Aide-Mémoire

Health New Zealand
Te Whatu Ora

Overview of oral health services for 0-18 year olds

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To:	Hon Simeon Brown, Minister of Health		
From:	Deborah Woodley, Director Starting Well		
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Contact for further discussion (if required)

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Attachments

Appendix 1:	Comparison of CDA spend and service access

Purpose

1. You requested advice on oral health services for children and adolescents, including the services that are funded, access rates and performance over time, and opportunities for improvement.

Summary

2. Oral health impacts many areas of overall wellbeing. Government investment in oral health is focused on improving childhood outcomes to provide the foundations for good oral health into adulthood.
3. While there has been some change in the last decade in oral health outcomes for children and adolescents, disparities for Māori, Pacific and those living in high deprivation areas remain. Access rates to services in the community have reduced, while hospital waitlists for dental surgical procedures have grown.
4. Improved access to community-based services and an increased focus on prevention and early intervention are required to improve oral health outcomes and reduce demand for hospital-level treatment.

Background

5. Oral health impacts people's general wellbeing and quality of life. Poor oral health is largely preventable but is one of the most common chronic health conditions experienced by New Zealanders of all ages. Evidence links poor oral health to several risk factors and determinants to other chronic diseases such as diabetes, cardiovascular disease and some cancers.
6. Good oral health during childhood is a key predictor of good lifelong oral health experience. Government investment in oral health services focuses on providing free services for children and adolescents up to their 18th birthday, with limited funding for some dental treatments for adults on a low income.
7. Other areas that contribute to oral health include community water fluoridation, the broader social determinants of health, public health actions to support healthy food environments, and the oral health promotion initiative[1]. Additional information on these areas can be provided if requested.

Oral Health services for children and adolescents

Young children are seen through Health New Zealand's Community Oral Health Service

8. The Community Oral Health Service (COHS) delivers oral health services to children from birth to school year 8 (12 or 13 years of age). The delivery model for the COHS

[1] The oral health promotion initiative provides free toothbrushes and toothpaste to whānau with children under five years old.

changed through the reorientation of the school dental service from 2007 to 2017.

9. The COHS is delivered via a mix of fixed and mobile clinics mostly at schools and/or community venues. The service is largely delivered by oral health and dental therapists supported by dental assistants, with an estimated total workforce of 850 FTE. The service delivers assessments and some treatments in scope of therapists. Children requiring more extensive treatment will be referred to dentists who hold a Health New Zealand contract.

10. COHS is a Health New Zealand employed service, delivered in the community, but funded through Hospital and Specialist Services (HSS). As the service is bulk funded from within HSS baseline funding, the total funding of the service is not able to be reported on nationally and significant analytical work is required to understand this investment over time.

11. Children are expected to be seen every 6 to 18 months depending on the level of need. In 2024, 36,119 (59%) of children at age 5 and 50,171 (72%) of children at school year 8 were seen. Of the total children enrolled, 264,432 (34%) were overdue for their scheduled examination. Hawke's Bay has the highest proportion of children overdue at 52%, with over 40% of children overdue in Waikato, Taranaki, Auckland region, West Coast, Northland, South Canterbury and Tairāwhiti.

Adolescents and children requiring oral health services are seen by private practices under the Combined Dental Agreement

12. Services for adolescents (from school year 9 until their 18th birthday) and special dental services for children (that require treatment by a dentist) are predominantly contracted out by Health New Zealand through the Combined Dental Agreement (CDA). There are around 800 CDA contract holders, most of which are private dental practices. There are a small number of COHS that continue to deliver services to adolescents.

13. The delivery model for CDA services is through either fixed private practices in the community or providers that deliver services by mobiles, including at schools. The total funding of the service in 2024/25 was around[2] $70 million. This spend has increased 47% since 2022/23, from an average spend of around $47 million between 2014 and 2022. Funding is demand driven, with budgets including cost adjustments set within baseline funding.

14. In 2024, 208,402 (66%) of adolescents aged 13 to 17 received oral health services through the CDA. The number of children receiving special dental services under the CDA was 22,225. Despite the large increase in spend under the CDA, the overall proportion of children and adolescents seen is unchanged, with more adolescents not seen in 2024/25 than in 2014/15 (refer to Appendix 1).

Some providers deliver oral health services integrated with primary care

15. A small number of Māori and Pacific health providers are delivering oral health services across age groups, some integrated with their wider primary care services. These providers usually have a bespoke mix of funding for services that may include a CDA,

[2] The budget for CDA is demand driven, with providers submitting claims for services. As providers have up to 12 months to submit claims, the total spend for services in 2024/25 is not yet confirmed.

regional funding agreements and funding for adults on a low income.

Hospital dental services provide services that are unable to be delivered in community

16. Some children and adolescents will require hospital-level dental treatment, either due to medical complexities, special care needs, or because they require treatment under general anaesthetic (e.g., if they have extensive decay). The service is usually delivered by general or specialist dentists supported by dental assistants employed by Health New Zealand and funded through HSS.

17. In 2024, there were 10,470 hospitalisations for dental treatment of children aged 0 to 18, of which 86% were potentially preventable. As of 31 March 2025, there were 5,616 children and adolescents waiting for dental surgery, of which half had been waiting longer than four months.

18. There are funded initiatives under way to increase access to dental surgery for children. For example, across the Northern region, around $10 million has been invested over 2022 to 2025 to outsource volumes.

Oral health services for children and adolescents that are not funded

19. There are some areas of oral health services for children and adolescents that are not funded. These services include orthodontics[3] and community delivery of specialist services such as endodontic, periodontic or oral surgery.

How well is the oral health system performing?

20. Oral health outcomes for children have not significantly changed in the last decade and disparities remain for Māori and Pacific populations and those living in high deprivation areas. The proportion of children with caries at age 5 has remained steady at 60% for Māori, 65% for Pacific and 33% for other ethnicities. The level of decay is measured by the mean number of decayed, missing and filled teeth (DMFT) for those with caries at school year 8. Mean DMFT scores improved up until 2020, but have since worsened with 2024 results of 2.80 for Māori, 2.26 for Pacific and 2.14 for other ethnicities.

21. Service access for children has also reduced over time. In 2015, around 80% of children were seen at age 5 and school year 8, which dropped to 50-60% over 2020/21. Around 10% of children were overdue for their scheduled examinations in 2015, which climbed to over 40% in 2020/21. Both measures have seen slight improvements since 2020/21, however rates are not back to 2015 levels and there is wide geographic variation in the rates. Service capacity continues to be impacted by workforce shortages, and many services only operate during school hours and school terms.

22. Service access rates for adolescents plateaued between 2015-2019 at around 66%[4]. Rates dropped to around 56% over 2020/21, before increasing back to 66% in 2024. There remains geographic variation in access rates, as well as lower access rates for Māori and Pacific populations. Factors that are contributing to low access rates include the capacity and distribution of CDA providers and barriers that make access difficult

[3] Except where required because of congenital abnormalities or funded through ACC.
[4] Rates were 43% for Māori, 69% for Pacific and 75% for non-Māori, non Pacific

such as locations and practice hours.

23. Service access was disrupted during 2020/21 due to COVID-19 pandemic restrictions. This created a backlog of children that were not seen and has been difficult for services to catch up without additional funding. The impact of this has been greatest in the Auckland area due to longer periods under pandemic restrictions.

24. The waitlist for dental surgical procedures for children and adolescents has tripled from 1,666 in 2016 to 5,616 in March 2025. The total number of completed dental surgical procedures over the same period has increased by 1,600 per year, likely due to additional investment to outsource volumes. Therefore, the growth in the dental paediatric waitlist is largely due to growing demand due to inadequate preventative measures and community-based service provision.

25. Overall, these measures indicate long-standing performance issues with the system of oral health care for children and adolescents. In some areas, the compounding impact of these challenges is resulting in critical service gaps.

Opportunities for improvement

New models for delivery of oral health services are needed

26. The performance measures illustrate the current models of services are not working. Communities report issues accessing services including not knowing when and where the services are available, and services not operating at times or in locations they can easily access. There are also capacity issues across the system, including workforce shortages of up to 50% in some districts and limited CDA provider options in some areas.

27. The separate way that services for children up to year 8 and services for adolescents from school year 9 are funded, managed and delivered across two appropriations[5] adds complexity when considering different models of care or reallocation of resources to respond to need.

28. Health New Zealand will over the next 12 months complete analysis and modelling to better understand the combined investment across the community-oral health spend and whether reallocation of this investment needs to be considered based on need.

29. The community-based intent of the COHS does not fit well with the delivery of other largely hospital services delivered through HSS. Community-based services are best located and managed in the community. However, shifting the delivery and management of COHS out of HSS has significant employment and infrastructure implications that would need to be considered.

Additional workforces are needed to increase the level of preventative care earlier

30. The service models for both the COHS and CDA focus on regular check-ups to assess, and treat or refer, with limited education and preventative measures. There is opportunity

[5] COHS is funded from the HSS appropriation and CDA is funded from the Primary, Community and Public Health appropriation.

to consider additional workforces and delivery models to scale up education and prevention measures. For example, toothbrushing programmes in early childhood settings have proven to be effective, such as the Childsmile programme in Scotland.

31. Oral health education and Lift the Lip checks are already being delivered through Well Child Tamariki Ora and B4 School Check services. Expansion of this to include other measures like administering fluoride varnish and the inclusion of oral health education with other services such as Healthy Homes providers, could also be considered. Further advice can be provided on these areas if requested.

Opportunity to test approaches through mobile dental clinic investment

32. Budget 22 allocated $12 million capital investment for the delivery of up to 20 mobile dental clinics in two tranches. Tranche one involved seven mobile clinics, with six of these being delivered to Māori and Pacific health providers delivering integrated models of oral health care across age ranges.

33. Tranche one has highlighted the challenges described above in trying to reallocate existing oral health funding to support the establishment of these new models. Therefore, Health New Zealand has allocated additional operating expenditure from its baseline to support these new models of care.

34. Decisions on allocation of mobile dental clinics for tranche two have yet to be made. However, there is further opportunity to test new models of care and use of other workforces through tranche two. Additional information on this initiative can be provided if requested.

Review of services under the Combined Dental Agreement

35. Health New Zealand has committed to reviewing the services provided under the CDA over the next 12 months. The review will look at evidence, including international examples, on oral health care for children and adolescents and make recommendations on changes to the CDA that are affordable within its current budget. This will include whether annual visits are required, or a needs-based approach should determine the frequency of visits.

36. The review is likely to make recommendations on priority areas to consider for future investment and wider changes to the oral health system, including whether the combined community oral health investment needs to be reallocated.

Next steps

37. Health New Zealand will progress analysis and modelling of the combined community oral health investment, review of services under CDA and work to implement tranche two of mobile dental clinics investment over 2025/26.

38. We can provide further information if requested on the following opportunity areas:

    a) Prevention actions and the additional workforces required to increase preventative care.

    b) Budget 22 mobile dental clinic investment.

Appendix 1: Comparison of CDA spend to service access

Figure 1 – CDA spend (2014/15 to 2024/25)

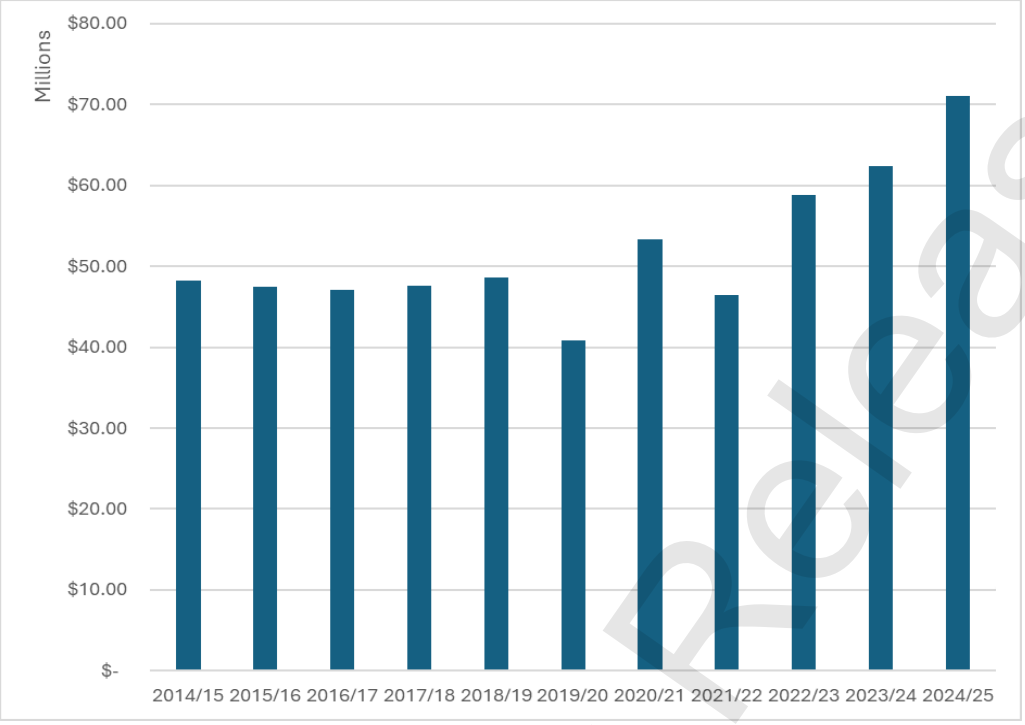
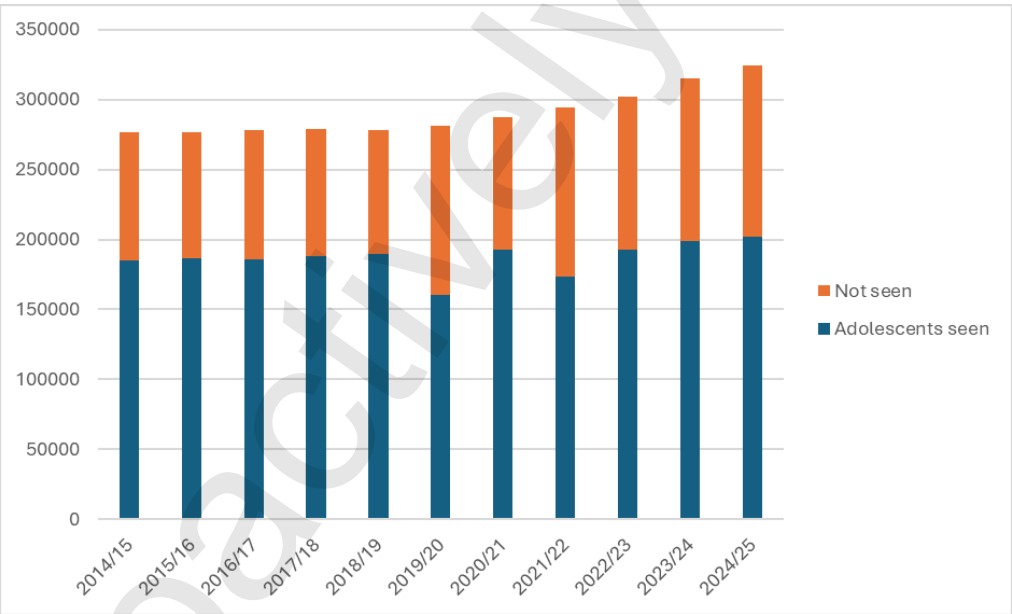


Figure 2 – Adolescent utilisation under the CDA (2014/15 to 2024/25)



The total proportion of adolescents seen under the CDA has not changed. While there has been a modest increase in the number of individuals seen (6%), utilisation rates have remained unchanged due to population growth of 17% over that time. Therefore, the increase in spend under the CDA has had minimal impact on utilisation of services with more adolescents not seen in 2024/25 than in 2014/15.