescents.

Action Area 5: Build the Oral Health Workforce

The new vision for oral health has significant implications for the oral health workforce. The current workforce is very segmented, with strong historical distinctions between public and private dentistry, and between the dentistry, dental therapy and dental hygiene disciplines.

Future oral health services will overcome these distinctions. The vision for community oral health services is for a more team-based approach to delivering oral health care. Dentists, dental therapists, dental hygienists and dental assistants will work together, within their individual scopes of practice, to enable greater continuity of care and more seamless delivery of services. Specialisation in public health dentistry will also be encouraged, so that an appropriately skilled workforce is available to work in the community and at the strategic level, planning, monitoring and evaluating the increasingly diverse delivery of dental services.

Building the workforce will take time. Some disciplines, specialties and regions have an oral health workforce that is less than plentiful. Māori and Pacific oral health professionals are in particularly short supply. In addition, community oral health continues to face the challenges of recruiting and retaining staff given the financial opportunities offered in the private sector.

However, by re-orientating publicly funded oral health care to the new vision and ensuring facilities meet the expectations of modern dentistry, it is expected that future community and public oral health will present opportunities and incentives of their own to new and existing oral health professionals.

Public health dentists at the strategic level

Different regions have different oral health needs. Promoting oral health at the regional level also requires pulling many strands of health care together. Delivering community dental services, promoting oral health in public health activities, contributing to PHO planning, advocating for water fluoridation, and maintaining relationships with the private sector are just a few of the activities required at the DHB level to effectively deliver oral health care to their populations. Realising the new vision will add to these requirements.

Strategic-level thinking on oral health issues has not always been a high priority at the DHB level. Lack of expertise or appropriate professional leaders who can bridge the gaps between funders and planners, the provider arms, and clinicians at the hospital and community level has no doubt contributed to this. However, the new vision for oral health will need to be supported by high-quality expert strategic planning by DHBs.

One way to achieve this is by engaging regionally focused dental public health specialists in lead DHBs to provide strategic oversight for oral health services, and to work with the strategic, planning and funding sections of each DHB on oral health issues.

The vision
needs support
from strategic
planners.

Dental therapists will be the core COHS workforce.

Dental therapists

The Ministry of Health continues to support the implementation of the recommendations of the Dental Therapy Technical Advisory Group (2004). It is anticipated that upgrades to Community Dental Service facilities, increases in training places, and the resolution of salary negotiations will address many of the remaining recommendations. However, the dental therapy workforce is still underdeveloped and there are shortages of therapists in some areas. DHBs with shortages, or difficulty meeting appropriate recall timeframes due to staffing shortages, will be expected to demonstrate strategies to increase the recruitment of therapists in their region.

Dental therapists will continue to be the core clinical workforce in community oral health services, and in other services providing oral health care to children up to the age of 18. Opportunities for dental therapists and hygienists in hospital dental services should also be explored. Both dental therapists and hygienists have the potential to make a valuable contribution to care for individuals with special needs, or who are medically compromised. Offering such opportunities will increase the diversity of clinical experiences available to dental therapists.

Dental assistants

A team approach to delivering oral health care increases the importance of including dental assistants in the clinical team. Greater use of dental assistants will free up dental therapists for more clinical activity, as well as providing the clinical benefits associated with ‘four-handed dentistry’.

Dental assistants are critical to the oral health team.

Community dental services will be required to ensure a dental assistant is available to support each therapist. The Ministry of Health will work with sector groups to determine appropriate recommended assistant-to-therapist ratios and models of care.

Dental assistants can also play an active promotion and prevention role, although the size, location and needs of the community will influence this.

General dentists

General dentists are a critical part of the oral health care team. They not only provide oral health care for adults, but also deliver the bulk of adolescent oral services, as well as special dental services for children. General dentists work in both the public and private sectors.

Community dentists will enhance service capabilities.

The vision for community-based, seamlessly delivered oral health care increases the need for appropriately trained general dentists to work at the community level. These ‘community dentists’ will add to the capabilities of community-based dental services by providing an on-site resource for more complex cases and special dental services. This will reduce the number of patients referred by dental therapists, or who require treatment under general anaesthetic or sedation. Increasing the capabilities of clinicians at the primary care level has the added benefit of reducing pressure on secondary services.

Continuity of care for adolescents is a particular concern in realising the new vision. Previously, differences in funding models have meant that private practice adolescent care has been detached from School Dental Service care, creating an artificial transition between ‘child’ and ‘adolescent’ oral health services. Community-based oral health services that include general dentists will reduce DHBs’ reliance on the adolescent contract, and will make the transition to adolescent (and subsequently adult) oral health care more seamless.

Similarly, community-based oral health services that include general dentists have the capability to extend their services to adult and older adult patients. Community dentists are already successfully utilised in this way by services taking a whānau ora approach to health care. Engaging a dentist allows all whānau to be treated at the same facility.

However, not all oral health services can or should be publicly funded. It is important to note that private dentists also have a role to play in realising the new vision. In addition to providing adult dentistry for the majority of the New Zealand population, private practitioners may also be an alternative source of child oral health facilities. Private practitioners in some areas have expressed an interest in investing in community dental facilities jointly with a DHB or other health provider. The Ministry of Health encourages DHBs, PHOs and other non-profit providers to explore these options where they provide value for money and effectively meet the needs of the community.

Private dentists also have a role to play.

Hospital and specialist dentists

Increasing the capability of community-level oral health facilities does not lessen the need for appropriately trained dentists in hospital dental services. However, in the future secondary services will return to their intended focus of delivering specialist oral health care for patients with complex needs – rather than also performing treatment that could be delivered in the community.

Within this vision is a specific objective of developing the workforce trained to work with special needs or medically compromised patients. The extent of services currently provided to these patients by hospital dental departments varies. However, in the future the Ministry expects that all DHBs will have access to oral health services that meet the needs of these groups. The availability of dentists appropriately trained to manage the needs of these patients is one factor influencing this. Paediatric Dentists and Special Needs Dentists will be particularly important in ensuring appropriate specialist oral health care is available.

To achieve this, joint work by the Ministry, the School of Dentistry and DHBs is needed to address the challenges faced by hospital dental departments in attracting and retaining dentists with this level of training and expertise.

Actions

DHBs and non-DHB providers of oral health services will:

- promote a team approach to service delivery, including dental therapists, general dentists and dental assistants, wherever feasible
- consider ways that general dentists can be employed and better utilised at the community level to promote continuity of care and reduce pressure on secondary dental services.

DHBs will consider:

- engaging approximately four to six regional specialists in dental public health to provide strategic oversight for oral health
- ways of re-focusing hospital dental services onto care for special needs and medically compromised patients, and other complex cases
- ways to better utilise dental therapists and dental hygienists in delivering oral health care to special needs and medically compromised patients
- the links between this vision for oral health and *Future Workforce*.

The Ministry of Health will:

- work with the sector on dental therapist to assistant ratios and models of care
- monitor the impact of the dental therapy / dental hygiene qualification on recruitment of dental therapists in the public sector
- facilitate joint work on attracting and retaining dentists with particular specialisations into hospital dental services
- work with the education sector to ensure the training and education needs of oral health professionals are articulated.

Action Area 6: Develop Oral Health Policy

Our vision is for good oral health for all, for life. Promoting good oral health for young people is the first step to achieving this, but it is not the only step. The vision also has implications beyond this. The four priority groups identified earlier as the key focuses of the oral health vision include low-income adults, older adults, and special needs and medically compromised patients. There has been very little policy work on these groups to date. Clearly, future policy work will be required if we are to achieve our vision.

Future policy work is required for the vision.

People with special needs, disabilities, or who are medically compromised

Earlier in this document we discussed the need to build the capacity of the workforce trained to manage patients with special needs or who are medically compromised. However, this is only one challenge in ensuring oral health services are available and appropriate to the wide range of individuals with special needs, or disabilities, or who are medically compromised. Strengthening services for these groups will need to address a broader range of issues. A review of these services is therefore a priority for the Ministry of Health following the completion of child and adolescent work.

The scope of such a review will be agreed with DHBs closer to the time, but an initial list of issues that may be considered includes:

- appropriate definitions of the distinct groups within this category
- oral health services available for these groups, and the current level of utilisation
- funding for different types of care (eg, comprehensive, basic or emergency care)
- continuity of care
- the responsibilities of DHBs, residential homes and individuals in terms of funding and delivering oral health care
- disability awareness amongst health providers
- availability and accessibility of oral health information for adults with disabilities.

A core element of any review will be consideration of oral health service delivery for patients with cleft lip and palate or other craniofacial abnormalities. In particular, the funding package and scope of oral health care for these patients should be given attention, with particular consideration of funding for prosthodontic interventions.

The outcomes of any review will obviously have significant implications for DHBs and hospital dental services. The Ministry anticipates working closely with sector groups in planning and undertaking a review of this nature.

Low-income adults

Any review of hospital dental services will also necessitate an examination of services for low-income adults. Although data on adult oral health is limited, we have strong reason to suspect that inequalities in oral health status are also evident in adulthood – particularly among those groups with poor oral health in childhood. The vision for oral health has a particular focus on groups subject to inequalities. We therefore need to ensure that an appropriate level of service is available to adults who may not otherwise be able to access oral health care.

Future policy work will focus on the scope of care that can or should be publicly funded, as well as the appropriate location and environment for services for lower-income adults. Ideally, over time community-based facilities will develop the capability to provide services to this group. In some areas this may begin to be realised as child and adolescent services are re-orientated, NGO providers are developed, and greater links are built with primary care services.

A fundamental question remains, however, about the scope of care that can or should be publicly funded. Future policy work will focus on this question, as well as the appropriate location and environment for low-income adult services. Further consideration will also be given to ways of promoting adult oral health that are outside of the clinical environment. This work will have implications for primary and secondary-level services, and will also require cross-agency input (for example, from the Ministry of Social Development).

Older adults

As the population of New Zealand ages, the health issues that face older adults become more pressing in planning for health services. International research and predictive modelling conducted locally suggest that older adults of the future will have very different oral health needs to previous generations. They will also have different expectations for their oral health, and for the services that are provided to care for them.

However, older adults are a heterogeneous group, and no one policy direction will be satisfactory or appropriate for all individuals of this age. Policy work will therefore examine the needs of four groups:

- independent older adults
- moderately dependent older adults
- highly dependent older adults
- older adults from groups experiencing particular inequalities (both independently and as part of the other three groups).

Policy work will focus on the responsibilities that individuals, the public and private sectors (including the health and aged care sectors) have in promoting oral health for each of these groups, and the implications this has for funding services.

This work will have implications for both the primary and secondary care level of services.

Actions

- The Ministry of Health will plan its future oral health work programme around these policy areas.

Action Area 7: Research, Monitoring and Evaluation

The vision for oral health is based on the evidence and research that are currently available. However, there is limited New Zealand-specific research, and so gaps remain in our knowledge of the oral health needs of many groups in the population. Significant questions need to be answered before firm policy directions or implementation actions can be set. Procedures for monitoring and reviewing progress in realising the vision also need to be established.

For these reasons, this document is a work in progress. The vision for oral health will evolve based on the outcomes of future research and the success we have in realising the objectives of the seven key action areas.

Monitoring and reviewing the re-orientation of child and adolescent services

Re-orientating child and adolescent services is fundamental to realising the long-term vision for oral health. Already the Government has committed significant new investment to this initiative. As a result, the Ministry will be developing a framework for monitoring the uptake and outcomes of the re-orientation by the health sector. Monitoring and review processes will include specific consideration of the efforts to reduce inequalities, particularly in terms of access to services.

New funding to support the re-orientation will be rolled out over five years. There will be a phased approach to monitoring and reviewing DHBs' progress during this time. In the first two years, the focus for reporting will be on:

- programme re-orientation and design – particularly preschool oral health initiatives
- commitments in annual plans to realising the vision, and approval of business cases for re-orientated oral health services
- links with primary care
- actions specifically directed towards reducing inequalities.

In 2007/08 the Ministry will begin requiring additional oral health measures of DHB performance through the indicators of DHB performance (IDPs). These will be more process orientated, and relevant to year-on-year performance by DHBs. Percentage caries free and DMFT indicators will remain, but as outcome indicators. It is likely that DHBs will be asked to set annual targets for the new process indicators, with targets for caries free and DMFT outcomes set over the longer term.

At the mid-point of the five-year roll-out, the Ministry will review the overall progress of the health sector in re-orientating child and adolescent services. This will be used to report to the Minister of Health on the delivery of a community-based oral health service for young people.

A formal evaluation will also be conducted at the end of the five years.

Research needed to support change

More research is required to build the oral health evidence base in New Zealand. This document has already identified adolescents, special needs and medically compromised patients, adults, and older adults as populations where our knowledge base is particularly weak. To address this, the Ministry has commissioned the New Zealand Oral Health Survey. This will provide up-to-date information on the oral health status, behaviours and service utilisation of New Zealanders of all ages.

The Survey will be held on a 10-yearly cycle. Conducting the Survey concurrently with the re-orientation of child and adolescent services has additional benefits. In particular, there will be substantial baseline data for evaluating the impact of changes over the longer term, because results can be compared with subsequent surveys.

The Survey will provide an initial data set and pool of descriptive statistics, but the Ministry expects researchers to provide more complex analysis of the data and to conduct follow-up studies on individual areas. These will be used to inform the next steps in progressing the vision. The Ministry will particularly encourage research into the oral health and oral health behaviours of the following groups:

- Māori
- Pacific peoples – particularly similarities and differences in needs to those of Māori
- other minority groups (eg, refugees, Asian peoples)
- pre- and post-natal women
- older adults.

Research that will not naturally occur or arise from the Survey data but is also critical includes:

- the oral health status and needs of people with special needs or who are medically compromised – particularly those with cognitive, behavioural, and physical disabilities
- interventions that promote oral health
- workforce analysis
- service-mix.

It is anticipated that research groups associated with oral health workforce education and training schools at the University of Otago, and increasingly the Auckland University of Technology, will be key leaders in conducting such research.

Research is needed to build our evidence base.

A nationally agreed data set

There has been considerable interest in developing a defined national minimum data set. The Ministry would like to see this progressed and will be facilitating an advisory group to determine what data will be useful and how it can best be collected.

The Ministry will also be examining existing data stores (eg, data required by service specifications) and exploring ways that this can be better analysed.

Actions

- The Ministry of Health will develop a more detailed monitoring framework for publicly funded oral health services, and process-orientated IDPs.
- The Ministry, DHBs and non-DHB providers of oral health services will be encouraged to undertake research and evaluation of oral health and oral health programmes in New Zealand.
- A National Oral Health Survey will be conducted and the data made available to research groups.
- Researchers will be encouraged and supported to conduct further analysis of oral health data.
- The Ministry and DHBs will continue to work towards cost-effective, administratively simple methods of capturing reporting data that will be used to evaluate oral health and performance in delivering services.

Part III: The Way Forward

The vision for oral health will not be realised overnight. Re-orientating child and adolescent services alone is estimated to be a five-year process, with additional research, discussions and policy work required before ongoing directions can be set. Clearly a commitment from the Ministry and the health sector to oral health is required over the long term if change of this magnitude is to be achieved.

The following principles are important in guiding the way forward.

- Keep the vision fluid and responsive to the needs and priorities expressed by the population.
- Keep reduction of oral health inequalities at the core of the work.
- Involve, discuss and collaborate with DHBs, providers and communities as to the actions that will realise the vision.
- Ensure the vision is progressed at the population, group and individual levels to achieve long-lasting change.

The new vision will be realised in several phases. The Government has committed to supporting the first phase, with significant investments in capital and operating funding for child and adolescent oral health services. DHBs are expected to show a similar commitment to the new vision, and to prioritise funding for oral health while these services are re-orientated. Where funding has to be considered against other priority areas, DHBs should ensure that clinic upgrades, preschool programmes, and services that target inequalities take priority.

Realising the new vision will require DHBs, PHOs, Māori and other providers, representative organisations, communities, and the oral health workforce to work together in ways that are completely new for oral health. Fundamental to successfully achieving the new vision will be building and maintaining collaborative relationships between each of these groups. The Ministry will also work closely with groups over the next few years as the vision develops. Collaboration through intersectoral technical advisory groups that will inform child and adolescent programme design guidelines will be the first opportunity to launch this new era of engagement.

The vision for oral health described in this document is a turning point for oral health in New Zealand. We encourage all those interested in oral health to seize this opportunity so that we can realise a better oral health future for all New Zealanders.

A significant commitment is required for long-term change.

Collaborative relationships are critical.

References

Associate Minister of Health and Minister for Disability Issues. 2002. *Health of Older People Strategy: Health sector action to 2010 to support positive ageing*. Wellington: Ministry of Health.

Counties Manukau DHB. 2005. *Let's Beat Diabetes: A five-year plan to prevent and manage type 2 diabetes in Counties Manukau*. Endorsed by Counties Manukau District Health Board.

Dental Therapy Technical Advisory Group. 2004. *The Recruitment and Retention of Dental Therapists*. Wellington: Ministry of Health.

DHBNZ. 2004. *National School Dental Service Review Final Report*. [Report to the Ministry of Health] URL: www.moh.govt.nz/oral_health

Mauri Ora Associates. 2004. *Review of Māori Child Oral Health Services*. [Report to the Ministry of Health] URL: www.moh.govt.nz/oral_health

Minister for Disability Issues. 2001. *New Zealand Disability Strategy: Making a world of difference – Whakanui Oranga*. Wellington: Ministry of Health.

Minister of Health. 2000. *New Zealand Health Strategy*. Wellington: Ministry of Health.

Minister of Health. 2001. *Primary Health Care Strategy*. Wellington: Ministry of Health.

Minister of Health. 2002. *The Pacific Health and Disability Action Plan*. Wellington: Ministry of Health.

Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health.

Ministry of Health. 2004. *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumai: Implementation Plan 2004–2010*. Wellington: Ministry of Health.

Ministry of Health. 2004. Oral Health Toolkit.

Ministry of Health. 2004. *Pacific Health and Disability Workforce Development Plan*. Wellington: Ministry of Health.

Public Health Advisory Committee. 2003. *Improving Child Oral Health and Reducing Child Oral Health Inequalities*. Wellington: National Advisory Committee on Health and Disability.

Watt RG. 2005. Strategies and approaches to oral disease prevention and health promotion. *Bulletin of the World Health Organization* 83(9): 711–18.

National Oral Health Steering Group

Dr Stewart Edward, Chair

Dr Robin Whyman, Chief Advisor Oral Health

Dr Sophia Armstrong, New Zealand Dental Association

Karen Boyce-Bacon, New Zealand Dental Therapists Association

Claire Caddie, Hawkes Bay District Health Board

Dr Neil Croucher, Northland District Health Board

Sue Dashfield, Counties Manukau District Health Board

Janice Donaldson, DHBNZ

Dr Lyndie Foster-Page, Taranaki District Health Board

Margaret Hill, South Canterbury District Health Board

Louise Kuraia, Ngati Hine Trust

Rebekah Male, Ministry of Health

Kim Smith, Te Ao Marama

Teresa Wall, Ministry of Health