New Zealand Dental Association

Roadmap

Towards Better Oral Health for New Zealand

New Zealand Dental Assoc.

For the common good since 1905.
NZDA.org.nz

2025-2030

Contents

New Zealand Dental Assoc.

Why a Roadmap for Better Oral Health?

Access to Care

New Zealand Dental Association

Roadmap

Towards Better Oral Health for New Zealand

roadmap.nzda.org.nz

Foreword

Why a Roadmap for Better Oral Health?

Tēnā koutou katoa and warm greetings

Good oral health remains an aspiration that is yet to be achieved by many New Zealanders.

The United Nations General Assembly recognises that oral diseases are a major global health burden and share common risk factors with other non-communicable diseases.

In 2019 the General Assembly reaffirmed its strong commitment to prevention and control of non-communicable diseases and included strengthening efforts to address oral health as part of universal health coverage.

The World Health Organization (WHO) recognises oral health as an integral part of general health and as a basic human right. The WHO Global strategy and action plan on oral health 2023-2030 emphasises that improving oral health is a collective responsibility within and outside oral health communities.

The New Zealand Dental Association's membership consists of over 98 percent of New Zealand dentists working across all sectors (public, private, NGO and not-for-profit providers, academia, and Defence) with people from all walks of life. The Association and its members have insights informed by clinical experience and their work in communities into the consequences of poor oral health. We actively advocate for evidence-based policy that provides the best opportunity for oral health equity across all communities.

The Association is an independent professional association for dentists. The Association acknowledges the significance of Te Tiriti o Waitangi and that it establishes and formalises the relationship between Māori and the British Crown. It has a fundamental role serving as a foundational document for policy development in Aotearoa and it safeguards Māori values, traditions, and practices, while also acknowledging and legitimising the presence of settlers in Aotearoa and the governance by the British Crown.

The Association acknowledges the enduring strength and resilience of whānau Māori, while also recognising that the impacts of colonisation since the 19th century have contributed to inequities in oral health. Despite these challenges, whānau Māori continue to uphold rich traditions of wellbeing and are central to creating solutions that restore and enhance oral health outcomes across all ages. The Association acknowledges the significance and importance of Te Tiriti of Waitangi to improving Māori health.

A Strategic Vision for Oral Health (Good Oral Health for All, for Life) was published in 2006 by the Ministry of Health. The aspiration was for high-quality oral health services that promote, improve, maintain, and restore good oral health and proactively address the needs of those at greatest risk of poor oral health.

Much work has been undertaken to improve oral health and oral health services and to improve equity in oral health in New Zealand. However, 2006 remains the last time a clear government plan for oral health was expressed.

The 2023 New Zealand Dental Association Oral Health Summit featured a great deal of discussion and significant concern at persisting inequities in the oral health of

Dr David Excell
BDS, FICD
President
NZDA

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

Dr Robin Whyman
BDS, MComDent, FRACDS, FRACDS (DPH), FADI, Hon Life NZDA
Director (Dental Policy)
NZDA

New Zealanders. The summit recognised that these issues have many contributing factors, including environments that promote poor oral health, barriers to oral health care for some New Zealanders, and the need to train and retain a dentist and oral health workforce which is representative of the New Zealand population. There was particular concern at continuing high levels of refined sugar in the diets of New Zealanders and less-than-optimal coverage for community water fluoridation.

The New Zealand Dental Association's position is that all New Zealanders have the right to good oral health.

The Association has considered the strategic objectives outlined in the Global strategy and action plan on oral health 2023-2030 and developed its Roadmap Towards Better Oral Health for New Zealand, including priorities for actions to improve the oral health of New Zealanders.

The Association offers this Roadmap Towards Better Oral Health for New Zealand as a platform for further actions and plans to improve, maintain, and restore good oral health and proactively address the needs of those at greatest risk of poor oral health.

Ngā mihi nui and kind regards

Dr David Excell BDS FICD
President, New Zealand Dental Association

The Board of the Association wish to acknowledge the leadership of our Immediate Past President, Dr Amanda Johnston, over the tenure of her presidency.

Dr Amanda Johnston
BDS FICD
Immediate Past President
NZDA

Section 2:

Current Issues in Population Oral Health and Oral Health Services

Section 2.1

State of Oral Health

The New Zealand Dental Association position is:

- That oral health is an integral part of general health and a basic human right.
- That oral health and dental care must be considered as an integral part of Health Policy making.

Oral health encompasses a range of diseases and conditions. Those with the greatest public impact include tooth decay (dental caries), chalky teeth (molar hypomineralisation), gum disease (periodontal disease), oral cancer, oro-facial and dental trauma, and congenital malformations such as cleft lip and palate.

In the 2009 New Zealand Oral Health Survey, 90% of New Zealand adults had some or all their natural teeth, but one in three had untreated tooth decay, one in three had early signs of gum disease and 15% had moderate or severe gum disease. The D3Group estimates that 19% of children have molar hypomineralisation, which can be a contributory cause to tooth decay and early tooth loss. Further analysis of data in the New Zealand Oral Health Survey found 40% of the adults reported a history of dental trauma and, in 2023, over 35,000 people registered new claims for dental and facial injuries with ACC. In 2022, the New Zealand Cancer registry recorded 631 people with cancer of the lip, oral cavity and pharynx. All of these oral conditions have chronic and cumulative effects, and people affected require ongoing oral health care throughout life.

Many oral conditions are theoretically preventable, but they are also complex multifactorial conditions with socio-economic, environmental and biological determinants. Oral conditions have risk factors in common with other chronic conditions, such as diabetes, heart disease and respiratory diseases. Oral health is integral to general health, and oral health needs to be included within health policy decisions for people of all ages, ethnicities and abilities.

Section 2.2

Tooth Decay and Inequity

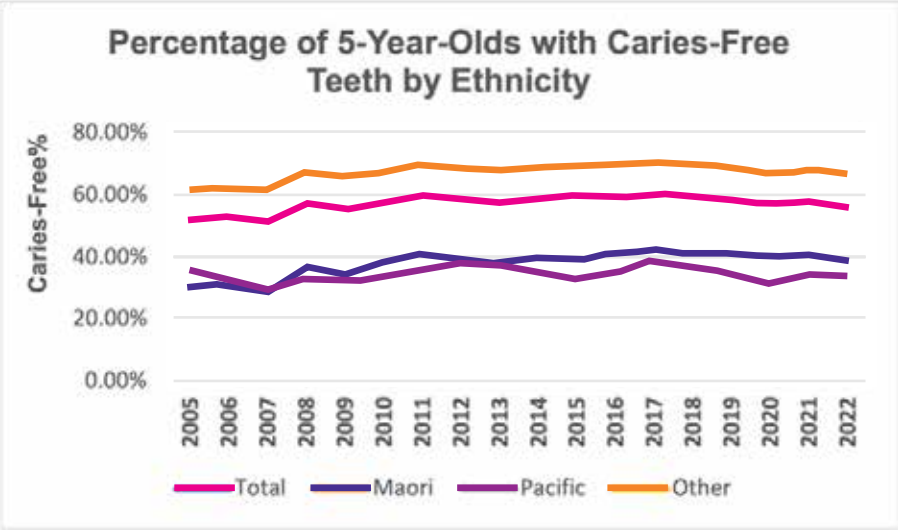
The New Zealand Dental Association position is:

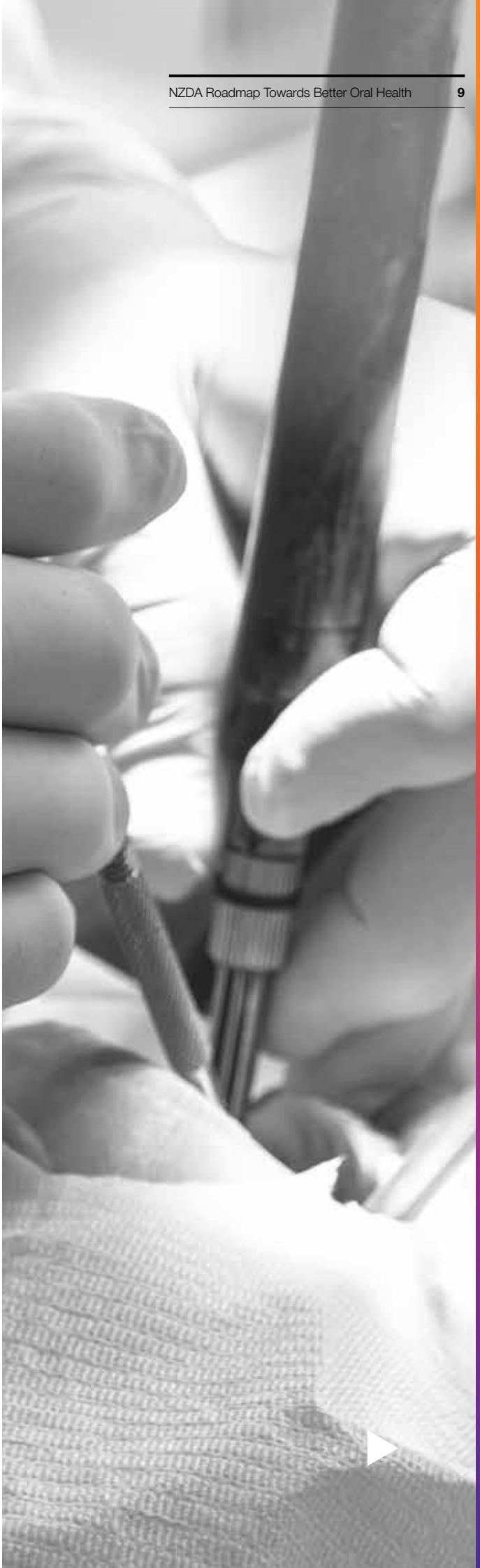
- That health equity is the right of all New Zealanders and this includes oral health.
- There are considerable fiscal, economic and social costs in not addressing oral health inequities.
- Oral health inequities are unfair and unjust.
- That poor oral health is a well established contributor to reduced quality of life.
- That dental decay is the leading cause of oral disease, it's effects are responsible for significant health loss and costs.
- That improving oral health equity requires giving every child the best start in life, including preventive dental care and appropriate treatment services to maintain their oral health.

Tooth decay is the most common chronic disease among New Zealanders of all ages and is responsible for significant health impact and costs. It is a largely, but not entirely, preventable disease that can have a substantial impact on personal appearance, self-esteem, social interaction, employment, the ability to speak and chew, and on general health. Untreated decay can lead to pain, dental abscesses and serious infections.

Although tooth decay is largely preventable, we do not all start out with the same early years of life, we live in differing social environments, and we have different levels of access to care. Early childhood oral health is measured as children decay-free and the severity of dental decay at age 5. Early childhood oral disease has remained largely unchanged, with persistent inequities throughout a period of more than 15 years, from 2005 and 2022.

Figure 1: Precentage of 5-year-olds with caries-free teeth by ethnicity





> **“ In 2023/2024, an estimated 321,000 (7.4%) New Zealand adults had one or more teeth removed due to decay, abscess, infection or gum disease. Approximately 31,000 (3.3%) children had one or more teeth removed over the same period. ”**

Improvements have occurred in both the severity of dental decay and the proportion of children decay-free at Year 8 (age 12-13 years) over the same period. However, inequities have persisted.

These differences are creating very different levels of oral health within our population with disproportionate impacts on the health and well-being of whānau, Māori, Pacific people, people with disabilities and people with low incomes, across the age spectrum.

Dental decay is a chronic and cumulative disease. The Dunedin Multidisciplinary Health and Development Study has demonstrated that people with the least favourable dental health at age 45 years had higher decay scores at age 5 years, lacked exposure to community water fluoridation in the first 5 years of life, had lower childhood IQ and lower childhood socio-economic status, and parental ratings of their own or their child’s health were poor.

The impact will grow with time in groups most at risk. Healthy diets, fluorides and dental care mean that most adults in New Zealand now retain most of their teeth into later adulthood. While this can be a positive outcome, dental decay continues through adolescence and into adulthood. In older adulthood, other health conditions complicate dental health. Untreated dental decay and periodontal disease can cause serious complications, including severe pain and infection.

Section 2.2

Tooth Decay and Inequity
Continued ...

In 2023/2024, an estimated 321,000 (7.4%) New Zealand adults had one or more teeth removed due to decay, abscess, infection or gum disease. Approximately 31,000 (3.3%) children had one or more teeth removed over the same period. Pacific children were twice as likely to have had a tooth removed compared to non-Māori and non-Pacific children. Additionally, children living with the greatest levels of deprivation were over 3 times more likely to have a tooth removed than those experiencing the least socio-economic deprivation.

Dental care is one of the most common reasons for children's admission to hospitals, and for young children, dental disease is a leading cause of potentially avoidable hospitalisations. Admission rates to public hospitals for dental care have reached unsustainable rates, with approximately 8,000 children every year undergoing a general anaesthetic to have one or more teeth removed due to tooth decay. Ongoing research in New Zealand continues to show high rates of acute admissions to public hospitals for dental infections for people in their 20s and early 30s.

In 2024, The Frank Group assessed that the current settings for adults with poor oral health in New Zealand were creating substantial, economic, fiscal and social costs in sick days, lost productivity costs of funded dental and medical care, and low quality of life.

Achieving equity in health recognises that different people with different levels of advantage require different approaches and resources to achieve the same outcome. Equitable health outcomes are influenced by factors much broader than the health system, including the dental care system. Nevertheless, equitable oral health care is necessary for the success of any quality health system. It is key to improving better oral health outcomes for Māori, for Pacific peoples and for people with the least socio-economic advantage.

"Admission rates to public hospitals for dental care have reached unsustainable rates, with approximately 8,000 children every year undergoing a general anaesthetic to have one or more teeth removed due to tooth decay."

Section 3:

Oral Health Promotion and Disease Prevention

Section 3.1

Personal Care and Healthy Environments

The New Zealand Dental Association recommends healthy eating, regular and effective self-care and regular dental visits as the three essential steps to maintain healthy teeth and gums for all age groups.

It is important to limit the intake of sugary food and drinks, brush teeth and gums twice a day with fluoride toothpaste, and to regularly visit a dentist, and other oral health professionals when required.

While many oral conditions are preventable, oral health is strongly supported by healthy environments and by population level strategies to improve oral health.

The Association recommends regular and effective personal oral health care combined with policies that support healthy environments, and communities, and regular access to oral health care as the most effective ways to achieve good oral health in New Zealand.

Section 3.2

Sugars and Sugary Drinks

The New Zealand Dental Association position is that it supports:

- The introduction of a sugary drinks levy that aims to reduce the consumption of sugary drinks to reduce tooth decay and is consistent with the WHO guidelines.
- The government and the beverage industry introducing a sugar icon on the packaging of all sugary drinks to indicate the amount of sugar, in teaspoons, in each product.
- The regulation of the promotion, advertising and marketing of sugary drinks to children.
- The development of policies by local government to introduce 'water-only' policies at council venues and events and to limit the sale and advertising of sugary drinks in and around schools.
- Mandating schools and early learning services to adopt 'water-only' policies.
- WHO guidelines that recommend free sugars should be less than 10% of daily energy intake.
- The introduction of a daily allowance for the intake of free sugars for New Zealanders, in line with the recommendations from the WHO.
- Encouraging the public to switch their sugary drinks to water by expansion of nationwide social marketing campaigns such as "Switch to Water" and "All Rizz no Fizz".

Dental decay is a complex multifactorial disease with socio-economic and biological determinants.

Sugary drinks are one of the most significant risk factors for tooth decay, obesity, type 2 diabetes and other noncommunicable diseases. It is for this reason we urge governments to act and to address one of the main commercial determinants of tooth decay – the sugary drink industry.

As a nation we consume sugar at an alarming rate. The health effects of a diet high in sugar are well known, and our poor health statistics clearly reflect this. New Zealand is in the midst of an obesity and type 2 diabetes epidemic. We are the third most obese nation in the OECD. More than a third of all New Zealanders aged over 15yrs are obese, and one in ten children. The impacts of these health conditions place a massive drain on our already overburdened health system.

In 2023/2024, an estimated 321,000 (7.4%) New Zealand adults had one or more teeth removed due to decay, abscess, infection or gum disease. Approximately 31,000 (3.3%) of children had one or more teeth removed over the same period. Dental care is one of the most common reasons for children's admission to hospitals, and for young children, dental disease is a leading cause of potentially avoidable hospitalisations. Admission rates to public hospitals for dental care have reached unsustainable rates, with approximately 9,000 young people aged under 18 years every year undergoing a general anaesthetic to have one or more teeth removed due to tooth decay.

The World Health Organization (WHO) guideline recommends that the daily intake of free sugars be limited to less than 10% (or 50gm) of total energy intake in both adults and children. The WHO defines 'free sugars' as monosaccharides (e.g. glucose, fructose) and disaccharides (e.g. sucrose) added to foods and drinks

“ Sugary drinks are one of the most significant risk factors for tooth decay, obesity, type 2 diabetes and other noncommunicable diseases. It is for this reason we urge governments to act and to address one of the main commercial determinants of tooth decay – the sugary drink industry. ”

by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates. It does not include naturally occurring sugars in fruits, vegetables, and dairy products.

The New Zealand Dental Association recommends water as the best drink of choice for oral health. The quality of reticulated water supplies in New Zealand is regulated and monitored. Water has no added sugar, no calories and is non-acidic, and for over half of the population reticulated tap-water provides the benefit of community water fluoridation.

Section 3.3

Community Water Fluoridation

The New Zealand Dental Association position is:

- That it strongly supports Community Water Fluoridation (CWF) as an effective, safe, and affordable public health measure.
- That New Zealanders should have access to optimally fluoridated water, wherever this is practical and affordable.
- That the delivery of community water fluoridation is a core public health responsibility of public health authorities in conjunction with water suppliers.
- That government must ensure the delivery of community water fluoridation is included in the considerations for the development of the organisation, funding and responsibilities for delivery of safe drinking water in New Zealand.

Fluoride is a naturally occurring element. It is found in the air, soil, water, seawater, plants and many foods. In New Zealand, fluoride occurs naturally in all water supplies, but at a level that is too low to protect against tooth decay. Community water fluoridation (CWF) which is the process of adjusting the fluoride level in reticulated water supplies to 0.7-1.0 parts per million helps protect against tooth decay.

The US Centres for Disease Control and Prevention named CWF as 'one of the top 10 most effective public health tools of the 20th Century'.

A comprehensive 2014 New Zealand review of the scientific evidence for and against the efficacy and safety of community water fluoridation by the Prime Minister's Chief Science Advisor and the Royal Society of New Zealand Te Apārangi concluded that:

> "From a medical and public health perspective, water fluoridation at the levels used in New Zealand poses no significant health risks and is effective at reducing the prevalence and severity of tooth decay in communities where it is used."

> "Our assessment suggests that it is appropriate, from the scientific perspective, that fluoridation be expanded to assist those New Zealand communities that currently do not benefit from this public health measure – particularly those with a high prevalence of dental caries."

Further updates were completed in 2021 by the Office of the Prime Minister's Chief Science Advisor and in 2024 by the Ministry of Health. The 2024 review concluded that evidence published since 2021 indicates that there are clear benefits from CWF even when alternative forms of fluoride, such as fluoride toothpastes, are available. CWF promotes equity and there has been no high-quality evidence published since the reviews in 2014 and 2021 to suggest a causal link between fluoride at the levels used in New Zealand for CWF and significant harm to health.

Similarly, following a 2016 review of community water fluoridation the Australian NHMRC stated that existing evidence consistently shows that CWF reduces tooth decay, and is not associated with cancer, Down syndrome, cognitive dysfunction, lowered intelligence or hip fracture and there is no reliable evidence of an association between community water fluoridation at current Australian levels and other human health conditions.

A recent UK study in Cumbria, published in 2022, again concluded that children born at the commencement of fluoridation and children born after fluoridation had commenced, had lower rates of decay after adjustment for confounding effects. Both groups had reductions in dental service costs that exceeded the cost of fluoridation.

Section 3.3

Community Water Fluoridation
Continued ...

In New Zealand the Health (Fluoridation of Drinking Water) Amendment Act was passed in 2021 and allows the Director-General of Health to direct the addition of fluoride to a drinking-water supply after consideration of the scientific evidence on the effectiveness of fluoridation, the prevalence and severity of dental decay and whether the benefits outweigh the financial costs. The amendment to the Health Act aims to provide a nationally consistent approach to decisions regarding community water fluoridation.

Following passage of the Act, the Director-General issued 14 directives to local councils in July 2022 to fluoridate their water supplies. Implementation dates were between June 2023 and June 2026. A further 27 local authorities were advised by the Director-General of Health in November 2022 that the Director-General is now considering whether to issue directions to fluoridate in relation to one or more of their drinking-water supplies.

Introduction of CWF by the first tranche of Councils would increase population coverage from 51% to 60% and the second tranche could further increase coverage to 68%.

However, the Association is concerned that early signs indicate that water suppliers and the Ministry of Health are experiencing delays in implementing the directives. A recent High Court ruling questioned the process followed by the Director-General of Health when issuing the first directives in July 2022.

> **“ New Zealanders should have access to optimally fluoridated water, wherever this is practical, to reduce and control levels of tooth decay. ”**

In late 2024, the Director-General reaffirmed the directives that had been issued, but the Association remains concerned that there may be ongoing delays to the implementation of directives under the Health (Fluoridation of Drinking Water) Amendment Act.

Community water fluoridation requires appropriate governance, community explanation and monitoring systems that are the responsibility of water suppliers and public health authorities.

It also requires adequate funding for the installation and maintenance of the capital infrastructure and modest operational investment for day-to-day operations.

New Zealanders should have access to optimally fluoridated water, wherever this is practical, to reduce and control levels of tooth decay.

Other common sources of fluoride in New Zealand are fluoridated toothpastes, fluoride mouth rinses and a range of professionally applied fluoride products.

Section 3.4

Fluoridated Toothpastes

The New Zealand Dental Association recommends and endorses:

- The availability of affordable fluoridated toothpaste with at least 1000ppm fluoride as a public health measure to reduce tooth decay.
- Brushing twice a day with a toothpaste with at least 1000ppm fluoride for all ages.
- Children up to 5 years of age should use a smear of toothpaste and from 6 years of age and older a pea sized amount should be used.
- Children should be supervised when brushing their teeth with fluoride toothpaste.
- Toothpaste should be labelled in ppm fluoride.
- The use of toothpaste with a higher concentration of fluoride (5000ppm) for teenagers, adults and older adults who are at elevated risk of developing dental caries, after seeking the advice of a dentist or another appropriate oral health or health practitioner.

The New Zealand Dental Association does not recommend or endorse:

- The use of non-fluoride toothpastes to control dental decay.

Fluoride toothpaste is the most widely known and available source of topical fluorides. Since the 1970s, fluoride toothpaste, independently or together with water fluoridation, has been responsible for the decrease in the incidence of dental caries.

Most fluoridated toothpastes on sale in New Zealand contain 1000-1500ppm fluoride. Toothpastes with fluoride in this range of concentrations have been shown to be effective in preventing, arresting and treating dental caries.

The 2009 New Zealand Ministry of Health Guidelines for the Use of Fluorides provide evidence-based support for the use of fluoride toothpastes as effective in preventing dental caries. The Guidelines agreed that fluoridated water and fluoride toothpastes provide ideal building blocks and that additional fluoride interventions can be considered for people at higher risk of dental caries.

The most recent (2019) Australian guidelines for the use of fluorides reported that evidence supports the use of 5000ppm toothpastes in populations at high risk of dental caries, including root caries. Their use was recommended on the advice of a dentist or other appropriately trained oral health or health practitioner.

The Association supports the fluoride toothpaste recommendations in the 2009 New Zealand guidelines and the more recent recommendation of the Australian guidelines for the use of high strength (5000ppm) toothpastes for people at high risk of dental caries.

Section 3.5

Professionally Applied Fluorides

The New Zealand Dental Association position is:

- The New Zealand Dental Association supports the use of professionally applied fluoride products as part of programmes to reduce or manage dental decay.

Topical fluorides can be used to prevent or control dental decay in a variety of formats, but commonly as fluoride varnishes, gels and foams, and as Silver Diamine Fluoride to arrest dental decay.

This paper does not explore the use of professionally applied fluorides as this in the realm of clinical guidelines which are beyond the scope of this Roadmap Towards Better Oral Health for New Zealand.

However, the New Zealand Dental Association does note that Silver Diamine Fluoride has recently been approved for use as a medicine by Medsafe in New Zealand.
The Association supports the introduction of Silver Diamine Fluoride in New Zealand.

The Association has supported a multidisciplinary group to develop clinical guidelines appropriate to contemporary practice in New Zealand and will contribute to continuing clinical education for dentists and oral health professionals.

Section 3.6

Tobacco

The New Zealand Dental Association position is:

- That it supports smoking cessation programmes and initiatives in dental practices.
- That it supports programmes and initiatives in the wider community focused on smoking cessation.
- That it supports targeted measures to reduce smoking rates among at risk groups.
- That it supports smoke-free environments and policies, and measures aimed at eliminating exposure to second-hand smoke.
- That it supports New Zealand's Smokefree 2025 goal that smoking rates for all population groups will be less than 5%.
- That it supports the Smokefree Aotearoa 2025 Action Plan.

Oral health professionals play a powerful role in supporting patients to enhance their overall wellbeing by providing brief interventions, clear guidance, and culturally responsive follow-up. These positive engagements can significantly contribute to reducing tobacco use and fostering healthier futures.

The Association upholds the importance of this work as a vital expression of ethical and professional responsibility, and strongly supports targeted, mana-enhancing interventions that uplift communities most affected by tobacco use. It is estimated that around 6.8% of adults are daily smokers. Māori and Pacific people, are significantly more likely to be smokers than other groups and smokers are more prevalent among people living in deprived neighbourhoods (10.7%) compared with adults in the least deprived neighbourhoods (3.1%).

Higher rates of smoking lead to significant health inequalities and are directly linked to cancers, respiratory diseases, heart disease, stroke and other disorders.

Tobacco is the main cause of premature death and disability in New Zealand and results in almost 5,000 deaths every year, killing more than half of those who use it. The health-related effects of smoking carry substantial costs in terms of health care support and lost productivity. Tobacco related costs to the health system were estimated to be $2.5 billion.

> **"Good oral health and the use of tobacco in any form do not go together. The use of tobacco is harmful to health and oral health and is a common cause of addiction, preventable illness, disability and death."**

Good oral health and the use of tobacco in any form do not go together. The use of tobacco is harmful to health and oral health and is a common cause of addiction, preventable illness, disability and death. The use of most tobacco products leads to an increased risk of oral cancer, oral mucosal lesions, and periodontal disease. Tobacco use is also associated with reduced healing capacity of the oral and periodontal tissues, which increases the risk of poor healing with surgical procedures in the mouth and for oral tissues, including an increased risk of failure for dental implants.

Combined exposure to alcohol and tobacco creates a higher risk of oral and pharyngeal cancers that is the product of the increases in risk associated with exposure to either habit.

The Association supports programmes and initiatives in the wider community focused on smoking cessation.

Section 3.7

Vaping

The New Zealand Dental Association position is:

- That it supports vaping as a smoking cessation tool.
- That it supports smoking cessation programmes and initiatives in dental practices.
- That it supports programmes and initiatives in the wider community encouraging and supporting older people who smoke to switch to vaping.
- That is supports targeted measures to reduce smoking and vaping rates among at risk groups.
- That it supports New Zealand's Smokefree 2025 goal that smoking rates for all population groups will be less than 5%.
- That it supports strengthening the regulatory framework for vaping products in order to minimise youth vaping.

Emerging evidence suggests that vaping can be a safer alternative to smoking traditional tobacco products. A 2024 Cochrane Review provided the strongest evidence to date that e-cigarettes are more effective than traditional nicotine replacement therapies, such as patches and gum, in supporting people to quit smoking.

While vaping poses fewer risks than smoking, the ultimate goal remains supporting individuals to become free from all forms of nicotine dependence. Current daily vaping rates in New Zealand have increased significantly since being introduced into New Zealand in the mid-2000s. It is now estimated that 9.7% of adults aged 15 years and older vape on a daily basis. Daily vaping among 15–17-year-olds has also increased to 15.4%, and for those aged 18-24 years 25.2% are daily vapers.

Vaping was initially introduced as a tool to support smoking cessation, which may help explain the higher uptake seen among Māori and Pacific peoples. In 2022/23, nearly a quarter of Māori reported vaping daily. Māori were 2.5 times more likely to vape than non-Māori, and those living in the most socio-economically disadvantaged communities were 2.8 times more likely to vape than those in the most advantaged areas. These trends highlight the importance of ensuring that harm reduction tools are equitably designed,

> **"It is now estimated that 9.7% of adults aged 15 years and older vape on a daily basis. Daily vaping among 15–17-year-olds has also increased to 15.4% and for those aged 18-24 years 25.2% are daily vapers."**

regulated, and supported to meet the needs of communities most impacted by smoking-related harm. There is no conclusive evidence at this time to prove adverse causal effects of e-cigarettes on oral health. However, systematic reviews have shown that mouth and throat irritation and periodontal damages are the most reported oral side effects.

Section 3.8

Alcohol

The New Zealand Dental Association position is:

- That it supports alcohol cessation programmes and initiatives in dental practices.
- That it supports programmes and initiatives in the wider community focused on alcohol cessation.
- That it supports targeted measures to reduce alcohol-related harm among at risk groups.
- That it supports measures to limit alcohol advertising and sponsorship, particularly in sports.
- That it supports measures to address deficiencies in the Sale and Supply of Alcohol Act.

The Association supports programmes and initiatives in the wider community that are focused on curbing alcohol-related harm.

Alcohol is the most widely used drug in New Zealand. Every year more than 800 deaths are caused by alcohol consumption. Alcohol is a psychoactive substance with addictive properties and is classified as a Group 1 carcinogen by the International Agency for Research on Cancer.

Harmful alcohol use is a significant burden to society. In 2024, the NZIER estimated a $9.1 billion cost of alcohol-related harm based on disability-adjusted life years. By comparison, alcohol excise revenue was $1.2 billion in 2020. Alcohol also puts considerable pressure on the health sector, particularly emergency services, as well as on our police and justice systems.

> **“ The impacts of alcohol consumption on oral health may include an increased likelihood of the occurrence of dental caries, periodontal disease, tooth wear, staining, halitosis and trauma. ”**

Alcohol is associated with a risk of developing malignancies such as breast cancer, colorectal cancer and cancer associated with the oral cavity, oropharynx, larynx and oesophagus. Alcohol is also a major risk factor for other non-communicable conditions such as cardiovascular disease and liver cirrhosis. There is no safe amount of alcohol consumption.

The impacts of alcohol consumption on oral health may include an increased likelihood of the occurrence of dental caries, periodontal disease, tooth wear, staining, halitosis and trauma. Alcohol consumption increases the risk of facial and oral injuries from falls, traffic accidents and violent confrontations.

Brief interventions from healthcare practitioners can reduce alcohol consumption among hazardous and harmful drinkers, indicating an important role for oral health practitioners in delivering these educational interventions.

Alcohol has a synergistic effect when combined with smoking, increasing the risk of oral cancers. Smokers have a 10 times higher risk of developing oral cancers than non-smokers, but when combined with alcohol, the risk multiplies up to 300 times more compared to people who neither smoke nor drink.

Section 3.9

Injury Reduction

The New Zealand Dental Association position is:

- That it supports the development of safer environments that minimise the risk of dental or maxillofacial injuries, particularly from falls and road traffic accidents.
- That it supports measures to reduce interpersonal violence and alcohol-related harm.
- That it supports the use of mouthguards in contact sports and in recreational activities with a high risk of dental or maxillofacial injury.
- That it supports the use of custom-made mouthguards as they can offer greater comfort and a higher level of protection.
- That it supports the use of full-face helmets for mountain bikers as they greatly reduce the incidence of dental injuries in case of accidents.
- That it supports greater focus on prevention and the importance of initial care for dental injuries.

Dental and maxillofacial injuries constitute an important public health issue. They are often irreversible, frequently complex, difficult and costly to treat. Young children and teenagers have been identified as high-risk groups, particularly when learning to walk and when new and/or high-risk activities are involved.

Data from the 2009 New Zealand Oral Health Survey identified that 40% of the adults surveyed reported a history of dental trauma, and in 2008 32,110 people registered an orofacial injury with ACC. A retrospective audit of maxillofacial surgery department data at Dunedin and Southland Hospital between 2009 and 2020 reported 1,561 patients with 2,480 maxillofacial fractures.

Dental injuries occur from predominantly sport and recreational activities, falls, interpersonal violence, road traffic accidents and work environments.

Prevention of dental and maxillofacial injuries should be of high priority. Developing and promoting policies and protocols that focus on minimising the risk of oral injuries is a key to prevention. Appropriate health and safety requirements should be observed in workplaces. Recreational equipment and environments should be designed to minimise oral injury.

> “Following an oral injury, prompt assessment by a dentist, including proper diagnosis, treatment planning, treatment and follow up, are important to improve the chances of a favourable outcome.”

Public education programmes should promote awareness of potential oral injuries and emphasise the importance of parental supervision and protective equipment. Appropriate protection should be normalised and expected in the community.

Following an oral injury, prompt assessment by a dentist, including proper diagnosis, treatment planning, treatment and follow up, are important to improve the chances of a favourable outcome. Traumatic injuries to teeth require early assessment and appropriate management to enable optimum recovery.

In New Zealand awareness of ACC funded cover for oral injuries is needed, and continued focus is required to ensure ACC funding supports affordable, equitable, timely and appropriate access to care for oral injuries.

Section 4:

Access to Care

Section 4.1

Universal Health Coverage and Oral Health Care

The New Zealand Dental Association position is:

- That it supports the FDI World Dental Federation in the goal of equal access to oral health services for all populations.
- The Association advocates to address barriers to access to oral healthcare and promotes the universal health coverage (UHC) as providing an opportunity for oral health services to become more integrated into the wider healthcare system, and to be more accessible and responsive to the oral healthcare needs of the population.

Universal health coverage (UHC) is described by the World Health Organization as meaning all people have access to quality health services when and where they need them, without financial hardship. UHC encompasses the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

Universal health coverage does not suggest free coverage for all health interventions, regardless of cost, as this is not sustainable. It is more than an issue of health financing, but it must also consider delivery systems, workforce, facilities, information and communication systems, technology, quality assurance and governance. It should encompass more than a minimum package of care and aspire to progressive improvements and include population-based services, including community water fluoridation and reductions in dietary sugars.

Section 4.2

Child and Adolescent Oral Health Services

The New Zealand Dental Association position is:

- That all New Zealand children and adolescents are entitled to high quality oral health care including diagnosis, prevention and treatment services to maintain their dental health.
- That it is very concerned by the declining rates of access to publicly funded dental care and the persistent inequities in the oral health of children and adolescents.
- That children, adolescents and young adults at particular risk of dental caries should receive targeted preventive dental care and appropriate treatment services to maintain their oral health and aid in the reduction of inequalities in oral health.
- That it considers there may be a need for redesigning services to ensure they can be freely and appropriately accessed by those most in need.
- That it supports Māori determining the design, delivery and monitoring of their health services to support achieving equitable health outcomes.
- That it supports maintaining the right of families to access private dental care.

While child and adolescent oral health services are publicly-funded and free at point of access, there is increasing concern about the sustainability of these services and their ability to deliver timely services in New Zealand.

Between 2017 and 2021, the number of children aged between 0 and 12-13 years overdue for care increased from 118,518 to 321,680 and represented an increase from 15% to 41% of children. These children were predominantly enrolled with the Community Oral Health Services of Health New Zealand | Te Whatu Ora. Data reported for 2023 indicates that the number of children overdue for care had improved to 191,120, but also suggests that the number enrolled may also have fallen substantially, meaning that the number overdue was less representative of an overall lack of access to care. In the Auckland region, 50% of children remained overdue for care in 2023.

Adolescents from Year 9 until their 18th birthday predominantly receive care from contracting dentists in private practice through funding from Health New Zealand | Te Whatu Ora. In 2023, 137,505 adolescents were seen by contracting dentists, representing 73% of the estimated eligible adolescent population. A further 2,854 adolescents were seen by providers with alternative funding mechanisms (e.g., Hauora Māori providers). Approximately 71% of adolescents accessed oral health services annually from 2016 to 2019.

Historically, New Zealand children and adolescents have had better of access to dental care than adults. However, significant concerns are developing that access rates for children and young people, although free at point of care, have fallen substantially since 2019.

> **“Children, adolescents and young adults at greatest risk of dental caries should receive preventive dental care and appropriate treatment services to maintain their oral health and to aid in the reduction of inequalities in oral health.”**

There are concerns that historical data may have under-represented the rates of access by Māori, Pacific and Asian children and adolescents as result of inaccurate systems to capture and report ethnicity. Timely access to oral health care, and accurate data recording, are essential parts of maintaining high-quality healthcare.

In addition, as described in Section 2 of this Roadmap report, there are persisting inequities in the levels of dental decay, and other oral diseases. The Association is concerned that for many years the focus in New Zealand has been on horizontal equity, that is everyone receiving the same type of care. This is built from the assumption of everyone having the same needs. The Association considers it is timely to consider the issues of vertical equity in our delivery of child and adolescent oral health services. Vertical equity considers the basis of need and that different groups have differing health needs, and that some require more health care. It has also been described as proportionate universalism by Professor Michael Marmot in his exploration of health inequalities in England.

The Association is concerned by the rates of access to funded dental care and by the persisting inequities in oral health. It considers there may be a need for targeting of funding and services, to ensure they can be freely accessed by those most in need. Redesigning services should maintain the right of families to access private dental care. Redesign must consider the responsibilities that Te Tiriti o Waitangi confers on the Crown in the context of universal public funding for publicly-funded child and adolescent services. The Association supports Māori determining the design, delivery and monitoring of their health services, to support achieving equitable health outcomes. This should include the funding and delivery of culturally appropriate health services where appropriate.

Children, adolescents and young adults at greatest risk of dental caries should receive preventive dental care and appropriate treatment services to maintain their oral health and to aid in the reduction of inequalities in oral health.

Section 4.3

Adult Access to Care

The New Zealand Dental Association position is:

- That all New Zealanders have the right to good oral health.
- That it is concerned about accessibility of oral health care, and in particular the affordability of health care for adults.
- That it will continue to advocate for actions consistent with the access to care plan outlined in the New Zealand Dental Association 2019 paper.
    1. Funding of dental care for young adults.
    2. Designing and testing dental service models that are appropriate for communities and for high-need population groups.
    3. Develop and implement adult oral health care programmes that meet the needs of local communities and high-need population groups.
- That it supports Māori determining the design, delivery and monitoring of their health services to support achieving equitable health outcomes.
- That pharmacy charges to patients for prescriptions issued by a dentist should be the same as those for prescriptions issued by a medical practitioner in primary care.
- That patients attending a dentist should have access to funded laboratory services for histology and routine blood tests on the same basis as primary care.

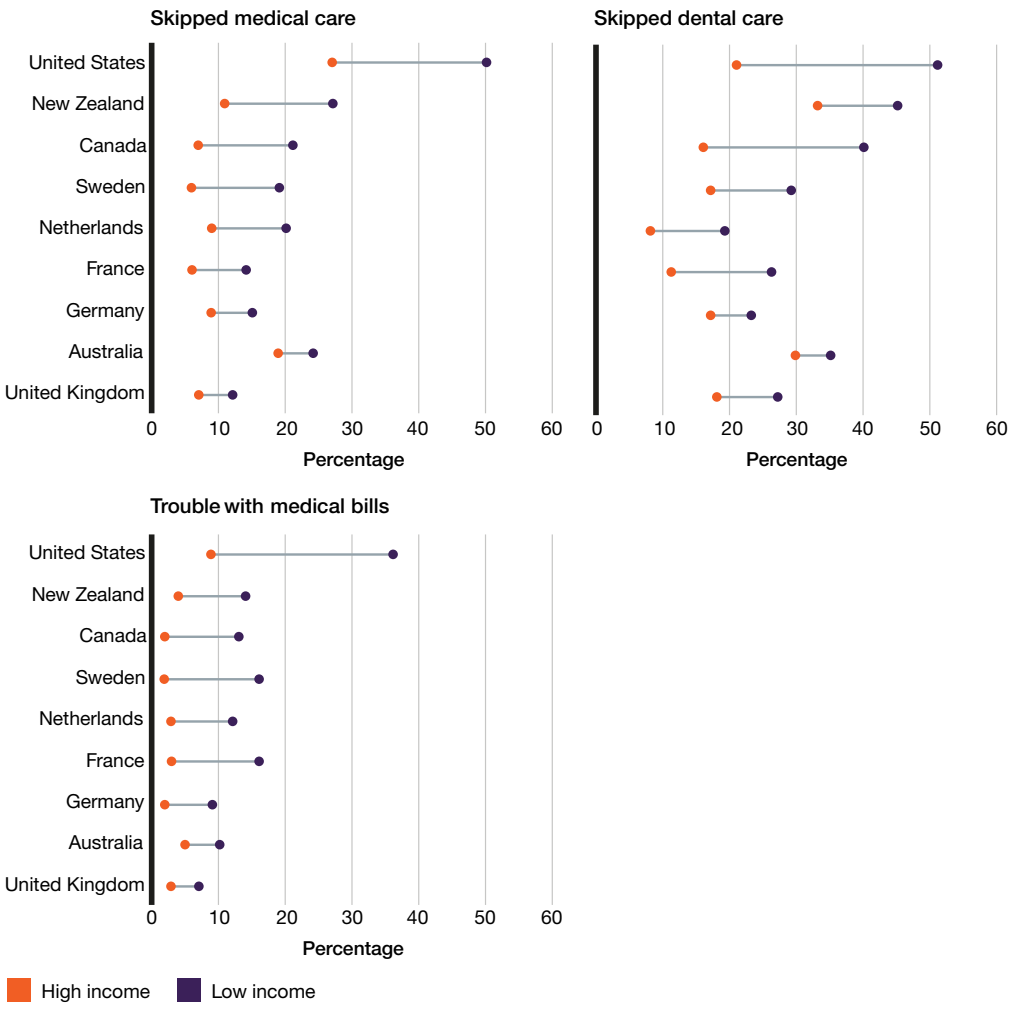
The New Zealand Dental Association believes that adult dental care must be considered a health service and recognised as a human right. There is no sensible reason for oral health issues not being considered as part of general health and as part of health services.

However, the 2023/24 New Zealand Health Survey reported that of New Zealanders in the highest quintile of deprivation (NZ Dep 5) only 36% visited a dentist in the past 12 months, 72% only attend a dentist for a problem and 52% had avoided dental care in the past 12 months due to cost. In contrast, for adults in the same category 74% had seen a GP in the last 12 months and only 18% avoided a GP visit due to cost.

The UK King's Fund reported in 2023 that in a comparison study of 9 countries New Zealand had the second highest rate of people on lower incomes skipping dental care, after the United States.

“ The New Zealand Dental Association believes that adult dental care must be considered a health service and recognised as a human right. There is no sensible reason for oral health issues not being considered as part of general health and as part of health services. ”

Figure 2: People on low incomes in New Zealand are more likely to skip dental check-ups than skip medical care or have trouble paying medical bills, than in comparator countries except the United States (King's Fund 2023)



Source: **Doty *et al* 2020**

Income is based on self-reported pre-tax income that is lower (somewhat below or much below the national average) or higher (somewhat above or much above the national average). Data are self-reports of 'skipped needed doctor visits, tests, treatments, follow-up or prescription medicines because of cost, past year', 'Skipped dental care or check-ups because of cost, past year', and 'Had serious problems or unable to pay medical bills, past year'

Anandavica S. *How does the NHS compare to the health systems of other countries? The King's Fund June 2023*. Available at https://www.kingsfund.org.uk/insight-and-analysis/reports/nhs-compare-health-care-systems-other-countries. (Accessed on 25 June 2025)

Section 4.3

Adult Access to Care
Continued ...

Consequently, health providers in our Emergency Departments and in primary care regularly report that people attend with dental problems. However, there is little they can do beyond pain relief and management of overt infections. Attendance at these services creates an additional burden on already stretched services and imposes additional costs and delays in accessing appropriate care. In the worst situations these delays lead to people being admitted to hospital with serious infections. The length of stay in hospital can range from 1-2 nights, to a hospital stay greater than 7 nights, according to a review of people who were admitted to intensive care due to a head and neck infection of dental origin.

In 2019, the New Zealand Dental Association published the paper *Access to Oral Health Services for Low-income Adults. Building on our policy position.* This paper, developed with PwC, found that investing in basic dental services for low-income adults can have a positive return on investment for government and improve societal well-being. The paper outlined a roadmap of 4 steps to improve access to oral health services. The first step of extending urgent dental grants was acted on by the government in 2022. However, further work remains, and the New Zealand Dental Association supports ongoing policy programmes to improve access to dental care for people aged 18 years and over in New Zealand.

“ The Association considers it is time to consider the issues of vertical equity in our delivery of oral health services. ”

While affordability is a key aspect to improving access to dental care, it is not the only factor. Many associated issues influence the decision of people not to attend a dentist. These include fear and past experiences of dental care, not having a regular dental practice to attend, high prescription co-payments when the prescription is written by a dentist, lack of access to funding for laboratory tests taken by a dentist and copayments for hospital dental outpatient visits but not for other secondary health service outpatient appointments.

As discussed in the previous section, there are persisting inequities in the levels of dental decay, and other oral diseases. The Association considers it is time to consider the issues of vertical equity in our delivery of oral health services. Vertical equity considers the basis of need and that different groups have differing health needs, and that some require more health care.

The Association is concerned that the separation of funding for adult oral health care across several government policy areas (Social Development, ACC and Health), and the limited ability to combine funding to ensure affordable access to care, are barriers to affordable access to care. New Zealand Dental Association members have also noted that very limited funding of dental care under health insurance policies in New Zealand can create a further barrier to care.

The Association supports the right of Māori to lead the design, delivery, and monitoring of health services that reflect their values, aspirations, and tikanga. Achieving equitable health outcomes requires sustained investment in culturally grounded services led by and for Māori. Service design and funding must honour Te Tiriti o Waitangi and reflect the Crown’s obligations to uphold tino rangatiratanga in all publicly-funded oral health services.

Section 4.3.1

Older Adults

The 2012 New Zealand Older People's Oral Health Survey collected information about the oral health of older New Zealanders living in residential aged-care facilities, and living at home but requiring assistance with their activities of daily living.

Overall, 43% of people who were living in residential care, and 48% living at home, retained one or more of their natural teeth. There were concerning levels of untreated decay in these groups. In residential care 61% had untreated dental decay in the crown of a tooth at 33% had root decay. For those living at home 43% had untreated decay in the crown of a tooth and 33% had untreated root decay.

As with other population groups, the 2012 survey of older people's oral health reported similar disparities in the oral health among vulnerable population groups, as did other surveys of adult oral health.

New Zealand lacks an oral health policy for older adults, irrespective of dependency levels.

The Association supports policies and enhanced service provision to improve the primary prevention of oral disease, such as reasonable access to enhanced fluoride toothpastes, oral care plans in residential care facilities, and enhanced access to oral health services. The Association also supports considering dependent older adults as a vulnerable population group when designing, funding, and delivering programmes to protect and enhance their oral health.

Section 4.3.2

People with Disabilities and Complex Health Needs

Whaikaha-Ministry of Disabled People estimates that there are over 1 million New Zealanders living with a disability and Health New Zealand | Te Whatu Ora estimates that one in four New Zealanders live with multiple chronic health conditions such as diabetes, cardiovascular diseases, stroke and cancers.

Disability and complex chronic health conditions may lead to complex oral health needs and a higher incidence of oral disease.

In New Zealand, oral health services for some people unable to access oral health care services in the community are provided at Hospital Dental Services. They are delivered by clinicians in dental units at many, but not all, New Zealand hospitals.

Where available, the services can provide dental treatment that is an essential part of hospital treatment for a current medical or surgical condition. The service can also provide hospital admission because of the need for special management facilities, including general anaesthesia, when the person's health or disability precludes access to dental care in the community.

The clinicians in these services provide high quality support to specific groups of vulnerable people. However, services are fragmented, there is a great deal of variability in services available at different hospitals, and care can be less than optimal due to a lack continuity and insufficient capacity.

Health New Zealand | Te Whatu Ora have identified in *Workforce Plan 2024* that they are experiencing shortages in their dental workforce to deliver these services.

The Association supports the funded availability of specialised oral health services for people requiring access to hospital-based dental services and the dental workforce that delivers this care, many of whom are Association members.

“In New Zealand oral health services for some people unable to access oral health care services in the community are provided at Hospital Dental Services. They are delivered by clinicians in dental units at many, but not all, New Zealand hospitals.”

However, the Association is concerned that access to care for people with disabilities and complex health needs is variable across New Zealand, and that continuity of care is frequently poor. There are limited options for people with disabilities and complex health conditions that do not require hospital-based care to obtain funded care in primary and community–based oral health services.

The Association supports designing, testing and implementing adult oral health care programmes and dental service models that are appropriate for vulnerable population groups in the community. These services and programmes should complement hospital-based dental services.

The Association also supports the professional development of general dentists, specialist dentists, and oral health professionals required to support people with disabilities and complex health needs, as well as the development of intra- and inter-professional teams to deliver these services.

Section 4.4

ACC Access to Care

The New Zealand Dental Association position is:

- That all New Zealanders have the right to good oral health.
- That it is concerned about accessibility and affordability of accident-related oral health care for children and adults.
- That it is concerned to ensure adequate compensation for ongoing dental care that may be needed after an accident.

Dental and maxillofacial injuries are frequently sudden and unexpected events. Dental injuries to teeth have a limited capacity to heal, and frequently require treatment shortly after the injury, followed by ongoing dental treatment that can continue for many years. Maxillofacial injuries involving bone or soft tissues of the face have a greater ability to heal but can be significant injuries that may involve hospital level care, time off work and create ongoing treatment and rehabilitation needs.

The New Zealand Dental Association believes that dental and maxillofacial injuries to children and adults must be considered a health service, their treatment recognised as a human right and recognised within New Zealand's Accident Compensation scheme.

Financial coverage by the Accident Compensation Act 2001 for dental and maxillofacial injuries must be sufficient to enable timely, equitable and fair treatment. Coverage must include time for rehabilitation from dental and maxillofacial injuries, including sufficient income-related compensation when a person is unable to work as a result of dental or maxillofacial injuries and compensation for the ongoing dental care that may be needed after an accident.

"The New Zealand Dental Association believes that dental and maxillofacial injuries to children and adults must be considered a health service, their treatment recognised as a human right and recognised within New Zealand's Accident Compensation scheme."

Section 5:

Workforce

Section 5.1

Dentist and Dental Specialist Education and Competencies

The New Zealand Dental Association position is:

- That a general dentist requires undergraduate education and training in a university programme accredited by the Dental Council of New Zealand, or to have been assessed and approved by the Dental Council of New Zealand to have an equivalent level of education and training to a New Zealand trained dentist.
- That a dental specialist requires a postgraduate programme of education and training accredited by the Dental Council of New Zealand, or to have been assessed and approved by the Dental Council of New Zealand to have an equivalent level of education and training to a New Zealand trained dental specialist.

Undergraduate dental education involves the teaching of future dentists to prevent, diagnose and treat oral diseases and meet the dental needs and demands of the individual patients and the public.

Graduating dentists should be able to carry out the full scope of practice of dentistry as defined by the Dental Council of New Zealand using modern, appropriate, effective and currently accepted methods of treatment. Dentists require interpersonal communication skills to work successfully with patients, members of the dental team, wider health system teams and colleagues. These skills are fundamental for dental practice in New Zealand.

Dental education should include the development of cultural awareness and cultural safety appropriate to practise in New Zealand.

It is important for undergraduate dental education to take into consideration the broadening role of dentists in line with the broadening definition of oral health and quality of life. Dentists require a strong understanding of the relationship between oral health and general health and the role of dentists in intra- and inter-professional collaboration in the delivery of oral health services.

Dental specialists have undertaken a further period of education and training of at least three years in scopes of practice established in the Health Practitioners Competence Assurance Act. Dental specialists have a higher level of training and experience in their specialist scope of practice than general dentists or other oral health practitioners.

Section 5.2

Dental Workforce Demographics, Demand and Supply

The New Zealand Dental Association position is:

- That an increase to the number of New Zealand government-funded dental student positions is required:
  - to improve the representation of Māori and Pacific peoples in the dentist and dental specialist workforces.
  - to improve the regional distribution of the dentist and dental specialist workforce.
  - to address the estimated increases in workforce requirements and low baseline levels of access to dentists.
  - to address the plateau in overseas qualified dentists registering in New Zealand; and
  - to address a substantial reliance upon overseas trained dental specialists.
- That dentists and dental specialists are the practitioners that encompass the practice of dentistry, and that in addition to clinical dentistry their practice can include clinical leadership, teaching, research and management.
- That the development of inter-disciplinary workforce teams, including oral health therapy and clinical dental technology, and integration of oral health into primary care teams can strengthen access to oral health care.

The New Zealand Dental Association is aware that a complex range of issues influence the number of dentists in New Zealand, and their distribution within the country.

There is substantial regional variation in the number of dentists as a ratio to the population. The number of dentists has increased steadily over the past 25 years, overseas trained dentists as a proportion of the dentist workforce have doubled but plateaued at approximately one-third of the workforce since 2010. While a greater number of Māori and Pacific peoples will be required for the dentist workforce to match their proportions in the New Zealand population, it is notable that many of the dentists educated in New Zealand have remained in New Zealand to practice over the past decade.

Dental therapy and dental hygiene training programmes have changed to a Bachelor of Oral Health and the number of dental therapists is declining with retirements. In contrast, the numbers of oral health therapists are growing, and they hold a wider scope of practice that includes dental therapy and dental hygiene. There are further changes to the scope of practice of oral health therapists developing, with newer graduates able to provide a limited amount of adult dental care.

While on overall assessment the number of dentists per 100,000 population has grown, the growth does not take sufficiently accommodate for an increasingly dentate older population with higher oral health needs, or that baseline levels of access to dental care in New Zealand are comparatively low.

Section 5.2.1

Active Dentist and Dental Specialist Numbers

During the period 2012 to 2024 the New Zealand population grew from 4.4 million to 5.1 million. The population 15 years and older, who primarily receive dental services with dentists, increased from 3.5 million to 4.4 million. The dentist population increased from 2,127 to 2,724.

Despite the increasing number of dentists, the ratio of dentists to the New Zealand population declined 4.9% during this 12-year period. Further analysis suggests that dentists were working 18.9% more hours each week. The pattern of a declining ratio of dentists to the population, and a greater average number of hours worked each week, suggests a dentist workforce under increasing demand to address the oral health needs of the population.

Beneath these headline figures are greater challenges in the dental workforce available to the population.

Section 5.2.2

Regional Variation

There is substantial regional variability in dentist to population ratios. In 2024, central Auckland and the Southern region (both former DHB regions) accounted for over 1 million people, 20% of the population and 18% of the dentists. Both regions had more than 50 FTE/100,000 population greater than 15 years of age. Auckland is the largest city and the Southern region influenced by the dentist workforce of the University of Otago Faculty of Dentistry.

The challenge of headline figures and regional variability is illustrated by the Southern region though. In 2022 Dunedin had 120 FTE dentists per 100,000 people greater than 15 years of age while Invercargill had 58 and Gore 15. Dunedin City has a large proportion of dental specialists which is consistent with them being a large component of the teaching staff of the University of Otago School of Dentistry.

In 2012, 60% of the former DHB areas of the country had a dentist ratio of 45 FTE to 100,000 population over 15 years of age, or lower. By 2024, this has increased to 85% of the former DHB areas. At dentist to population ratios of this level other international jurisdictions (eg Ireland) have described dentist workforce difficulties, including lack of access to care and inability to recruit and retain a dentist workforce.

Research by the New Zealand Dental Association in 2022 found that 38% of urban and suburban dentists, and 61% of dentists in rural locations, reported their workload as greater than they would like. A greater proportion of rural practitioners experienced poor mental health than those in other localities.

Section 5.2.3

Low Baseline Utilisation of Dental Care

Modelling by the Ministry of Health of dentist workforce demand has estimated that a workforce growth of 11.3% will be needed in the period 2020 to 2029.

However, that growth is based on the 2020 assumption that only 1.7 million people will use dental services. Put another way and based on a 2020 population of 5.1 million people, 4.2 million of who are aged over 15 years, this assumes service access by only 33.7% of the total population and 41.6% of the population aged 15 years and over.

The 2022/23 New Zealand Health Survey estimated that 1.95M people aged 15 years and over (49% of that population) visited a dental health care worker in the past 12 months. A number of these visits would have been to oral health practitioners other than a dentist, such as a dental hygienist or clinical dental technician. On that basis, workforce modelling estimates of around 42% of the population with access to a dentist in the past 12 months appear to be reasonable.

As described in section 4.3, these levels of utilisation of dental services are associated with poor access for people in the highest category of deprivation, and with delays in access to care.

Section 5.2.4

Demography of the New Zealand Dentist Workforce

The New Zealand dentist workforce is significantly under-representative of Māori and Pacific peoples at 4.4% and 1.8% respectively in 2024.

Over the last 10 years, overseas-qualified dentists have comprised approximately one third of the dentist and dental specialist register. In the period prior to 2010, there was a steady increase in the proportion of overseas-qualified dentists from approximately 5-10% in the mid-1990s.

Dental specialists with an overseas qualification comprise a slightly greater proportion of the number of dental specialists registered, at 44.5%, while it is 31.4% for general dentists. The primary countries of origin for qualifications of overseas trained specialists are the UK, Australia and the USA.

Unlike the 20-year period of steadily increasing numbers of overseas qualified dentists, the situation now appears to have plateaued. For the foreseeable future, maintaining and enhancing the New Zealand dentist workforce appears to be increasingly reliant upon the supply and retention of dentists from New Zealand training.

There is a single source of New Zealand-trained general dentists: the University of Otago Faculty of Dentistry programme. The government provided funding for 54 New Zealand students per annum from the mid-1980s until an increase to 60 funded positions per annum in the graduating class of 2018.

Historically, New Zealand lost graduates overseas, especially to the UK and Australia, resulting in approximately two-thirds of the Otago class remaining in New Zealand 10 years after graduation. However, overseas employment opportunities for dentists with a New Zealand qualification diminished from the 1990s, particularly due to EU employment restrictions.

Graduating numbers from the University of Otago remaining in New Zealand have generally been high since 2015, as a result of small numbers of internationally funded students over the New Zealand government-funded cap continuing to reside and work in New Zealand.

“There is a single source of New Zealand-trained general dentists: the University of Otago Faculty of Dentistry programme. The government provided funding for 54 New Zealand students per annum from the mid-1980s until an increase to 60 funded positions per annum in the graduating class of 2018.”

Section 5.2.5

Changing Dental and Oral Health Therapist Numbers

A new scope of practice known as Oral Health Therapy was introduced by the Dental Council in 2017. In 2012, there were 804 dental therapists and 593 dental hygienists and orthodontic auxiliaries (1,397 practitioners). By 2022 the total workforce of oral health therapists, dental therapists and dental hygienists/orthodontic auxiliaries had increased to 1,752 practitioners (753 OT, 593 DT and 406 DH/OA). However, the scopes of practice for these workforces make it complex to assess their impact on New Zealanders' ability to access dental services.

Dental therapists largely had a scope of practice in dental care for people aged under 15 years (a very small number had an adult scope of practice). Dental hygienists had a scope of practice in preventive and periodontal care for children and adults, but mostly for adults. Oral health therapists have a combination of these scopes.

An adult scope of practice for oral health therapists has been introduced by the Dental Council, but to date access to training has been limited and almost all oral health therapists have a limitation on their scope of practice excluding dental care for adults other than the traditional preventive and periodontal services. This is changing, but it is unknown how much additional care will be made available to the population by the extended scope of practice.

Meanwhile, the numbers of dental therapists are declining, creating access issues for children who have traditionally been provided most of their dental care by dental therapists. Health New Zealand | Te Whatu Ora and Te Aka Whai Ora | Māori Health Authority acknowledged this issue in their Health Workforce Plan 2023/24. They indicated then that the public dental system is 220 (20%) short of oral health therapists currently and would need an additional 10% of trainees on top of the current pipeline by 2032.

Section 5.2.6

Public Sector Oral Health Workforce Plans

Neither the 2023/24 Health Workforce Plan nor the 2024 Health Workforce Plan of Health New Zealand | Te Whatu Ora comprehensively considered the dental workforce needs of the country. The plans are limited to considering the publicly funded sector needs of Health New Zealand | Te Whatu Ora.

As discussed, the 2023/24 Health Workforce Plan estimated that Health New Zealand | Te Whatu Ora had a projected shortage of 220 dental or oral health therapists.

The 2024 Health Workforce Plan indicates a plan to secure 100 additional places in undergraduate education for a range of allied health professions that include oral health therapy. It also states,

“Acute shortages in dental workforces (oral, dental and maxillofacial surgeons and dentists; and oral health therapists) … produce specific challenges for patients requiring those care pathways….”.

The 2024 plan commits to creating **“6 advanced dental training roles”.**

Section 5.3

Wellness in the Dentist Workforce

The New Zealand Dental Association position is:

- That it aims to support dentists across the profession by focusing on four key recommendations made from its research with Revolutionaries of Wellbeing.
- Strategy and governance: the Association has a focus on setting up the systems and structures to influence wellbeing at a system level.
- Relationships: the Association is working closely with other key stakeholders to advocate for a greater focus on wellbeing in dentistry.
- Communications and resources: the Association aims to provide dentists and dental practices the tools to better lead wellbeing themselves, and is encouraging greater storytelling of the realities of dentistry.
- Member support: the Association is strengthening access to wellbeing supports, collegiality and social wellbeing through NZDA networks.

Dentistry is a demanding profession which challenges practitioners physically, mentally, intellectually and emotionally. Dentists across the world struggle with the various demands of the role, and dentists in New Zealand are no different.

In 2022, the New Zealand Dental Association engaged Revolutionaries of Wellbeing (ROW) to help it better understand wellbeing across the dental profession. ROW undertook a qualitative and quantitative research project with 517 dentists surveyed and 4 focus groups with dental students, practice owners, contractors and public sector practitioners across practice settings. The report provides a strong understanding of the drivers of wellbeing within the dentistry profession, including the psychology of the 'average' dentist, a greater understanding of what 'good' looks like and the qualities and competencies of a thriving dentist.

The ROW research found that the profession is challenged across a range of psychosocial risks, from patient interactions, staff relationships, the complaints process, the fear of making mistakes, and isolation. Dentists were struggling across a number of fronts. Notably, the pursuit of 'perfection' has led to dentists being unwilling or unable to speak openly about their mistakes or their struggles.

The New Zealand Dental Association has established the Well Aware Together programme to support dentists, and to be a world leader in wellbeing in dentistry.

Section 6:

Clinical Governance and Clinical Leadership, and Appropriate Policy Settings

Section 6.0

Clinical Governance and Clinical Leadership, and Appropriate Policy Settings

The New Zealand Dental Association position is:

- **That there is a need to improve political and resource commitments to oral health.**
- **That there is a need to strengthen leadership beyond a sole part time clinical leader and to create oral health units in the Ministry of Health | Manatū Hauora and Health New Zealand | Te Whatu Ora.**
- **That there is a need to consider oral health in policy development across the health sector and across government.**

The New Zealand Dental Association position is that achieving good oral health requires a focus on equitable population health that includes oral health, healthy environments, a healthy, competent oral health workforce that is sufficient to deliver services, and safe, cost-effective services that enhance the experience of health care.

Recent reform of the New Zealand health sector has shown limited focus on oral health, dental services or the dental workforce. The New Zealand Dental Association does note that in all of the five sector strategies that supported the 2023 New Zealand Health Strategy, oral health or dentistry was briefly mentioned. The documents collectively make arguments for the need for improved access to community-based and affordable dental services.

This is consistent with a concern of the public about the accessibility of oral health care, and particularly the affordability of health care for adults.

A great deal of oral health improvement will be influenced and achieved by factors outside of the control of dentists and other providers of oral health services, including housing, socio-economic conditions, incomes levels, and poverty.

However, improving oral health requires oral health to be recognised in health policy development. Oral health needs to be integrated into relevant population health and universal health coverage programmes that are wider than just those for child oral health and the early years of life.

There is a need for greater political and resource commitment to oral health to support communities to improve oral health and to support dentists and other providers of oral health services.

The New Zealand Dental Association is concerned that there is no current Oral Health strategy or strategic vision for oral health improvement.

The recently approved programme of work for Health New Zealand | Te Whatu Ora was limited to the 0-17 years age group.

The New Zealand Dental Association is also concerned that there is limited evidence of a functional and well-resourced oral health unit in the Ministry of Health | Manatū Hauora or Health New Zealand | Te Whatu Ora. Clinical leadership is provided at the Ministry of Health | Manatū Hauora by a national clinical leader who is qualified in dental public health. However, the FTE of that role was reduced in 2024, and the role is stretched to provide business as usual. Clinical leadership in Health New Zealand | Te Whatu Ora remains embryonic and is not clear to the sector. A clinical network has been established in 2025.

One person without a team of staff cannot provide the level of leadership necessary to advocate and ensure commitment to improving oral health. It requires a clinical leader to be recognised, with sufficient seniority in the health system, and to have a team with a mandate and a work programme.

Section 7:

Data, Digital and Oral Health Information

Section 7.0

Data, Digital and Oral Health Information

The New Zealand Dental Association position is:

- That New Zealand requires surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers.
- That efficient and effective integrated health information systems which include oral health, are required to improve clinical care for dental and oral health patients and to inform oral health planning, management and policymaking across the life course.
- That integration of electronic patient records for oral health with wider health information systems, including medical and pharmacological records, and across public and private providers of health care, can facilitate both improvements to people-centered care and population-level health monitoring.
- That strong regulation of data protection and confidentiality, including clinical governance, is required.
- That artificial intelligence methodologies have the potential to improve individual patient care, population oral health monitoring, and policy and programme development. However, transparency and clinical governance protocols are necessary to ensure the accuracy and veracity of system responses.

Population oral health information and health surveillance systems in New Zealand are currently a patchwork from a variety of sources. Limited surveillance information is provided on 5-year-old and Year 8 child oral health status and access to care in publicly-funded child and adolescent programmes. While strong time series data are available in these datasets, there is increasing concern that, as service coverage declines, it has diminishing accuracy.

Dentistry and other oral health workforces are highly regulated under the Health Practitioners Competence Assurance Act (2003). As a result, periodic supply-side information on the oral health workforce is available through Dental Council workforce reports.

However, very limited other population-level information on adult oral health, services, workforce, demand and risk factors is available. This has led to assumptions that are not necessarily correct, and difficulties in planning and monitoring oral health. A recent example is emerging information by researchers at the Universities of Canterbury and Otago, who are investigating water supply mapping and community water fluoridation coverage. This research has revealed concerning periods of less-than-optimal supply of fluoridated water and an overestimation of the coverage with community water fluoridation for Māori.

Looking ahead, digital transformation, powered by interoperable data and secure platforms, is reshaping healthcare and many aspects of daily life.

Section 7.0

Data, Digital and Oral Health Information

Continued ...

The use of shared data will enable targeted interventions that may improve both individual and community health. As the industry evolves, new roles and functions will emerge.

Oral health professions encourage the integration of electronic patient records for oral health with wider health information, including medical and pharmacological records, and the sharing of data across public and private providers of health care. Greater connectivity can facilitate both improvements to people-centred care and population-level health monitoring. As systems develop, strong regulation of data protection and confidentiality will be required.

Artificial Intelligence (AI) methodologies, including both generative and predictive AI, are being increasingly applied to optimise health and health service delivery. AI has the potential to lower barriers for timely and equitable access to oral healthcare, increase oral health awareness, support clinical decision making and increase treatment compliance.

Properly trained and deployed, with appropriate and strong clinical governance systems, predictive AI can facilitate improved health outcomes in the community at the patient, practice, and population health levels. Without appropriate transparency and governance, there are multiple potential consequences of misuse, including adverse clinical, financial, and/or reputational outcomes, data privacy and security breaches, misuse of time and resources, unintended inequities, and loss of trust in healthcare professionals and organisations.

At present, generative AI tools using deep learning algorithms to identify patterns in large datasets can produce convincing and apparently authoritative content, but often without the ability for verification or validation, and with unclear governance protocols. If used in clinical or population-health decision-making without verification of the accuracy and veracity of the responses, there is substantial potential to cause harm to people and patients.

Section 8:

Oral Health Research

Section 8.0

Oral Health Research

The New Zealand Dental Association position is:

- That achieving good oral health requires a strong ongoing focus of research in New Zealand that supports population health, workforce development and improved clinical practice in a contemporary New Zealand context.
- That research requires funding support, and the New Zealand Dental Association supports researchers having access to small grant funding that is specifically directed to oral health, and having access to larger research grant funds such as the Health Research Council.

The New Zealand Dental Association's position is that achieving good oral health requires a strong ongoing focus on research that supports the public health aspects of oral health and that supports the educational programmes of our universities.

Research enables universities to develop well-qualified undergraduate and postgraduate students. As a relatively isolated country with a single university providing dentist and dental specialist education, the research programme of the University of Otago is particularly important to the development of a well-qualified workforce and the provision of high-quality dental care in New Zealand.

New Zealand has had small but dedicated research teams, primarily at universities, who have provided important insights on oral health issues from a variety of research programmes. A number of these teams have generated world-leading research in areas of life course research, health services research, oral diseases (including oral pathology), oral microbiology and dental materials.

Translation of research findings into practice is equally important and should include evidence-informed clinical practice guidelines. Researchers play an important role in supporting the development and evaluation of population oral health policies, and in evaluating and applying the evidence generated by basic science, clinical and public health research and in supporting clinical practice in New Zealand.

The New Zealand Dental Association provides financial support to dental research through the New Zealand Dental Research Foundation. It has also administered the Ministry of Health Oral Health Research Fund for over 10 years. Collectively the NZDRF and Ministry of Health funds provide around $250,000 per annum in modest grants to support emerging researchers, postgraduate research and research programmes of established teams.

The ability of research teams to access funds beyond these small grants, (such as the Health Research Council) is critical to ensure viable programmes at our universities and research institutes.

Section 9:

Environmental Sustainability

Section 9.0

Environmental Sustainability

The New Zealand Dental Association position is:

- That the New Zealand Dental Association supports measures to improve the environmental sustainability of dental practice through measures to improve energy efficiency, waste minimisation, and the promotion of sustainable dental practice in the dental community.

As global awareness of environmental sustainability grows, healthcare sectors, including dental practices, are stepping up their responsibility to minimise environmental impact. Acknowledging this imperative, New Zealand's dental sector is committed to contributing to nationwide efforts to mitigate climate change and preserve the environment for future generations (Ministry for the Environment, 2019).

The New Zealand Dental Association has recently developed comprehensive guidelines with field experts that have drawn on the international literature regarding the sustainability of dental practice. The guidelines encompass materials use, waste management, conservation efforts, procurement, and green design. They aim to empower dental practices to conserve resources, reduce waste, and minimise environmental impact.

The New Zealand Dental Association is committed to the continued implementation of sustainability in the dental practice and will continue to monitor, advocate for and provide guidance on best practice.

The New Zealand Dental Association is aware of the Minamata Convention on mercury and ongoing practices to phase down the use of dental amalgam in restorative dentistry. The New Zealand Dental Association supports these efforts while also recognising that in specific clinical situations, and based upon the needs of individual patients, the use of dental amalgam remains appropriate and safe.

Section 10:

Queries and Comments

For queries and comments please contact:

Dr Robin Whyman
Director (Dental Policy)
NZDA

Roadmap@nzda.org.nz

or visit:
roadmap.nzda.org.nz

New Zealand Dental Association

Roadmap

Towards Better Oral Health for New Zealand

Roadmap

Towards Better Oral Health for New Zealand

New Zealand Dental Assoc.

For the common good since 1905.
NZDA.org.nz

roadmap.nzda.org.nz