

New Zealand Dental Association

Report Card

2026

The 2026 Oral Health Report Card



Tracking
progress
towards
improving
Kiwis' oral
health



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Dental Assoc.**

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Report Card 2026

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Policy action has led to a measurable increase in access to community water fluoridation and a reduction in inequity.

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The proportion of children under 15 years reported by parents as having visited a dental health care worker in the previous 12 months declined significantly, from 84.4% to 75.1%.

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Workforce constraints ... limit service capacity and contribute to ongoing challenges in accessing timely dental care.

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**View the online version of the
Report Card: roadmap.org.nz/reportcard**

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Associate Professor Tim Chambers for the Water Fluoridation Map.

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Foreword

Welcome to our 2026 Oral Health Report Card

Almost all of the problems dentists treat on a day-to-day basis in New Zealand are preventable.

Tooth decay, gum disease and oral cancer are among the most common noncommunicable diseases worldwide and have a severe and significant health, societal, and economic impacts. Unfortunately, you see it in every age group: kids coming in with cavities that education, water fluoridation, in-office preventive care, and decent policy around sugary drinks might have helped to prevent. Adults needing teeth to be extracted due to decay that started in their early 20s, because they could not afford to go to the dentist, is not uncommon.

It's the central frustration of the profession, and it's the reason this report card exists. Recent governments have done very little to address oral health inequalities and inequity in New Zealand. It always seems to get put in the 'too hard basket'. That's not a partisan point; it's just a fact, because it involves time and funding to address.

The scoring in this report card reflects where things actually stand currently for: children, young adults, older New Zealanders, and people with disabilities. Each group has well-understood needs, and the system isn't meeting them. In some cases, it never has. The green, amber, and red scores in this report represent an honest assessment of how wide those gaps have become.

What makes it frustrating is the economics. Prevention is cheap while treatment isn't. When we don't invest in preventative measures like water fluoridation, nutrition policies, and education, and then we compound that lack of action with little to no oral health funding for those who need it in early adulthood, we end up spending significantly more to treat disease further down the track.

We defer costs, and they come back to bite us. A filling (to fix a cavity when it is found early) is far cheaper than a root

canal down the track. But none of those bills accounts for the psychosocial cost, the time off work from pain, the shame of missing a front tooth, or the effect on someone's overall health. Families absorb costs the public system should be sharing, and yet most of this doesn't have to happen.

We need to have a clear plan that is focused on prevention, and clear government policy to support that plan.

Health NZ, with the support of the Minister of Health, have commissioned a review of dental care for children and adolescents aged 0-17 years. It is a start and we are pleased to support it, but oral health is about more than children and adolescents. It is important to prevent, diagnose and treat dental disease early; that means making sure everyone has access to quality oral health care and funding for those groups that are most vulnerable and most in need.

We also need to focus on the issues through all the ages and stages of life. To date the political will to address it has been lacklustre.

We have put this report card together because the profession has a responsibility to say clearly when things aren't good enough.

What we're asking for isn't extraordinary, we just want a proper plan, real investment, and oral health treated as part of general health.

The Government needs to come to the party, and we're helping to keep them accountable.



Dr Dave Excell, President
New Zealand Dental Association



Dr David Excell
BDS, FICD
President
NZDA



Dr Ellen Clark
BDS, MComDent (Dist), FICD
President Elect
NZDA

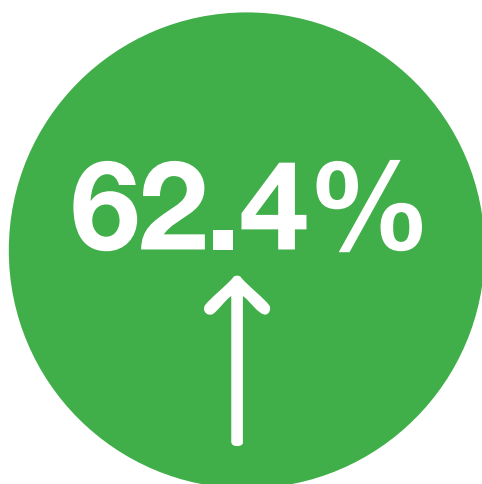


Dr Robin Whyman
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FADI, Hon Life NZDA
Director (Dental Policy)
NZDA

Key Oral Health Measures 2026

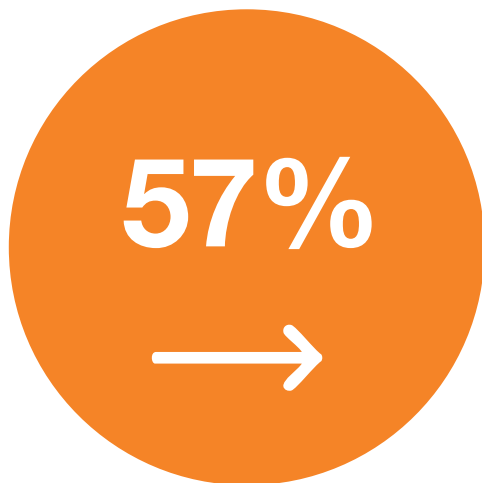
These seven key oral health measures provide headline indicators about oral health, prevention of oral disease, access to oral health services, and the capacity of the oral health workforce.

The full suite of measures aligned with the priorities for improving oral health outlined in the *NZDA Roadmap Towards Better Oral Health 2025–2030*, are provided in the following section of this *NZDA Report Card 2026*.



Proportion of NZ population receiving optimally fluoridated water

Following directives issued to fourteen water suppliers in July 2022, the proportion of the population receiving fluoridated water is estimated to have increased from 50.7% to 62.4%.



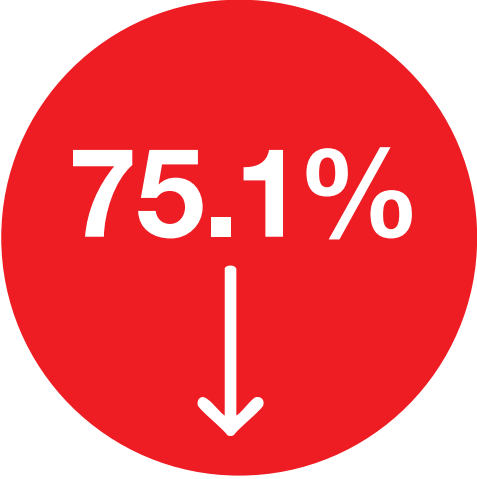
Proportion of 5-year-old children with no primary teeth decayed (2024)

There has been little change in this measure over the past 25 years.



Adults self-rated oral health as excellent, very good, or good

This represents a decrease from 79.5% in 2017/18 and is statistically lower than in 2019/20.



75.1%

A red circle containing the text '75.1%' in white. Below the text is a white arrow pointing downwards.

Children under 15 years that visited a dental health care worker in past 12 months

From 2014/15 to 2024/25, the proportion of children reported by parents to have visited a dental health care worker in the previous 12 months declined significantly, from 84.4% to 75.1%

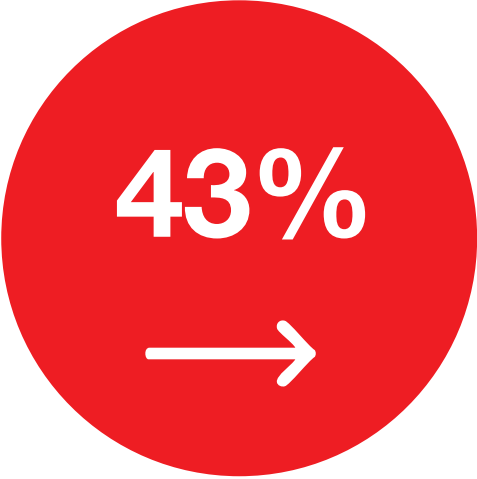


4,503

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Number of children on the public hospital waiting list for dental care in October 2025

The number of children on the waiting list for dental care decreased from 5,613 in October 2024 to 4,503 in October 2025. Over the same period, public hospital discharges increased from 898 per month to 1,005 per month. However, the number of adults on the public hospital waiting list for dental care declined only marginally, from 1,348 to 1,274.

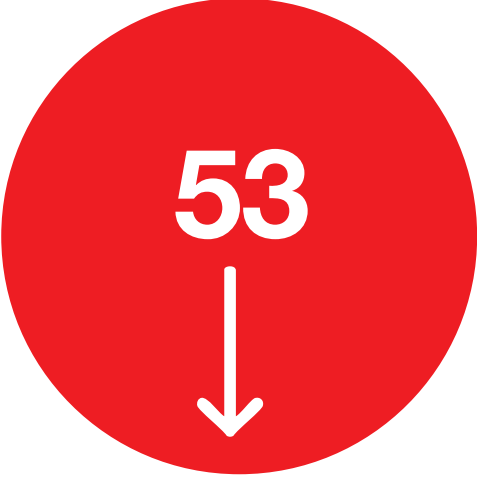


43%

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Adults reporting unmet dental needs due to cost

The New Zealand Health Survey 2024/25 estimated that 1,775,000 people experienced unmet dental care needs due to financial barriers in the previous 12 months. Despite increased investment in dental needs grants in 2022 and higher uptake, the reach of the scheme remains limited relative to the scale of unmet need. Current estimates indicate that the scheme reaches only around 4.7% of adults reporting unmet dental care needs due to cost.



53

A red circle containing the text '53' in white. Below the text is a white arrow pointing downwards.

Number of full time equivalent dentists per 100,000 population

The national average obscures significant regional variation. In 85% of former district health board areas, dentist workforce levels were at or below 45 full-time equivalents (FTEs) per 100,000 adults.

Community Water Fluoridation

62.4%



[Measure 1]

Percentage of NZ population receiving optimally fluoridated water

Baseline Access and Inequity

Prior to the implementation of the Health (Fluoridation of Drinking Water) Amendment Act 2021, it is estimated that 50.7% of the New Zealand population had access to community water fluoridation.

Access was unevenly distributed across population groups. Approximately 44.2% of the Māori population had access to fluoridated water, compared with 52% of the non-Māori population, indicating an existing disparity in exposure to this key preventive public health measure.

Progress Following 2022 Directives

Following directives issued to fourteen water suppliers in July 2022, community water fluoridation coverage is estimated to have increased to 62.4% of the population.

These changes are also estimated to have reduced the gap in access between Māori and non-Māori by 1.9 percentage points (Chambers et al. 2025). This suggests that policy interventions have contributed to both increased overall coverage and a modest reduction in inequity.

Ongoing Implementation Concerns

No further directives have been issued by the Director-General of Health since 2022.

The New Zealand Dental Association has expressed concern that, despite the enabling legislative framework now being in place, progress in expanding access to community water fluoridation has slowed. This raises questions regarding the pace of implementation and the extent to which the intended public health benefits are being realised.

Summary Assessment

Overall, the available data indicate that policy action has led to a measurable increase in access to community water fluoridation and a reduction in inequity.

However, coverage remains incomplete, and progress appears to have stalled since the initial phase of implementation. Sustained effort may be required to extend access further and ensure that the benefits of fluoridation are equitably distributed across the population.

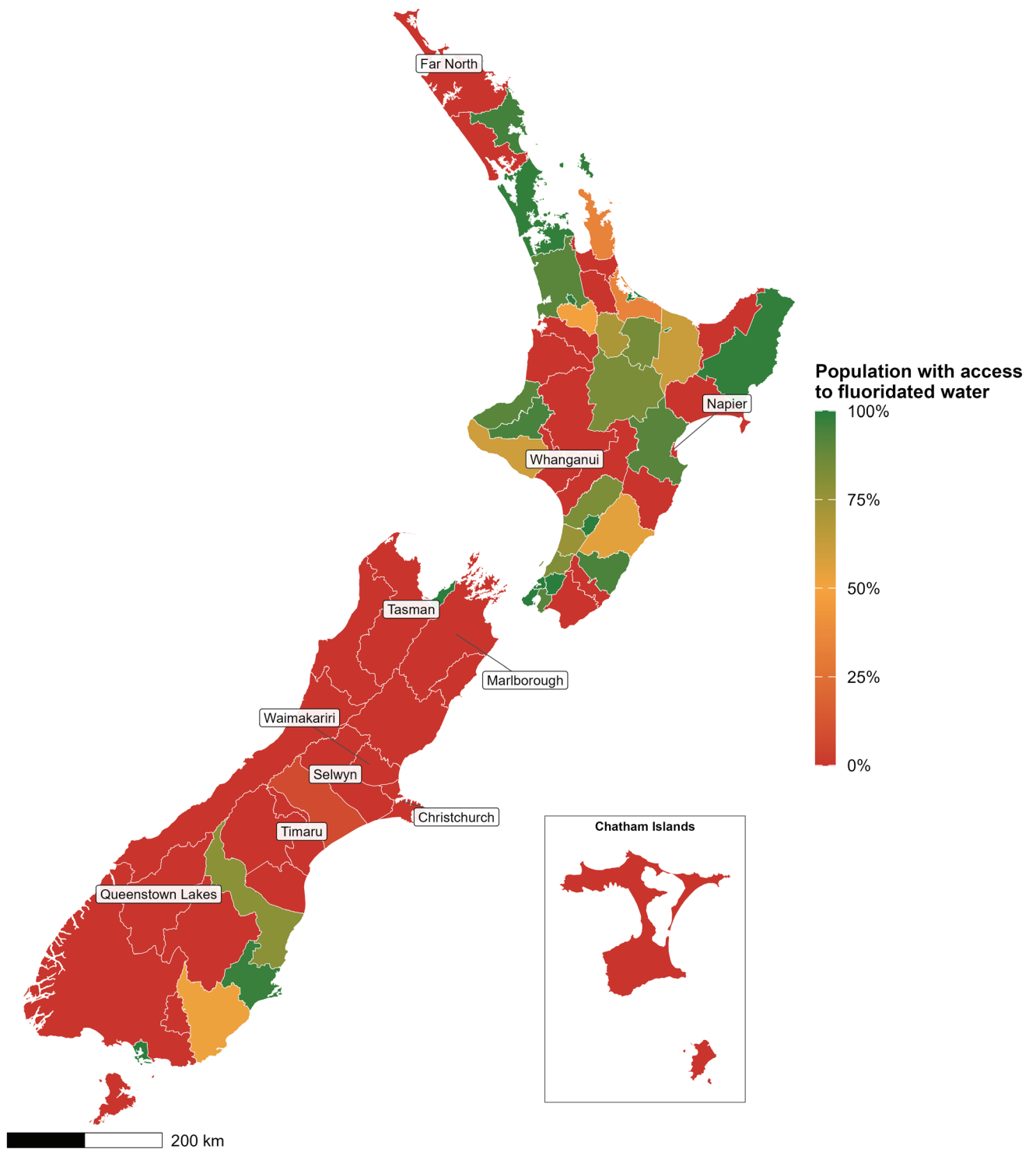
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Policy action has led to a measurable increase in access to community water fluoridation and a reduction in inequity.

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Percentage of population with access to community water fluoridation in 2026

By Territorial Authority



Notes:

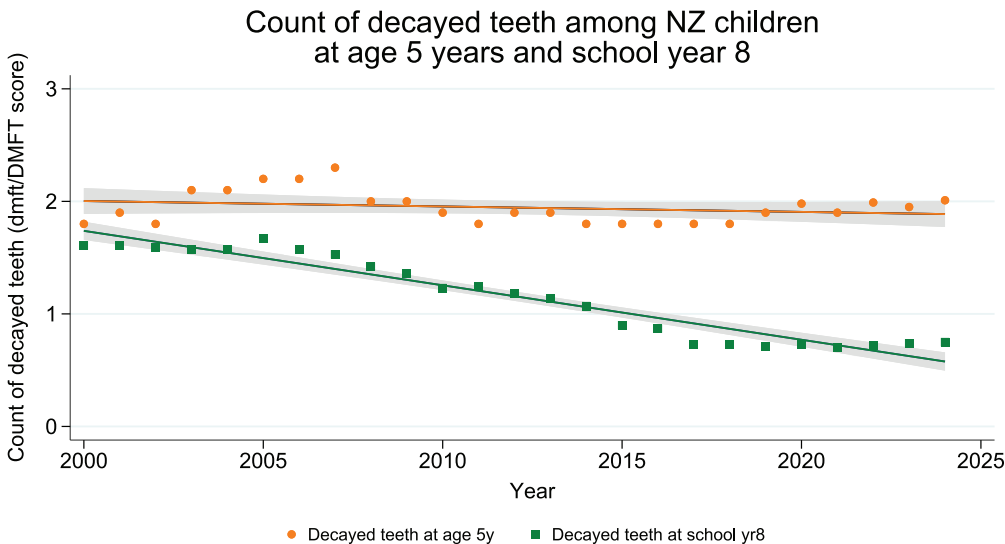
Percentages were calculated using the population on a public drinking water supply as the denominator. Actual percentages may vary depending on the proportion of the population on a domestic self-supply. Top ten councils by population without fluoridation are labelled. Red indicates no access to fluoridated water; orange indicates partial access; green indicates full access. Developed with funding support from the Clare Foundation and MoH Oral Health Fund. Contact: Associate Professor Tim Chambers tim.chambers@canterbury.ac.nz

Oral Health Promotion & Prevention

2.01
primary teeth
0.75
permanent teeth
→

[Measure 2]

Number of teeth impacted by dental decay for 5-year-old and Year 8 children



Data source: NZ Community Oral Health Service reports

Age 5 Children

The severity of early childhood dental decay, as measured by the number of teeth affected at age 5, has remained largely unchanged over more than two decades, from 2000 to 2024.

Persistent inequities are evident. Māori and Pacific children consistently experience disproportionately higher levels of decay, with over two times as many teeth affected than other children at this age. This indicates entrenched disparities in early oral health outcomes.

Year 8 Children

Over the same period, the severity of dental decay among Year 8 children (aged 12–13 years) has improved significantly, with an approximate 40% reduction across all ethnic groups.

Despite this overall improvement, inequities persist. In 2024, Māori and Pacific Year 8 children had up to two times as many permanent teeth affected by decay than other children.

Summary Assessment

Overall, the data point to contrasting trends in child oral health outcomes. While there have been substantial improvements in dental health among older children, early childhood oral health outcomes have remained static over an extended period.

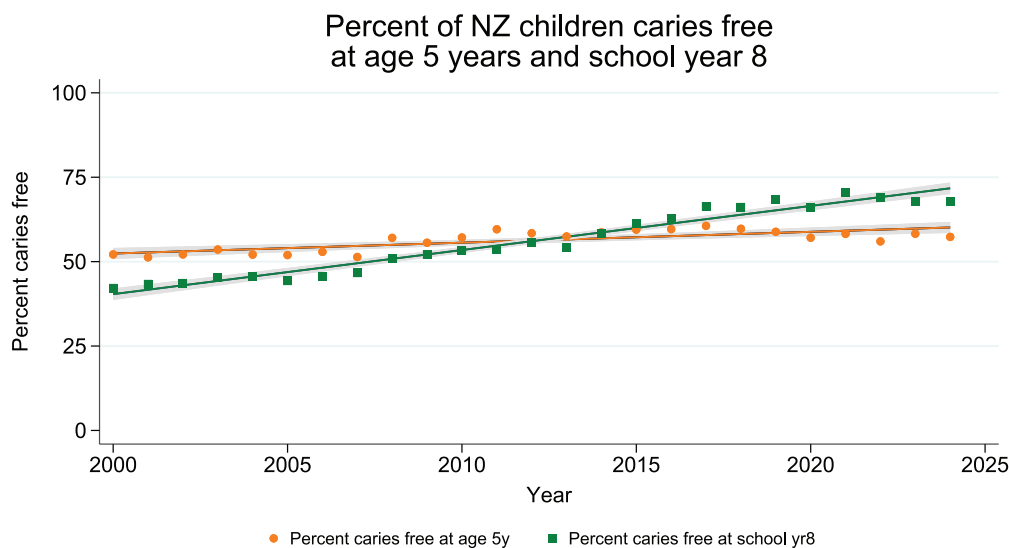
Across both age groups, persistent ethnic disparities are evident, with Māori and Pacific children experiencing a higher burden of dental decay. These findings highlight the need for targeted and sustained interventions, particularly in early childhood, to address inequities and improve long-term oral health outcomes.

Oral Health Promotion & Prevention

57.3%
5-year-olds
67.85%
Year 8
→

[Measure 3]

Percentage of 5-year-old and Year 8 children decay free



Data source: NZ Community Oral Health Service reports

Age 5 Children

The proportion of children aged 5 years with no teeth affected by dental decay has remained largely unchanged over the past 25 years, at approximately 57%.

Persistent inequities are evident across population groups. Māori and Pacific children continue to be more likely than other children to experience dental decay by age 5, indicating enduring disparities in early childhood oral health outcomes.

Year 8 Children

The proportion of Year 8 children (aged 12–13 years) with no permanent teeth affected by dental decay has improved across all ethnic groups, reaching 68% in 2024. Pacific children have demonstrated the greatest gains over this period.

Despite these improvements, inequities remain. Māori and Pacific children are still more likely than other children to have permanent teeth affected by decay, indicating that disparities persist into adolescence.

Summary Assessment

Overall, the data indicate improvement in oral health outcomes among primary school aged children, contrasted with long-standing stability in outcomes for pre-school children.

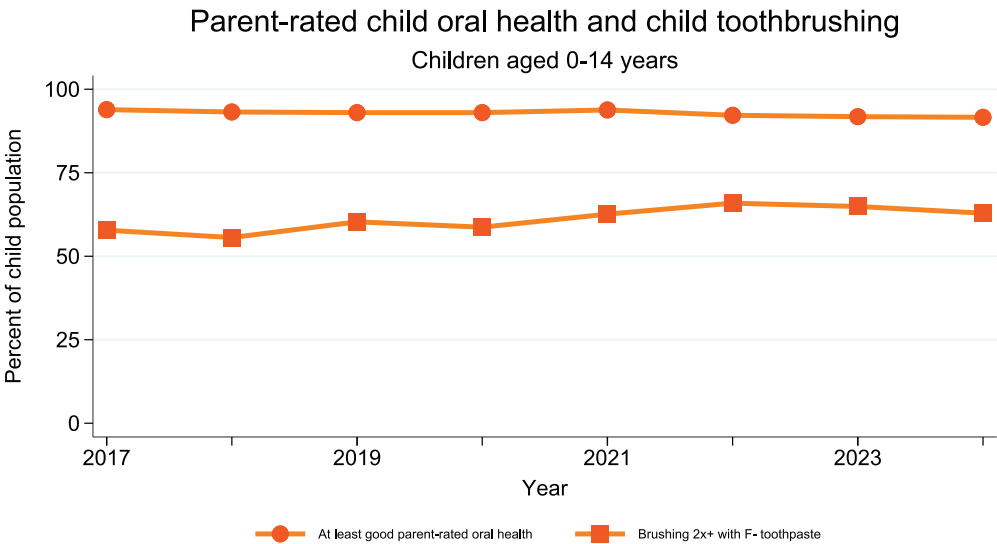
Across both age groups, persistent inequities remain, with Māori and Pacific children experiencing a higher burden of dental decay. These findings highlight the need for sustained and targeted interventions, particularly in early childhood, to improve oral health outcomes and address inequities.

Oral Health Promotion & Prevention

62.9%
→

[Measure 4]

Children under 15 years toothbrushing twice a day or more with fluoride toothpaste



Data source: NZ Health Survey

Perceived Oral Health

The New Zealand Health Survey indicates that more than 90% of parents rate their child’s oral health as excellent, very good, or good.

However, clinical data on the proportion of children with teeth affected by dental decay at age 5 and in Year 8 suggest that this high level of parental confidence may not accurately reflect underlying oral health status. This disparity raises concerns that perceived oral health may, in some cases, provide a false sense of security regarding children’s dental health.

Use of Fluoride Toothpaste

The proportion of children brushing their teeth twice daily with fluoride toothpaste has increased modestly, from 57.8% in 2017/18 to 62.9% in 2024/25.

Despite this improvement, usage remains relatively low, with limited progress observed over the past seven years. Twice-daily brushing with fluoride toothpaste is a well-established and effective measure for reducing dental decay.

Suboptimal use of fluoride toothpaste, combined with uneven access to fluoridated water, may be contributing to the persistence of dental decay among children.

Summary Assessment

Overall, while parental perceptions of child oral health are generally positive, these perceptions are not fully aligned with clinical indicators of dental decay.

At the same time, preventive behaviours—particularly the regular use of fluoride toothpaste—remain below optimal levels. These factors suggest that strengthening public health messaging, improving health literacy, and supporting preventive practices, including affordable access to toothbrushes and fluoride toothpaste, remain important components of efforts to improve oral health outcomes for children.

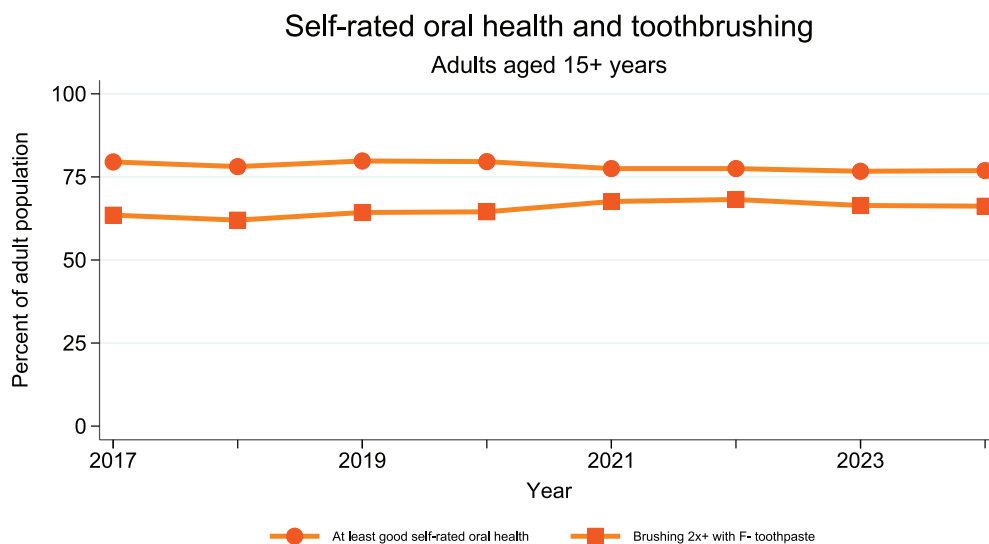
Oral Health Promotion & Prevention

76.9%



[Measure 5]

Adults self rated oral health



Data source: NZ Health Survey

Self-Rated Oral Health

The New Zealand Health Survey indicates that 76.9% of adults rate their oral health as excellent, very good, or good in 2024/25.

This represents a decline from 79.5% in 2017/18 and is reported as statistically lower than levels observed in 2019/20. The downward trend suggests a gradual deterioration in self-perceived oral health among the adult population.

Use of Fluoride Toothpaste

The proportion of adults reporting twice-daily toothbrushing with fluoride toothpaste has increased modestly, from 63.5% in 2017/18 to 66.2% in 2024/25.

However, usage varies significantly across population groups. Rates are higher among women (74%) and vary widely by demographic characteristics, ranging from 49.4% among Māori males to 83% among women in the least deprived socioeconomic quintile. These variations indicate uneven adoption of recommended preventive practices.

Implications for Prevention

Twice-daily use of fluoride toothpaste is a well-established and effective measure for reducing dental decay. Suboptimal and uneven usage across the population, combined with variable access to fluoridated water, may contribute to ongoing rates of dental disease among adults.

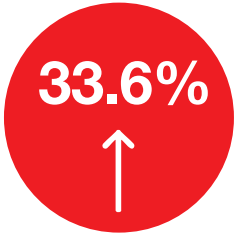
These patterns suggest that preventive behaviours are not yet sufficiently widespread to support optimal oral health outcomes at the population level.

Summary Assessment

Overall, the data indicate a decline in self-rated oral health alongside only modest improvements in preventive behaviours.

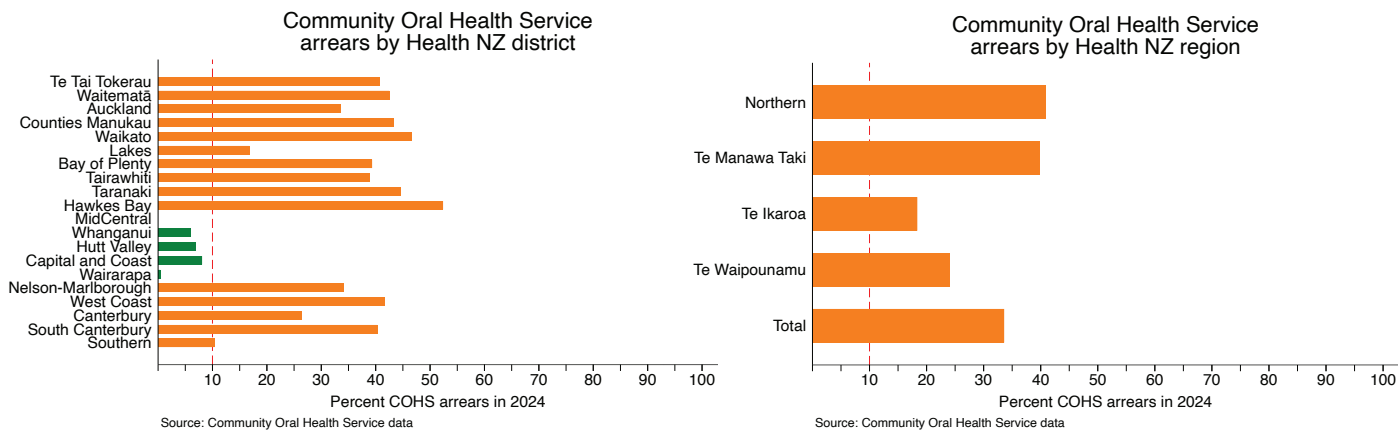
Persistent disparities in fluoride toothpaste use, particularly across gender and socioeconomic groups, point to uneven access to and uptake of effective preventive measures. Strengthening healthy environments, especially healthy food environments, and public health interventions to promote consistent and equitable preventive practices will be important to improving adult oral health outcomes.

Access to Care



[Measure 6]

Percentage of children 0-12 years overdue for scheduled care



Service Expectations and Benchmark

The Health New Zealand Service Specification for Community Oral Health Services sets clear expectations for the frequency of children’s oral health examinations. All children are expected to receive at least one examination by a dentist or oral health therapist every 12 months.

Children assessed as being at higher risk of oral disease should preferably be seen every six months, while those at lower risk may, in some circumstances, be examined at intervals of up to 18 months.

To support timely access and continuity of care, services are expected to maintain the proportion of children who are overdue for their scheduled oral health examination at no more than 10%.

Overdue Care in 2024

At the end of the 2024 calendar year, 33.6% of children were overdue for their scheduled oral health care at a national level.

Only three districts—Wanganui, Wellington/Hutt, and Wairarapa—met the national benchmark, with fewer

than 10% of children overdue. In all other districts, the proportion of children overdue exceeded the target, ranging from 10.4% in Southern to 52.4% in Hawke’s Bay.

In half of all districts (10 out of 20), 35% or more of children were overdue for care, indicating widespread challenges in delivering timely services. No data were provided for the MidCentral district.

Summary Assessment

The data indicate that the majority of districts are not meeting the national benchmark for timely provision of child oral health examinations.

High rates of children overdue for scheduled care suggest significant service capacity constraints and variability in performance across regions. These findings highlight ongoing challenges in ensuring timely access to preventive and routine care, with potential implications for oral health outcomes and equity.

Addressing these issues will likely require targeted efforts to strengthen workforce capacity, improve service delivery models, and reduce regional disparities.

Access to Care

75.1%



3.0%

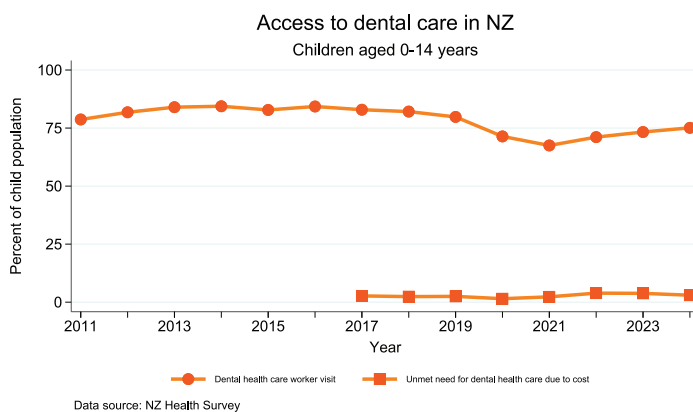


[Measure 7]

Children under 15 years that visited a dental health care worker in past 12 months and unmet need due to cost

[Measure 7]

Children under 15 years with unmet dental health care due to cost



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The proportion of children under 15 years reported by parents as having visited a dental health care worker in the previous 12 months declined significantly, from 84.4% to 75.1%.”

Dental Visits

Between 2014/15 and 2024/25, the proportion of children under 15 years reported by parents as having visited a dental health care worker in the previous 12 months declined significantly, from 84.4% to 75.1%, according to the New Zealand Health Survey 2024/25.

This trend indicates a reduction in engagement with routine oral health services over the past decade.

Access to Care

The decline in dental visits aligns with the proportion of children reported as overdue for scheduled care (see Measure 6).

Taken together, these findings suggest a deterioration in timely access to oral health services for children, despite the availability of publicly funded dental care that is free at the point of access. This pattern points to potential system-level barriers affecting utilisation and continuity of care.

Unmet Need and Cost

Despite reduced rates of attendance, the New Zealand Health Survey 2024/25 reports that only 3% of parents identified unmet dental care needs due to cost.

This relatively low figure may reflect high levels of public funding for child dental services. However, it may also indicate limited awareness of entitlements, or unmet need in areas not covered by public funding—such as orthodontic care—rather than an absence of access barriers.

Summary Assessment

Overall, the data indicate a decline in utilisation of dental services among children, alongside evidence of increasing delays in care.

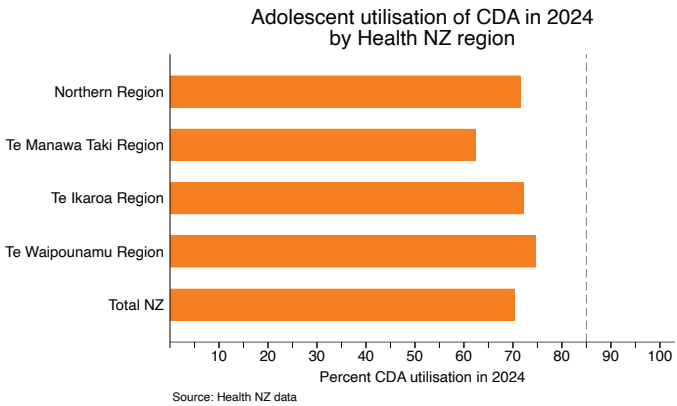
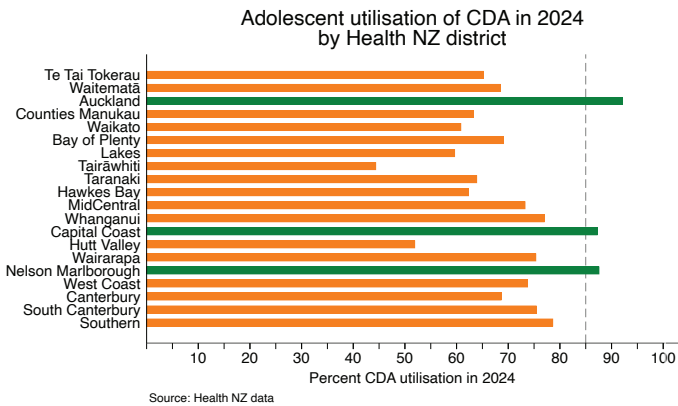
While cost does not appear to be a primary barrier for most children, other factors—such as acceptability of services, service availability, system capacity, and awareness—may be contributing to reduced engagement with oral health services. Addressing these barriers will be important to ensuring that children receive timely and preventive dental care.

Access to Care



[Measure 8]

Percentage of teenagers Y9 to 17 years accessing care



Service Expectation

Health New Zealand’s agreements with dental providers specify that enrolled teenagers should receive at least one consultation each calendar year.

The proportion of eligible teenagers seen annually is reported as a key indicator of access to oral health services for this age group.

Teenage Access in 2024

In the 2024 calendar year, 70% of eligible teenagers were seen by a dental provider.

While there is currently no formal Health New Zealand district-level target for teenage dental attendance, a historical benchmark of 85% provides a useful point of reference. In 2024, only three districts—Nelson Marlborough, Wellington, and Auckland—reported attendance rates exceeding this threshold.

District Variation and Data Interpretation

There is substantial variation in reported attendance across districts. The lowest recorded rate was in

Tairāwhiti, where 44.4% of eligible teenagers were seen during the year.

District-level results should be interpreted with caution, as they are based on the location of the dental provider rather than the residential location of the teenager. This may result in higher reported attendance in urban centres such as Wellington and Auckland, where teenagers from neighbouring districts (e.g. Hutt, Waitematā, and Counties Manukau) may access services.

Summary Assessment

Overall, the data indicate that a significant proportion of teenagers are not receiving annual dental care, and that access varies considerably across districts.

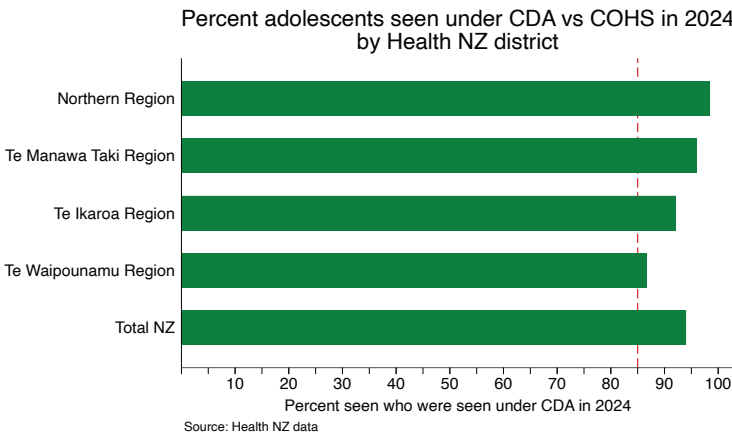
While some regions are achieving high levels of service utilisation, others lag substantially behind. These disparities, combined with limitations in the reporting methodology, highlight the need for improved monitoring and targeted interventions to ensure equitable access to oral health services for teenagers.

Access to Care

97%
v 3%
→

[Measure 9]

Teenagers seen by contracting dental practices v COHS (Child and Adolescent Services)



Service Delivery Model

Most teenagers who access publicly funded dental care are treated by contracted dental providers, typically private dental practices operating under Health New Zealand agreements.

In regions where there are insufficient contracted providers to meet demand, services may instead be delivered through the Community Oral Health Service or through alternative local arrangements, including Māori oral health providers. This reflects a limited degree of flexibility in service delivery models to maintain coverage.

Service Mix in 2024

In the 2024 calendar year, 97% of eligible teenagers who accessed care were seen by a contracted dental provider, while 3% were treated by the Community Oral Health Service.

This indicates that the primary model of service delivery for this age group remains centred on contracted dental providers. However, there is notable regional variation. For example, in Whanganui, 74.6% of eligible teenagers were seen by a contracted provider, while 25.4% received care through the Community Oral Health Service, reflecting a greater reliance on public provision.

Service Pressure and Workforce Constraints

A mixed service delivery model can support continued access in areas where contracted providers are limited. However, this approach also places additional pressure on Community Oral Health Services, which are primarily responsible for delivering scheduled care to preschool and primary school-aged children.

At the same time, many districts are experiencing shortages in the dental practice workforce. These workforce constraints may limit the capacity of contracted providers to deliver teenage services and increase reliance on already stretched public services.

Summary Assessment

Overall, service delivery for teenagers is predominantly reliant on contracted dental providers, with supplementary support from Community Oral Health Services where required.

However, regional variations and workforce constraints highlight vulnerabilities in the current model. Increased pressure on public services and limited capacity within private practices may impact access to care, particularly in districts with constrained workforce supply. Addressing these challenges will require coordinated workforce planning and consideration of sustainable service delivery models that meet the needs of local populations.

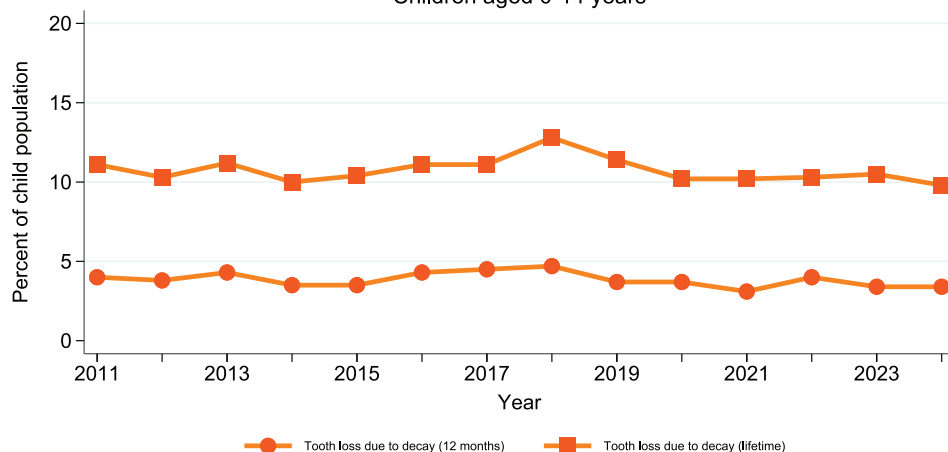
Access to Care

9.8%
3.4%
→

[Measure 10]

Children under 15 years with teeth removed due to decay in the past 12 months and with teeth removed due to decay in lifetime

Tooth loss due to dental decay in NZ
Children aged 0-14 years



Data source: NZ Health Survey

Tooth Removal Due to Decay

The New Zealand Health Survey 2024/25 indicates that approximately 10% of children have had a tooth removed due to decay at some point in their lives. In addition, 3.4% of children had a decayed tooth removed in the previous 12 months.

While these proportions may appear relatively small, tooth extraction represents the most severe clinical outcome of dental decay in children. As such, these figures reflect a subset of cases where disease has progressed beyond the point of preventive or restorative care.

Severity and Untreated Need

Many more children will have experienced dental decay that could be treated through restorative interventions, such as fillings, rather than extraction.

Given the high proportion of children reported as overdue for scheduled dental care, it is likely that a number of children have untreated decay that has not yet been addressed through either restorative treatment or tooth removal. This suggests the presence of unmet need at earlier stages of disease progression.

Summary Assessment

Although the proportion of children undergoing tooth extraction remains relatively low, these cases represent advanced and preventable oral disease.

The broader context of untreated decay and delayed access to care indicates ongoing challenges in the prevention and early management of dental disease in children. Addressing these issues will require improved timeliness of care, strengthened preventive measures, and earlier intervention to reduce progression to severe outcomes.

Access to Care

1,005
children

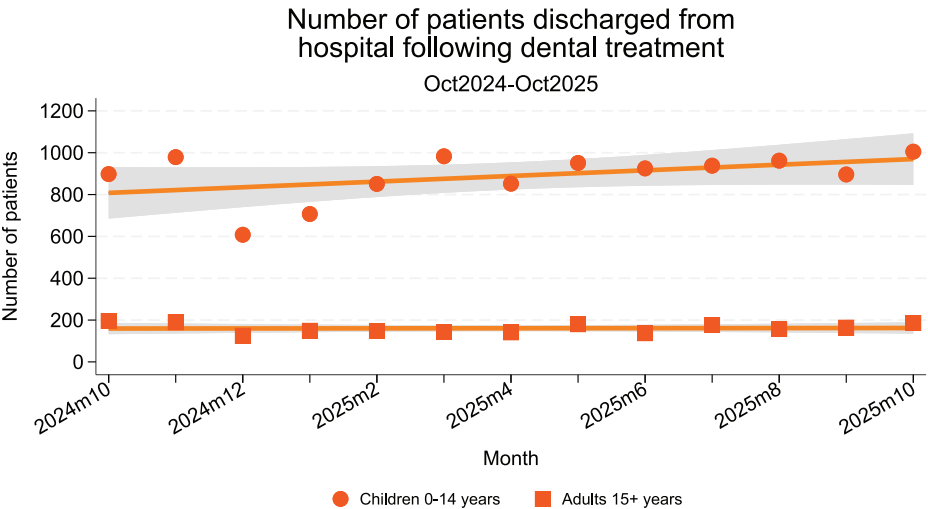


186
adults



[Measure 11]

Number of public hospital discharges per month for dental care for children under 15 years and for adults



Source: Health NZ

Children's Hospital Discharges

The number of public hospital discharges for children following dental care increased from 898 per month in October 2024 to 1,005 per month in October 2025.

This increase should be considered in the context of the government's health target to ensure that 95% of patients wait less than four months for elective treatment. For children, the observed growth in discharge volumes suggests that this target has contributed to an increase in the number of children receiving hospital-based dental treatment each month.

Adults' Hospital Discharges

In contrast, the number of public hospital discharges for adults following dental care has remained largely unchanged over the same period, at just under 200 per month between October 2024 and October 2025.

This stability indicates limited expansion in service capacity for adults and suggests that the drivers of increased activity observed in paediatric care have not had a comparable effect within the adult population.

Summary Assessment

Overall, the data indicate a divergence in hospital dental service activity between children and adults.

While discharge volumes for children have increased —potentially reflecting progress towards elective treatment targets—adult service activity has remained static. This pattern highlights differences in system responsiveness across population groups and may have implications for equitable access to hospital-based dental care.

Access to Care

4.503

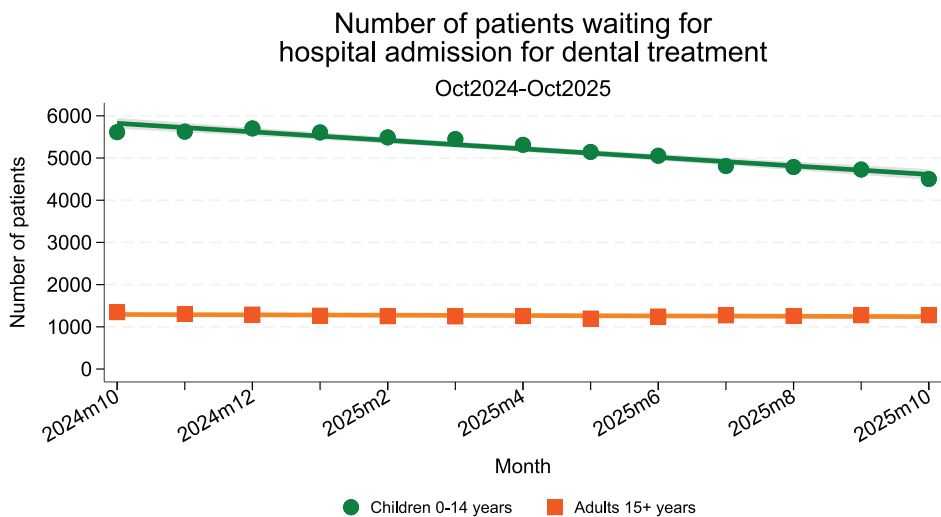
↓

1,274

→

[Measure 12]

Number of children under 15 years on the public hospital waiting list for dental care and the number of adults on the public hospital waiting list for dental care (adults)



Source: Health NZ

Children’s Dental Waiting List

The number of children on the public hospital waiting list for dental care decreased from 5,613 in October 2024 to 4,503 in October 2025.

This reduction should be considered alongside the increase in public hospital discharges for children following dental care (refer to Measure 11). Collectively, these indicators suggest that, at a national level, progress is being made towards the government’s health target of ensuring that 95% of patients wait less than four months for elective treatment.

However, there is notable variation across districts. The New Zealand Dental Association has raised concerns that demand for hospital-based dental care may be influenced by the number of children who are overdue for care within the Community Oral Health Service (Measure 6). This relationship indicates that access constraints in primary oral health services may be contributing to increased reliance on hospital-based treatment.

Adults’ Dental Waiting List

In comparison, the number of adults on the public hospital waiting list for dental care has declined only marginally, from 1,348 in October 2024 to 1,274 in October 2025.

Given that the number of adult discharges following dental care has remained stable at approximately 200 per month over the same period (Measure 11), there is limited evidence of progress towards the government’s elective treatment target for this population group. On the basis of these indicators, it is unlikely that the target of 95% of patients waiting less than four months is being achieved for adults.

Population Characteristics and Service Implications

Adults requiring dental care in public hospital settings are more likely to present with complex needs, including disabilities, significant comorbidities, or frailty. These factors may preclude treatment in primary care or outpatient settings, necessitating hospital-based care.

As such, this cohort represents a particularly vulnerable population group, and continued delays in access to treatment may have broader implications for health equity and overall wellbeing.

Summary Assessment

Overall, the data indicate measurable progress in reducing waiting times and increasing access to hospital-based dental care for children, although this progress is not consistently observed across all districts.

In contrast, outcomes for adults remain largely unchanged, suggesting persistent capacity constraints and highlighting challenges in meeting elective treatment targets for this group. These trends underscore the need for targeted policy and service responses to address disparities in access and to better meet the needs of high-risk populations.



Access to Care

7.5%



4.9%

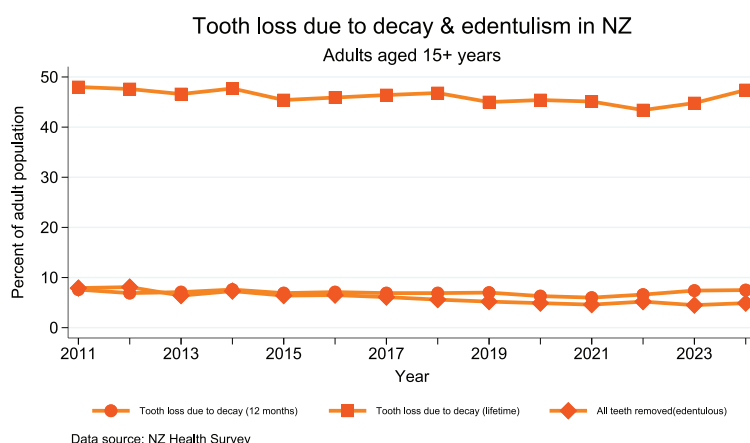


[Measure 13]

Adults with teeth removed due to decay in the past 12 months

[Measure 13]

Adults with all teeth removed due to decay, abscess, infection or gum disease in lifetime



Tooth Loss (Recent Experience)

According to the New Zealand Health Survey 2024/25, approximately 324,000 adults (7.5%) reported having at least one tooth removed in the previous 12 months due to decay, abscess, infection, or gum disease.

This proportion has remained relatively stable over time but is more than double the rate observed among children, indicating a significantly higher burden of severe oral disease among the adult population.

Complete Tooth Loss Among Adults

Over the decade from 2014/15 to 2024/25, there has been a notable reduction in the proportion of adults who have had all their natural teeth removed due to oral disease, declining from 7.3% to 4.9%.

Despite this improvement, complete tooth loss (edentulism) remains substantial, affecting approximately 212,000 adults in New Zealand. This indicates that while

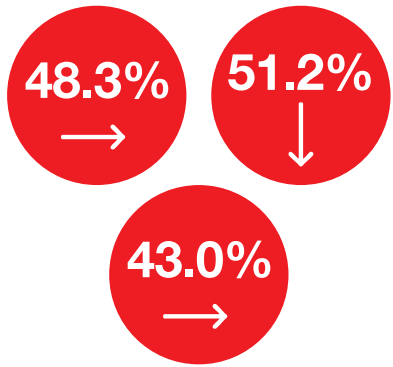
overall oral health outcomes are improving, a significant cohort continues to experience severe and cumulative oral health impacts.

Population Trends and Policy Gap

These trends are occurring within the context of an ageing population, alongside an increasing proportion of older New Zealanders retaining some or all of their natural teeth. While this represents a positive shift in oral health outcomes, it also introduces more complex and ongoing oral health care needs in older age.

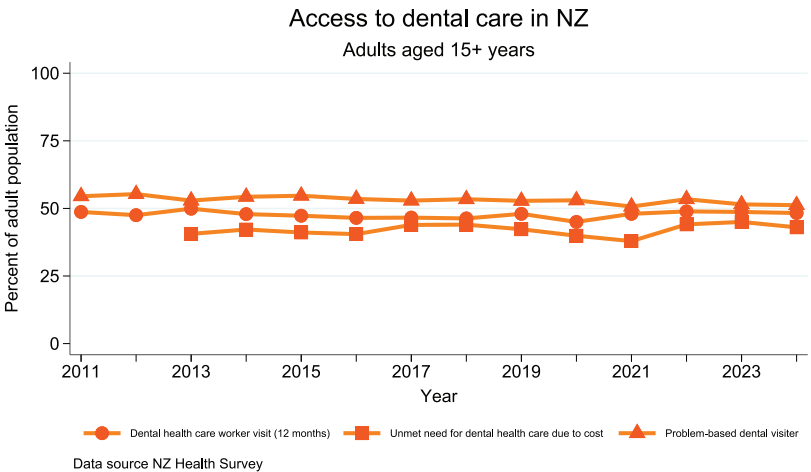
Taken together, these findings highlight persistent levels of untreated or advanced oral disease in the adult population, as well as emerging challenges associated with an ageing population retaining more natural teeth. Addressing these issues will require a more focused policy response, particularly in relation to the oral health needs of older adults.

Access to Care



[Measure 14]

Visited a dental health care worker in the past 12 months
Only visit a dental health care worker for dental problems
Unmet dental needs to cost



Recent Dental Visits

For more than a decade, fewer than half of New Zealanders have visited a dental health care worker within a 12-month period. In 2024/25, 48.3% of adults reported having had a dental visit in the previous year.

This sustained pattern indicates that routine engagement with preventive oral health services remains limited across the population.

Problem-Driven Care and Cost Barriers

In 2024/25, 51.2% of New Zealanders reported that they visit a dental health care provider only when experiencing a problem. While this represents a modest decline from 54.3% in 2014/15, problem-driven care continues to be the predominant pattern of service use.

Cost remains a significant barrier to accessing dental care. In 2024/25, 43.0% of adults reported unmet need for dental care due to cost. This suggests that financial constraints continue to limit access to timely and preventive services for a substantial proportion of the population.

Implications for Oral Health Outcomes

The combined effect of low rates of routine dental visits, reliance on problem-driven care, and persistent cost barriers indicates that access to dental services for adults remains constrained.

These factors are likely to contribute to delayed diagnosis and treatment, increasing the risk of more advanced oral disease and the need for invasive interventions. This pattern is consistent with the relatively high and stable rates of tooth extraction observed in the adult population.

Summary Assessment

Overall, the data indicate that access to dental care for adults in New Zealand is insufficient to support regular preventive care and early intervention.

Despite some improvement in problem-driven utilisation, persistent financial barriers and low rates of routine visits continue to limit effective engagement with dental services. These trends reinforce the need for policy responses aimed at improving affordability, promoting preventive care, and reducing inequities in access.

Access to Care

\$5.7M

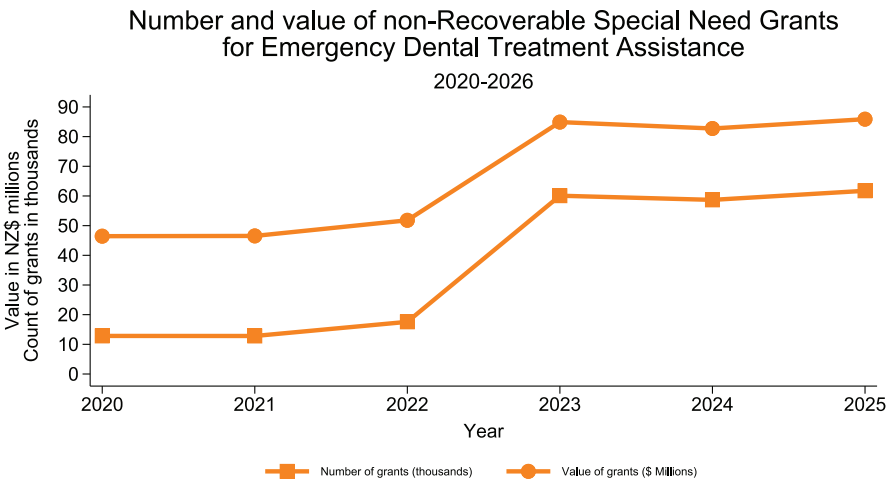
7,875

grants per month

→

[Measure 15]

Work and Income New Zealand dental needs grant expenditure and volumes



Scale of Unmet Need

According to the New Zealand Health Survey 2024/25, 43% of adults—approximately 1,775,000 people—reported unmet dental care needs due to financial barriers in the previous 12 months.

This indicates that a substantial proportion of the population is unable to access necessary dental services, highlighting the scale of unmet need within the current system.

Public Funding Response

Public financial support for adult dental care is primarily delivered through the Ministry of Social Development’s Dental Special Needs Grant.

In 2022, the annual grant limit was increased from \$300 to \$1,000, and eligibility criteria were broadened to include immediate and essential dental care in addition to emergency treatment. These changes were intended to improve access to care and reduce the financial burden on individuals with urgent dental needs.

Grant Uptake and Reach

Between September 2025 and March 2026, approximately 7,000 non-recoverable grants were approved each

month, equating to around 84,000 grants annually. Associated expenditure was approximately \$5 million per month, or \$60 million per year. This represents a substantial increase compared with pre-Budget 2022 settings, under which approximately 46,500 grants were issued annually at a total cost of \$12.8 million.

Despite this increased investment and uptake, the reach of the grant remains limited relative to the scale of unmet need. Current estimates indicate that the scheme reaches only around 4.7% of adults reporting unmet dental care needs due to cost.

Summary Assessment

While recent policy changes have significantly expanded the availability and uptake of financial support for dental care, current provision remains insufficient relative to the overall level of need.

The gap between the number of individuals experiencing cost-related barriers and those receiving assistance suggests that financial access to dental care remains a major and unresolved issue. Addressing this gap is likely to require further consideration of both the level and structure of public funding, alongside broader measures to improve affordability and access to care.

Access to Care



62%

[Measure 16]

Dental practices with an appointment on Monday

Timeliness of Access

Timely access to dental care is partly determined by how quickly patients are able to secure an appointment. In November 2025, the New Zealand Dental Association surveyed member dentists to assess appointment availability within one week.

The findings provide an indication of system responsiveness and capacity to deliver timely care in community-based dental practices.

National Availability

At a national level, 62% of dental practices reported having an appointment available on the following Monday, while 87% had availability within the following week.

These results suggest that, for most patients who seek care, appointments are generally available within a relatively short timeframe once contact with a provider has been made.

City–Provincial Differences

Notable differences were observed between major cities and provincial centres. In major cities, 67% of practices had an appointment available on the following Monday, compared with 51% in provincial areas.

Where no appointment was available within the following week, waiting times were also longer in provincial centres. The average wait in these cases was 13 working days in major cities, compared with 26 working days in provincial areas.

Summary Assessment

Overall, the data indicate that while appointment availability is relatively high at a national level, access varies by location. Patients in provincial areas face less immediate availability and longer wait times where delays occur.

These geographic disparities highlight the importance of considering service distribution and service capacity when assessing access to dental care across New Zealand.

Access to Care

93%

[Measure 17]

Practices taking on new patients

Importance of New-Patient Availability

Given that a substantial proportion of individuals seek dental care primarily when experiencing a problem, access to services is influenced not only by appointment availability but also by whether practices are accepting new patients.

New-patient availability is therefore a key component of overall access, particularly for individuals without an existing relationship with a dental provider.

New-Patient Availability

In November 2025, the New Zealand Dental Association surveyed member dentists to assess whether practices were open to new patients.

The survey found that most practices reported capacity to accept new patients, with 93% indicating that they were taking on new patients. There was little variation between major cities and provincial centres on this measure.

Summary Assessment

Overall, the high proportion of practices accepting new patients suggests that entry points into the dental care system are generally available once individuals seek care.

However, this relative availability should be considered alongside other access barriers, including cost, patterns of problem-driven utilisation, and geographic variation in appointment availability. Together, these factors continue to shape the extent to which individuals are able to access timely and appropriate dental care.

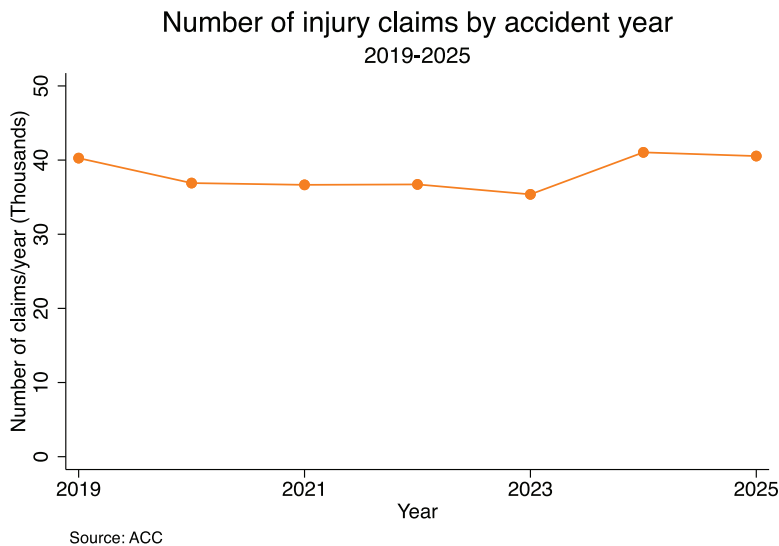
Access to Care

40,546



[Measure 18]

New ACC claims for dental injuries



Impact of Dental Injuries

Dental injuries are frequently sudden and unpredictable events. Unlike many other health conditions, damaged teeth have limited capacity for natural healing. As a result, dental injuries often require prompt clinical intervention and may necessitate ongoing treatment and monitoring over an extended period.

The acute and potentially long-term nature of dental trauma contributes to sustained demand for dental services, including both immediate care and follow-up treatment.

ACC Claim Trends

Accident Compensation Corporation (ACC) data provide an indication of the incidence of dental injuries requiring treatment. In 2019, there were 40,267 new dental injury claims.

Claim volumes declined to 36,902 in 2020 and 36,663 in 2021. This reduction was likely associated with the effects of the COVID-19 pandemic, including decreased participation in activities that carry a higher risk of

injury—particularly those involving interpersonal contact and reduced access to care during periods of restricted movement.

Since this period, claim volumes have returned to pre-pandemic levels. ACC recorded 41,043 new dental injury claims in 2024 and 40,546 in 2025, indicating a restoration of underlying demand for dental injury treatment.

Summary Assessment

Overall, dental injury claims have stabilised at levels comparable to those observed prior to the COVID-19 pandemic.

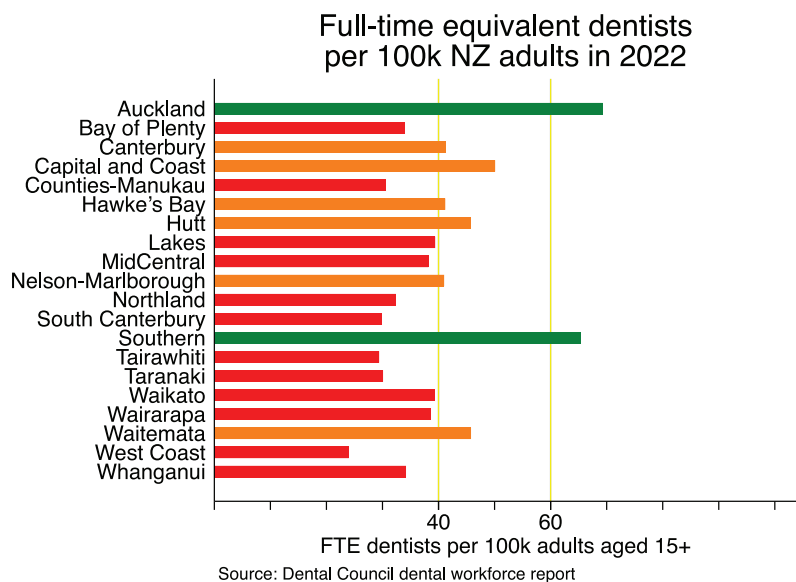
These data underscore the ongoing and largely unavoidable demand for dental trauma services, reflecting the unpredictable nature of injuries and the need for timely and, in some cases, long-term care. This demand represents an important component of overall dental service utilisation and should be considered in workforce and service planning.

Workforce



[Measure 19]

Dentists per 100,000 population aged 15 years and over



Population and Workforce Growth

Between 2012 and 2024, New Zealand’s total population increased from 4.4 million to 5.1 million. Over the same period, the population aged 15 years and over grew from 3.5 million to 4.4 million.

The dentist workforce also expanded, increasing from 2,127 to 2,724 registered practitioners. While this represents growth in workforce capacity, it should be considered in the context of overall population growth, including increases in the adult population who are more likely to require dental services.

Regional Distribution of the Workforce

In 2024, the Dental Council reported an average of 53 full-time equivalent (FTE) dentists and dental specialists per 100,000 population.

However, this national average masks significant regional variation. In 85% of former district health board areas, there were 45 or fewer dentist FTE per 100,000 people aged 15 years and over, indicating an uneven distribution of workforce capacity.

This distribution gap is further reflected at the local level. In 2022, six territorial local authority areas—Kaipara, Westland, Hurunui, Mackenzie, Waimate and the Chatham Islands—had no practising dentists or dental specialists. In addition, 42 territorial authorities (61%) had no dental specialists recorded, suggesting limited access to more complex or specialised care in many regions.

International Context

Dentist-to-population ratios in OECD countries typically range from approximately 50 to 70 dentists per 100,000 people.

New Zealand’s national average of 53 dentists per 100,000 population falls within this range but is below that of several comparable countries. For example, Canada has approximately 65 dentists per 100,000 population, Australia 61, and Ireland 73. These countries are of particular relevance due to reciprocal professional registration arrangements with New Zealand.

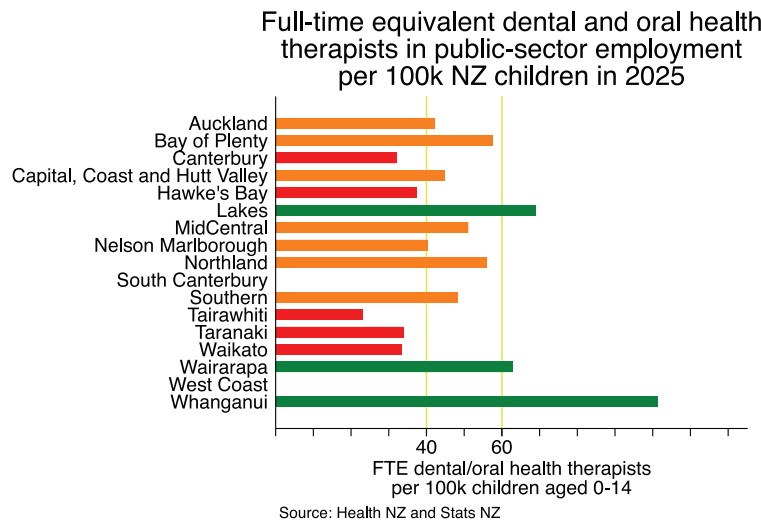
Workforce

81



[Measure 20]

Oral Health Therapists per 100,000 population aged 0-14 years



Workforce Transition

In 2024, the Dental Council reported 81 full-time equivalent (FTE) oral health therapists and five FTE dental therapists per 100,000 children aged 0–14 years.

This workforce is currently in transition following changes to undergraduate training and the phased replacement of dental therapy with oral health therapy. As a result, the composition and scope of practice of the child oral health workforce continue to evolve.

Regional Variation

Oral health therapists work across both public and private sectors and, within their scope of practice, may also provide care to adults. However, Health New Zealand public sector data show substantial regional variation in workforce distribution.

As at March 2025, Lakes and Whanganui recorded more than 60 FTE oral health therapists per 100,000 children. In contrast, Canterbury, Hawke’s Bay, Tairāwhiti, Taranaki and Waikato recorded fewer than 40 FTE per 100,000 children.

No oral health therapists were recorded in South Canterbury or the West Coast, although service provision in these areas may be supported by staff travelling from neighbouring districts.

Implications for Access

Variation in workforce availability across regions has implications for access to child oral health services. Districts with lower workforce capacity are more likely to face constraints in delivering timely and regular care.

These patterns are consistent with the high proportion of children reported as overdue for scheduled dental care in Measure 6 of this Report Card. This suggests that workforce distribution remains a key factor influencing service access and coverage.

Summary Assessment

The transition from a dental therapist workforce to an oral health therapist workforce represents a significant structural change in the delivery of child oral health services. However, uneven distribution and localised workforce shortages persist.

Addressing these disparities will be important to support equitable access to preventive and routine dental care for children, and to reduce the proportion of children who are overdue for care.

Workforce



[Measure 21]

Dental sector workforce vacancies

Dental Practice Workforce

The New Zealand Dental Association's November 2025 survey of member dentists found that 18.8% of dental practices reported vacancies for a dentist or dental specialist.

On average, these positions took approximately 24 weeks to fill. There was minimal variation between major urban centres (24.4 weeks) and provincial centres (25.5 weeks), indicating that recruitment challenges are widespread and not confined to specific geographic areas.

Health New Zealand Dental Workforce

Data from Health New Zealand (Health NZ) in December 2025 similarly indicate persistent workforce shortages within publicly funded dental services. At that time, 15.6% of dentist and dental specialist positions were vacant.

These vacancy rates have remained largely unchanged since December 2023, suggesting an ongoing and sustained shortfall in workforce capacity within the public sector.

Health NZ also reported a vacancy rate of 9.5% for oral health therapists. However, Health NZ's 2023 Workforce Plan identified a workforce shortfall of approximately 220 dental and oral health therapists. Despite this recognised need, the number of employed dental and oral health therapists declined slightly from 422.1 full-time equivalent (FTE) positions in September 2024 to 416.2 FTE positions in December 2025.

Interpretation of Vacancy Data

The New Zealand Dental Association has noted that reported vacancy rates within Health NZ are likely to reflect only positions that have received budget approval and authorisation for recruitment. As a result, these figures may underestimate the true level of workforce demand within the public system.

The actual requirement for dentists, dental specialists, and oral health therapists is therefore likely to be higher and more consistent with the workforce gaps identified in Health NZ's 2023 Workforce Plan.

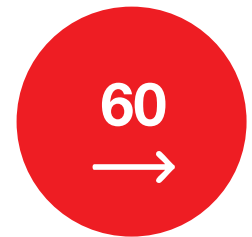
Summary Assessment

Overall, the available data indicate persistent and widespread workforce shortages across both private dental practices and the public health system. Recruitment timeframes remain prolonged, and vacancy rates have not shown meaningful improvement over time.

These workforce constraints are likely to limit service capacity and contribute to ongoing challenges in accessing timely dental care. Moreover, the potential underestimation of workforce requirements suggests that existing gaps may be more substantial than reported, reinforcing the need for coordinated workforce planning and sustained investment.

**“ Workforce constraints
... limit service capacity
and contribute to ongoing
challenges in accessing
timely dental care. ”**

Workforce



[Measure 22]

Number of government-funded student places in dentistry per annum

Current Training Capacity

There are currently 60 government-funded places available each year for students wishing to study dentistry in New Zealand. These places are provided exclusively through the University of Otago's Faculty of Dentistry.

However, the Faculty has the capacity to accommodate a larger cohort and currently enrolls approximately 100 students annually. The additional places are filled by international students rather than domestic candidates.

Historical Cap on Domestic Places

The cap of 60 government-funded domestic places has remained between 54 and 60 for several decades and is effectively consistent with the number of students admitted in the 1980s.

This static cap has persisted despite significant population growth, increasing demand for dental services, and growing evidence of workforce shortages.

Workforce Need and System Implications

The current level of domestic training capacity must be considered in the context of an established undersupply of dentists in New Zealand, as well as the ongoing maldistribution of the dental workforce across regions (see Measures 19 and 21).

At the same time, there is strong demand among prospective students to study dentistry, indicating that training capacity—rather than applicant interest—represents the primary constraint on workforce growth.

Maintaining the current cap on domestic places may therefore limit the ability of the education and health systems to respond effectively to workforce shortages and access challenges.

Policy Position and Recommendation

The New Zealand Dental Association considers the current cap on government-funded domestic dentistry places to be inadequate in the context of current and projected workforce needs.

It recommends that the number of funded domestic places be progressively increased to 90 students per year. This approach is intended to strengthen workforce supply, improve distribution over time, and support improved access to oral health services across New Zealand.

Summary Assessment

Overall, the present level of government-funded dental training places appears insufficient to meet current and future workforce requirements.

Expanding domestic training capacity represents a key policy lever to address workforce shortages and improve access to care, particularly when considered alongside broader workforce distribution and service delivery challenges.

Research Funding

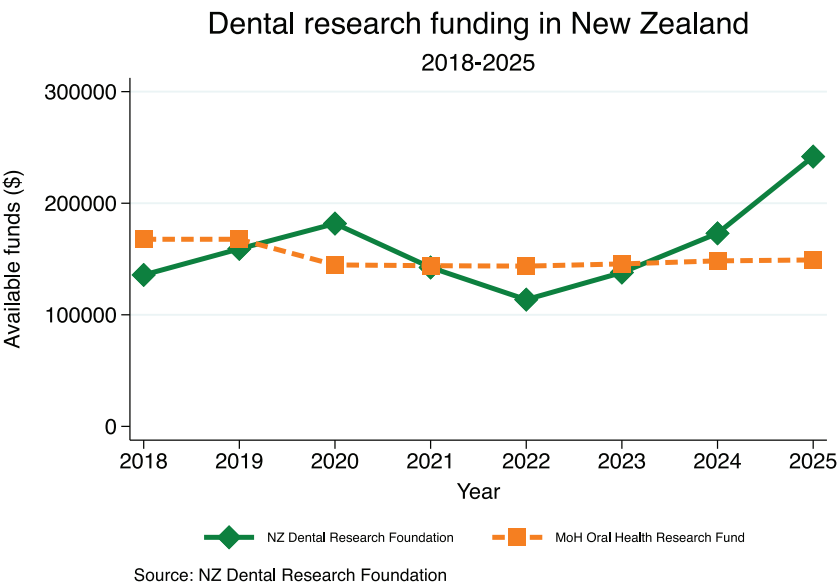


[Measure 23]

Oral Health Research: Targeted funding available for dental and oral health research.
NZ Dental Research Foundation

[Measure 23]

Health NZ Oral Health Research Fund



Strategic Importance of Research

The New Zealand Dental Association (NZDA) considers that achieving and sustaining good oral health outcomes requires an ongoing commitment to research. This includes research that strengthens public health approaches to oral health care and supports the educational programmes of New Zealand’s universities.

Investment in research is therefore a critical component of evidence-based policy development, service improvement, and workforce capability.

Dedicated Research Funding Streams

New Zealand currently has two primary funding streams dedicated to dental and oral health research.

The New Zealand Dental Research Foundation Trust, established in 1964, provides funding to support research in dental and oral health. In 2025, the Trust and its partner organisations awarded \$241,811 in research grants. Over the past four years, the Trust has increased the funding available to researchers by more than \$100,000, reflecting a sustained commitment to strengthening the research base.

In addition, Health New Zealand (Health NZ), formerly the Ministry of Health, contracts the New Zealand Dental Association—through the New Zealand Dental Research Foundation Board—to administer funding for oral health research projects. These projects are focused on improving oral health outcomes and informing service delivery. In 2025, this contract provided an additional \$149,166 in research funding.

Overall Research Investment

Combined, these two funding streams provided a total of \$390,977 for dental and oral health research in 2025.

This level of investment demonstrates an ongoing commitment within the sector to advancing oral health knowledge, supporting public health objectives, and contributing to the development of the future dental workforce.

However, the New Zealand Dental Association remains concerned about the challenging funding environment for oral health research teams, particularly within the broader context of constrained health research investment.

Summary Assessment

While dedicated funding streams continue to support dental and oral health research in New Zealand, the overall level of investment remains relatively modest when considered in the context of the scale of oral health challenges and system pressures identified elsewhere in this report.

Sustained and potentially expanded investment in research may be required to support innovation, inform policy development, and strengthen the evidence base for improving oral health outcomes across the population.



Report Card

The 2026 Oral Health Report Card

Indicator	Measure	Progress Status	Source
Oral Health Promotion and Prevention			
% of NZ population receiving optimally fluoridated water	62.40%	↑	Chambers et al NZ Dental Journal 2025
5-year-old children decay free and number of decayed missing or filled teeth	57.3%; 2.01 teeth	→	Health NZ 2024 data
Year 8 caries free and dmft	67.85%; 0.75 teeth	→	Health NZ 2024 data
Children under 15 years toothbrushing twice a day or more with fluoride toothpaste	62.9%	→	NZ Health Survey 2024/25
Adults self rated oral health – excellent v good or good	76.9%	↓	NZ Health Survey 2024/25
Adults toothbrushing twice a day or more with fluoride toothpaste	66.2%	→	NZ Health Survey 2024/25
Access to Care – children under 15 years			
% children (0–12/13y) overdue for scheduled care	33.6%	↑	Health NZ 2024 data
% teens Y9 to 17 years accessing care	70%	↑	Health NZ 2024 data
Teenagers seen by contracting dental practices v COHS (Child and Adolescent Services)	97% v 3%	→	Health NZ 2024 data
Children under 15 years with teeth removed due to decay in the past 12 months	3.4%	→	NZ Health Survey 2024/25
Children under 15 years with teeth removed due to decay in lifetime	9.8%	→	NZ Health Survey 2024/25
Number of public hospital discharges per month for dental care for children under 15 years	1,005	↑	Health NZ October 2025 data
Number of children under 15 years on the public hospital waiting list for dental care	4,503	↓	Health NZ October 2025 data
Children under 15 years with unmet need for dental care due to cost	3.0%	→	NZ Health Survey 2024/25
Children under 15 years that visited a dental health care worker visit in past 12 months	75.1%	↓	NZ Health Survey 2024/25

■ Of Concern
 ■ Not Improving
 ■ Within Target

Indicator	Measure	Progress Status	Source
Access to Care – adults			
Teeth removed due to decay in last 12 months	7.5%	→	NZ Health Survey 2024/25
All teeth removed due to decay	4.9%	↓	NZ Health Survey 2024/25
Dental health care worker visit in past 12 months	48.3%	→	NZ Health Survey 2024/25
Only visit dental health care worker for dental problems	51.2%	↓	NZ Health Survey 2024/25
Unmet need for dental care due to cost	43.0%	→	NZ Health Survey 2024/25
WINZ Dental needs grant expenditure and volumes	\$5.7M per month; 7,875 grants	→	MSD data March 2026
Practices with an appointment on Monday	62%	No previous data	NZDA November 2025 workforce survey
Practices taking on new patients	93%	No previous data	NZDA November 2025 workforce survey
Number of public hospital discharges per month for dental care for adults	186	→	Health NZ October 2025 data
Number of people on the public hospital waiting list for dental care (adults)	1274	→	Health NZ October 2025 data
New claims for dental injuries	40,546	→	ACC data calendar year 2025

Report Card

The 2026 Oral Health Report Card

Indicator	Measure	Progress Status	Source
Workforce			
FTE dentists per 100,000 population aged 15 years and over	53	↓	Dental Council Annual Report 2024/25
FTE Oral Health Therapists per 100,000 population aged 0-14 years	81	↑	Dental Council Annual Report 2024/25
Private dental sector dentist workforce vacancies	19%	No previous data	NZDA November 2025 workforce survey
Public oral health workforce vacancies – dentists and dental specialists	15.6%	→	Health NZ December 2025 data
Public oral health workforce vacancies – OHTs	9.5%	→	Health NZ December 2025 data
Number of NZ government funded student places in dentistry per annum	60	→	University of Otago
Research			
\$ available for funding dental and oral health research from the NZDRF Trust	\$241,811	↑	NZ Dental Research Foundation 2025 data
\$ available for funding oral health research from the HNZ/ MOH contract	\$149,166	→	NZ Dental Research Foundation 2025 data

New Zealand Dental Association

Roadmap

Towards Better Oral Health for New Zealand

Why a
Roadmap
for Better
Oral Health?

Current Issues in
Population Oral Health
and Oral Health Services

Data,
Digital and
Oral Health
Information

Clinical Governance
and Clinical Leadership,
and Appropriate
Policy Settings

Oral Health
Promotion
and Disease
Prevention

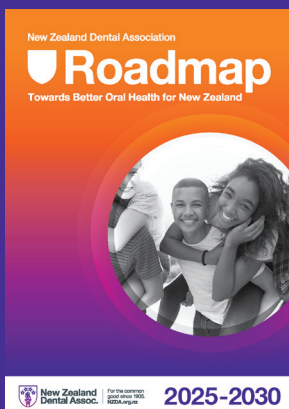
Workforce

Access
to
Care

Oral Health
Research

Environmental
Sustainability

roadmap.nzda.org.nz



NZDA Roadmap Towards Better Oral Health 2025–2030

NZDA Roadmap Towards Better Oral Health 2025–2030, has provided the Indicators and key oral health measures that have formed this NZDA Report Card 2026.

For more information and to read the full Roadmap visit roadmap.nzda.org.nz

New Zealand Dental Association

Report Card

View the online version of the
Report Card: roadmap.org.nz/reportcard

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roadmap.nzda.org.nz/reportcard



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Dental Assoc.**

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