Māori Oral Health Provider Toolkit

A toolkit to assist the planning, development, and implementation
of Māori oral health services in Aotearoa New Zealand

Prepared for the Māori Oral Health Quality Improvement Group

February 2020

Final

Mihi

E ngā mana, e ngā reo, e ngā hau e whā, tēnā koutou katoa. Koia nei te mihi ki a koutou ngā rōpū whakahaere I whai mahi te huarahi hauora hei hāpai te iwi Māori.

The Māori Oral Health Quality Improvement Group (QIG) acknowledge Māori health providers across Aotearoa New Zealand for their commitment to pursue and provide the health services that whānau Māori rightfully deserve. This toolkit takes Māori health providers a step further by encouraging them to consider the difference they can make to whānau health and wellbeing through the provision of oral health care.

Acknowledgement also to the Māori Oral Health National Coordination Service that has prepared this toolkit on behalf of the QIG. The QIG is available to provide further advice to Māori health providers about this toolkit and support to establish oral health services.

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Review of toolkit

This toolkit is reviewed and updated annually by the Māori Oral Health Quality Improvement Group.

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Introduction

Māori health providers are an integral part of the health system in Aotearoa New Zealand. As Maori owned and governed organisations providers deliver a range of health services to whānau Māori and wider communities from primary care, child health, community health, maternity, mental health, mobile nursing, public health and much more. But among the 280 providers around the country, only a few have ventured to establish oral health services, despite the overwhelming unmet need among whānau Māori.

Oral health disease is one of the most prevalent yet preventable chronic conditions impacting on whānau Maori. Māori disproportionately experience the greatest burden of poor oral health than any other population group in Aotearoa New Zealand. These outcomes are evidence of an oral health system that has not and is yet to deliver oral health services that are accessible, appropriate, and culturally responsive for Māori. Māori health providers have a strong history of providing health services to whānau Māori and are positioned well to be part of the solution to improve access to dental care for Māori and improve Māori oral health outcomes.

Te Tiriti o Waitangi sets out the right of Māori to participate in the delivery of health services for Māori. There is significant scope to grow and contribute to Māori oral health service delivery. And while this isn't an easy task, Māori health providers are well familiar with the health sector and what's involved to ensure Māori aspirations and rights to health are achieved. Whānau Māori have a right to good oral health, which requires access to culturally responsive services. This toolkit seeks to provide the relevant information for Māori health providers to set up an oral health service.

Purpose of the Toolkit

This toolkit has been designed to support Māori Health Providers (Providers) who are considering the establishment of an oral health service. The toolkit provides relevant information to plan, develop and implement the service, additionally it will guide Providers through necessary steps to ensure they make informed decisions.

The toolkit will assist Providers to navigate through the process and consider a range of necessary requirements. Establishing an oral health service requires significant time, planning and investment. The toolkit does not provide a review of the evidence for oral health delivery, rather the process for implementation and resources in the hope to make the task more manageable. The toolkit will be of most use to;

- Health service and project managers involved in the planning and design of oral health facilities
- Health personnel who have a role to oversee and monitor projects and services.

A last point of clarification is that this toolkit provides important information for the current environment of service delivery. As a Māori Health Provider there are increasing opportunities to challenge traditional models of dentistry. Oral health services have sat outside the mainstream provision of publicly funded health care. Except for children and youth, most of the adult population will be required to pay for dental care out of their own pocket. Therefore, it is important services are focused to provide whānau centred approaches and practices which aims to achieve improved health and well-being of all whānau.

Quality Improvement Group

This toolkit has been developed by the Māori Oral Health Quality Improvement Group (QIG) for Providers. The QIG was established in 2009 by the Ministry of Health (MOH). The role of the QIG is to provide advice and strategic direction on clinical quality, service planning and provision, and priorities to advance the oral health for Māori. The QIG meet quarterly with representation from eight Māori Oral Health providers from across Aotearoa New Zealand.

The group leads and participates in research projects, pilot programs and initiatives to facilitate innovation and expansion of health services to whānau. The group works alongside other partners and supports Provider's considering the provision of oral health services to whānau. Key work developed by QIG include;

- Ngā Ara Tika 2013/2016 – practice guidelines for Providers in primary care settings to work within an integrated practice
- Māori Oral Health Workforce Plan and Implementation Plan
- Māori Oral Health Provider Profile Series
- Oral Health Equity Improvement Matrix
- Quality Improvement; Indigenous Influences in Oral Health Policy, Process and Practice, Journal Articles

In addition, QIG members represent Māori Oral Health provider's views on a number of sector working parties, including Electronic Oral Health Records (EOHR) working group, Workforce Planning and Sector Standards.

Oranga waha, oranga niho

The World Health Organisation defines oral health as an integral part of a person's general health, wellbeing, and quality of life, as the effects of oral diseases goes beyond the oral cavity. Poor oral health is linked to other major chronic diseases such as obesity, cardiac disease and respiratory infections (Petersen, 2003). Oral health is a major health issue for all populations and has an impact on all systems of the body.

The oral health status of tamariki needs to be considered as an important health outcome as it affects a child's ability to eat, sleep and learn. It was reported by Satur, Gussy, Morgan, Calache, and Wright (2010) that the result of poor dental conditions and unmet dental treatment has a negative impact and flow-on effect for other health conditions. Illnesses, such as heart disease, diabetes and pneumonia can be affected later in adulthood, further presenting the view that a whānau ora approach is essential to good oral health.

The concept of whānau ora is about supporting whānau to achieve their maximum health and wellbeing (Ministry of Health, 2003), therefore health care systems and how they support Māori are essential to their health status. It requires the understanding of philosophical and cultural views for meaningful collaboration with communities, as good health cannot just be prescribed by politicians or health professionals (Durie, 1994). It will take the commitment from change makers and those that drive policy and services delivery, as (meaningful) change takes courage.

He mana taurite – oral health inequity

The oral health system does not equitably meet the oral health needs of Māori. In Aotearoa New Zealand, oral health disease is more severe among tamariki Māori, these differences or inequities in health outcomes extend into adolescence and adulthood. It is reported that 48% of Māori are less likely to be caries (decay) free compared to 62% of non-Māori (Ministry of Health, 2010). Disturbingly, rangatahi Māori have poorer utilisation rates compared to non-Māori youth and from 18 years of age have higher rates of unmet oral health disease and are more likely to delay treatment due to cost (Ministry of Health, 2010; PHAC, 2003; Ministry of Health, 2019). It is recognised that dental caries in indigenous children is strongly influenced by the determinants of health (Ministry of Health, 2006). Importantly, to fully tackle oral health inequity the social determinants of health such as income, housing and education, must be part of the solution.

The data presented below provides an overview of some of the oral health inequities for Māori compared to non-Māori. Decayed, missing and filled teeth is abbreviated to 'dmft' for primary (deciduous teeth) and 'DMFT' for permanent teeth.

What is the data telling us?

- Dental disease is one the most prevalent health issues for children under five years of age and is the most common preventable chronic childhood diseases.
- On average, the mean dmft of Māori children aged five was nearly 1½ times the mean dmft of non-Māori children of the same age between 2002 and 2016.
- The mean DMFT of Māori children in Year 8 was, on average, 1.3 times the mean DMFT of non-Māori children in Year 8 regardless of whether they were living in a fluoridated area or not between 2002 and 2016.
- Māori children aged five were less likely to be caries free than non-Māori within the same age group between 2002 and 2016.
- Māori children in Year 8 were less likely to be caries free than non-Māori within the same age group between 2002 and 2016
- In 2006/07 non-Māori were under 1.3 times as likely to visit a dental health care worker as Māori, this decreased to under 1¼ in 2016/17.
- In 2006/07 Māori children aged 14 or below were over 1.6 times as likely as non-Māori children of the same age to have had teeth extracted in the previous year.
- In 2016/17 Māori children aged 14 or below were under 1.3 times as likely as non-Māori in the same age group to have teeth extracted.
- Between 2006/07 and 2016/17 Māori adults were, on average, more than 1½ times as likely as non-Māori adults to have had teeth extracted.
- Between 2006/07 and 2016/17 Māori adults were, on average, under 1½ times as likely as non-Māori adults to only visit a dental health care worker for dental problems, or never visit.

Source; Ministry of Health, 2019. Wai 2575 Māori Health Trends report.

The history of Māori Oral Health Providers

The first Māori Oral Health Provider (MOHP) services were established in the mid-1990s as part of the development of Māori Health Provider services. As Māori owned and governed health services the establishment of Māori oral health services was in direct response to the unmet oral health needs among Maori, and the lack of response by health and government authorities to improve access to oral health care in these communities.

Providers such as Ngāti Hine Health Trust in Kawakawa, Te Manu Toroa in Bay of Plenty, and Tipu Ora in Rotorua are examples of the early pioneering kaupapa Māori based oral health services. The success of service responsiveness to whānau Māori would soon see the establishment of other Providers in the early 2000s. The Māori Health Provider sector has remained a small yet valuable part of the oral health sector contributing to improved oral health outcomes for Māori.

In 2003, the MOH undertook a review of Māori Health Providers who were delivering oral health services. The review assessed the types of services being delivered and the challenges and successes they faced. The review found many Providers were delivering health promotion aspects of oral health, but only a few were involved in the delivery of comprehensive dental treatment and prevention services (Mauriora Associates, 2004).

Recognising an opportunity to support and expand the Māori oral health provider sector, the MOH commenced a business case process to enable Providers to establish or enhance their existing oral health services. The process attracted five Providers which had their business cases approved for funding and in 2006, commencement of these new and additional oral health services would begin[1] (Ministry of Health, 2011).

Table 1: Overview of the types of services and funding arrangements MOHP have in place

Provider	Population Group	Funding Arrangement
Ora Toa, Porirua	Rangatahi, low income adults	CDA[2], private co-payment, WINZ[3], ACC[4]
Tipu Ora, Rotorua	Rangatahi, low income adults	CDA, private co-payment, WINZ, ACC
Te Tāiwhenua o Heretaunga, Hastings	Pepi, Tamariki, Rangatahi, low income adults	DHB Private/co-payment
Te Manu Toroa, Tauranga	Pepi, Tamariki, Rangatahi, low income adults	DHB, CDA, private/co-payment
Raukura Hauora o Tainui, Hamilton	Rangatahi	CDA Private/co-payments

In 2009, the MOH undertook an evaluation of the business case process to determine if the funding had led to increased capacity and capability to deliver oral health services. The findings showed that the ability of MOHP to participate in oral health services had increased. However, it would require the MOH and District Heath Board (DHB) involvement to provide guidance to know how Provider services could be further supported, and the involvement of the QIG to give greater support to the MOHP sector to address clinical and quality issues (Ministry of Health, 2011).

[1] A total of $1.2million was invested in the capacity and capability of Providers to procure capital equipment for their dental services. Fifteen Providers were invited to submit a business case; twelve responded; and five met the Ministry criteria to receive capital funding.

[2] CDA – Combined Dental Agreement. A service provided by private dentists (or in this case Māori oral health Providers) that are contracted by district health boards to deliver free basic dental care for adolescents Year 9 until their 18th birthday.

[3] Work and Income New Zealand – a WINZ administered special needs grant available (subject to criteria) to beneficiaries requiring emergency dental care.

[4] Accident Compensation Corporation will pay for some dental care required as a result of an accident.

Māori models of oral health service delivery

MOHP deliver a unique model of care based on kaupapa Māori practices and principles therefore, Providers are distinctly different to mainstream models of dentistry. Key differences include;

- Kaupapa Māori based services grounded within Māori principles and practices
- A model of community-based health care that aligns and integrates dentistry with wider publicly funded health services
- Whānau centred services which supports all whānau
- Integration with primary care and primary health care services
- Strong foundations and emphasis on oral health education, prevention, and treatment

(Mauriora Associates, 2004).

Future Direction; Policy into Practice

Traditional models of oral health services tend to focus on the treatment of disease, with mainly clinical solutions. Practices which focus on preventative and whānau ora approach would ensure individuals, whānau and community have greater potential to prevent the need for acute dental treatment and achieve long term improved oral health outcomes. This is a distinctive point of difference as Providers consider the right model of dental care for their communities and a shift away from predominantly acute and emergency dentistry.

In 2006, the government's Good Oral Health for all, for Life strategy identified a model of care that is key to achieve a more balanced and responsive model to meet whānau oral health needs. Many of the components reflect a model already delivered by MOHP including;

- Service delivery which prioritises prevention and early intervention
- Oral health, which is integrated into general health frameworks, working across all areas of health
- Provider led oral health care within a kaupapa model of care
- Community based oral health care models which provide for the whole whānau
- Funding models which allow Providers to be flexible to deliver programs that serve the community
- Early engagement, with a focus on Kura and Kōhanga Reo
- Workforce which represents the community and is responsive to the diversity of the community
- Greater capability at the primary care level, with secondary service providing for those that cannot be treated at primary care level

Strategic Context

There are key strategic documents and reports relevant to understanding the context of oral health, the services delivered, and in particular how Māori aspirations and rights to good oral health should be supported. These documents shape and determine how Providers will establish their services. For example, DHBs are largely responsible for publicly funded oral health services in the community and hospital-based dentistry. Providers should discuss their intentions with their local DHB and identify any opportunities for participating and partnering with services to strengthen their response to Maori.

Good Oral Health for all, for Life

In 2006, the MOH published the Good Oral Health for All, for Life, the strategy was not only a vision statement but a strategic document presenting action areas for policy work (Ministry of Health, 2006). The report would state that Aotearoa New Zealand has reached a turning point for oral health care with government investment to strengthen community based oral health services. The strategy sets out to ensure oral health services are accessible and responsive to the needs of all children.

One of the key actions in the strategy was the re-orientation of child and adolescent services across Aotearoa New Zealand. Within this, DHBs were asked to consider MHP in the planning, implementation and delivery of oral health services in communities. Furthermore, it would ask for a stronger focus on Providers to ensure strategies and models which are relevant to Māori cultural concepts, values and practices. The implementation of

approaches to reduce inequalities must reach beyond the health sector in order to tackle the structural determinants of health.

He Korowai Oranga

As Aotearoa New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Revised in 2016, the strategy weaves together the components necessary for achieving Pae Ora – healthy futures.

Pae Ora includes three interconnected elements;

- Mauri Ora - healthy individuals
- Whānau Ora - healthy families
- Wai Ora - healthy environments

Importantly, the strategy serves Māori populations, with recognition of the independence of their health aspirations beyond their physical health. He Korowai Oranga supports Māori aspirations to take control of their own health, literally translated it means 'the cloak of wellness'. The overarching aim of the strategy is to set the direction for which Māori can achieve their maximum health and wellbeing, a mandate for change and action which Providers are significant contributors and leaders.

Equity and Te Tiriti o Waitangi

Te Tiriti o Waitangi in health and health care services is well established. However, it has not been fully recognised, enabled, and elevated in health services structures, systems, and services. The WAI2575 Health Services and Outcomes Kaupapa Inquiry identified consistent failures of the Crown in its commitment to achieve equity of health outcomes for Māori.

Provisions to ensure Māori have adequate decision making, influence, investment and appropriate accountability mechanisms to ensure delivery of quality health care to Māori communities have not been met (Waitangi Tribunal, 2019). The Health & Disability system review has investigated how the health system could be better designed and delivered with a specific goal of achieving equity of health outcomes for Māori (NZH&D Review, 2019).

There are opportunities for the oral health system and services to be redesigned in way that embraces and elevates Māori models of oral health and are kaupapa Māori driven. This requires DHBs to consider models of care that are whānau centred, with an oral health workforce that is culturally and clinically safe to work with Māori communities. As mentioned earlier, Providers should discuss with DHBs how the strategic goals are aligned and work in collaboration to achieve oral health equity for Māori.

Oral Health services and funding

In Aotearoa New Zealand oral health care is provided via a mix of private and publicly funded services. Overall, the total amount of funding spent on oral health per year is $962 million, which can be broken down into public and private funded arrangements as outlined below (NZH&D Review, 2019). A full description of services for specific age groups is provided further in this section.

Table 2: Oral health funding in Aotearoa/NZ

	Age Group	Service provider	Funding Source	Funding amount
Publicly funded	Children aged 0 – 12 years or Year 8	DHB provider arm	Publicly funded	$200m
	Youth aged 13 to 17 years	Private dentists in the community via contracts with DHBs	Publicly funded	
	All age groups	Private and hospital dentists	ACC	$29m
	Sub-total Public funding			$229m
Privately funded	Adults 18 years and over	Private dentists	User pays	$702m
	Private insurance	Private dentists	User pays	$31m
	Sub-total Private funding			$733m
	TOTAL ORAL HEALTH FUNDING			$962M

Source; New Zealand Health & Disability System Review, 2019.

While Aotearoa New Zealand has a strong history of providing publicly funded dental care, as indicated earlier there are significant inequities in oral health outcomes for Māori across all age groups. Cost is a major barrier in accessing care for whānau, with 36% having visited a dental health care worker in the previous year compared to 53% of European/Other. Adults in most socioeconomically deprived areas are nearly twice as likely to only visit for dental problems compared to adults in least deprived areas, 74% compared to 38%. Affordability is crucial in the development and delivery of oral health services for Māori and should be considered in the business model development for any oral health service.

Tamariki; Birth to Year 8

Tamariki in Aotearoa New Zealand who meet the eligibility criteria for publicly funded health and disability services are entitled to free basic oral health services from birth to 17 years of age (until their 18th birthday). The aim is to promote good oral health from an early age so that the benefits flow on into adulthood.

Dental care is provided by dental therapists in schools, community or mobile dental clinics around a child's until the end of Year 8. Currently there are inequities in oral health outcomes in these age groups with tamariki Māori experiencing greater severity of oral health disease in terms of decayed, missing, and filled teeth, and having a lower caries free prevalence rate compared to non-Māori children.

Rangatahi: Year 9 to 18th birthday

Rangatahi can access free dental care via their identified dentist. At Year 8 or age 12 years students are enrolled with a dentist by the Community Oral Health Service. The dentist has a contract with their local DHB under the Combined Dental Agreement (CDA) to provide dental care for adolescents. Rangatahi can enrol at any age up until their 18th birthday, whether in or out of school.

The treatment covered under this agreement includes regular examinations, fillings, extractions and preventive services such as, fissure sealants and fluoride treatments. A fee may apply for other services such as larger tooth

coloured fillings in back teeth. Other specialised services such as orthodontic and cosmetic work (e.g. tooth whitening) is not covered. Data shows inequities in access to dental care with rangatahi Māori less likely to access dental care than non-Māori youth.

Provisions for adults Pakeke and Kaumatua

Low income adults with a Community Services Card (CSC) are eligible through a special benefit grant for dental care. This grant is for emergency dental treatment only and is available once per annum to the maximum value of $300. Another second support system for low income adults with community services cards are hospital outpatient dental services. Hospital services provide pain relief and infection control for people unable to access private care due to financial circumstances. Hospital outpatient dental services are limited to basic restorations and extractions.

Dental treatment requiring root canals, or preventive dental services, are not provided through hospital-based services. Patients accessing this service must have a CSC and are usually required to pay some of the cost of the treatment. These services are not available across all DHBs and access is largely dependent on and impacted by hospital capacity and capability.

In many areas hospital emergency departments only provide dental care if it is trauma related. Other after-hours care is usually provided by private dentists working on an on-call roster. The cost of this care is the responsibility of the individual.

Special needs and medically compromised patients

Specialised dental care is available from hospital-based services for people with medical conditions, intellectual or physical disabilities, mental illness or severe dental disease that prevents patients from using private dental services. Part charges will often apply to these services and criteria for referral varies by region. Circumstances where teeth have been damaged in an accident is usually covered in part by Accident Compensation Corporation (ACC) for all age groups.

Hospital Services

Tertiary hospitals offer some dental treatment to inpatients free of charge to vulnerable and medically compromised patients. Patients with significant health problems who require surgery will receive necessary dental care as part of their care plan. As described earlier, some hospitals offer relief of pain or essential dental services to CSC holders and a part charge is met by the CSC holder. Some hospitals also provide dental treatment under general anaesthetic for those children and adults who are not able to have their treatment under local anaesthetic.

Private Dental Services

Most adults receive their dental treatment privately at their own cost. There is no standard fee structure nationally, therefore fees are set by individual dental practices, as private business owners. Compared to a public hospital, there is often more treatment options available such as whitening and implants. Information on private dental fees for dental services can be found on the New Zealand Dental Associations (NZDA) website.

Developing a Business Plan

Before any facility planning occurs Providers should develop a business plan. The plan will set the direction and outline the type of services and model of care to be provided. Furthermore, it will determine the dental equipment, workforce and type of facility required. These plans should also align with wider Provider service, DHBs, and primary care developments. Providers are encouraged to access support from sector partners to support the development of the Plan.

Main sections of the oral health business plan include;

- Model of care
- Business model
- Workforce requirements
- Facility and dental equipment requirements

Business case development support

Providers may be eligible for business case development support. The MOH, Māori Provider Development Scheme (MPDS) fund[5], supports Providers to participate equitably and deliver effective health and disability services through organisational and workforce development opportunities. Providers may consider MPDS funding to help with the planning, service design, and evaluation processes. Information about the MPDS fund can be found at: https://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/2019-20-maori-provider-development-scheme. Applications usually open around May of each year.

Further, Te Puni Kokiri Maori Business Growth Support fund helps Māori organisations to grow their business. While they cannot assist with start-up funding to establish the service, Te Puni Kokiri could provide support by providing important information, advice, and brokering relationships. More information can be found at: https://www.tpk.govt.nz/en/whakamahia/maori-business-growth-support.

Ownership Plan

Providers may also consider possible partnership approaches or alternative configurations to determine the right model and mix of service for respective communities. For example, ownership plans may include;

- 100% owned and operated by the Provider (total facilities/contracts/equipment/staff)
- joint venture
    - public and/or
    - private dental operator – either party may provide contribution to joint venture from; contracts, staff, equipment, premises, mobile dental unit, any other services
    - partnership arrangement with each partner providing agreed components necessary to operate the oral health service with an agreed share of revenue and costs
- sub-contractual arrangement
    - the Provider supplies contracts, patients, facilities and subcontractor provides staff, delivery of services, and day to day management, for an agreed fee arrangement share
- lease arrangement
    - Provider leases facilities, equipment and staff from another oral health service provider

The joint-venture, partnership or sub-contract type business could be negotiated with either a public entity such as the DHB or private service provider or through an arrangement with a tertiary education provider. Such business arrangements are negotiated and agreed to by the parties, in addition they should be clearly recognized in a set of formal legal documents. Importantly, there are both positives and negatives associated with each of the oral health service components, careful consideration will be required to determine the most suitable ownership model available to a new entrant Provider.

[5] Maori Provider Development Scheme.

Types of service models include;

- patient type; tamariki, adolescent, adult
- service type; treatment, oral health education, prevention, promotion, other i.e. social services
- population type; urban, rural, mixed, mobile
- clinician type; dentist, dental therapist, oral hygienist, oral health educator, other
- service ownership type; 100% owned and operated, other business arrangement, existing location type, health centre (alongside), school, marae, other

Choice of premise could include but not limited to;

- mobile dental unit, towed or self-drive, single or multiple chair
- fixed dental surgery; community health setting, whānau ora centre, combination of both
- other community setting(s).

For each of these options, there are best practice guidelines readily available from several sources both in Aotearoa New Zealand and internationally, to assist a Provider to define a set of criteria for the most suitable business model based on needs and budget.

Service Agreements

The majority of current MOHP deliver a range of mostly treatment type oral health services to whānau, largely adolescents, under the CDA with their respective DHBs, as well as fee paying adult services. MOHP have also operated other types of services under contract to their DHB. These include oral health promotion, hapu mama programmes, community dental services, adult "relief of pain" treatment services and other unique one-off programmes.

These types of service agreements require a Provider to have access to a dental surgery and clinicians, both dentists and dental therapist (with adolescent scope) and auxiliary staff such as, chairside assistants and reception services. If a dentist is part of its clinical staff component, a Provider may also have service agreements with other Crown Agencies, such as ACC or Ministry of Social Development (MSD) under which specified dental care can be provided to individuals. These claims are paid by the funder on an individual basis, as well as the provision of services to private fee-paying patients.

In order to obtain the Combined Dental Agreement[6] to treat adolescents, a Provider will require to negotiate such an arrangement with its DHB. Therefore, it is critical for Providers to identify and build a relationship with the relevant decision makers at their DHB. Including, input into DHB's strategic oral health and Māori health service plans as these documents underpin the approach for a service agreement and funding. In addition, the CDA is a nationally negotiated contract with little ability for additional funding and scope within these arrangements.

For treatment services provided under ACC and MSD, the agreement is the sole requirement of the dentist providing the oral health service who is currently registered with the Dental Council of New Zealand (DCNZ). Again, the services which a Provider can provide to patients under either ACC or MSD for "emergency dental treatment" are tightly specified and have largely unnegotiable payment terms attached to them.

To treat private fee-paying patients there is no need for a contract with any organisation. However, there are strict and mandatory requirements established by organizations including the DCNZ, New Zealand Dental Association (NZDA), the MOH and other agencies, that will need to be addressed before a Provider is able to deliver such services.

Dental Facilities

The decision to operate from a fixed dental clinic with several chairs to a mobile dental unit will depend on the business plan. Most Providers operate a mix of mobile dental units and fixed clinics, referred to as a "hub and spoke" model of care. This option allows for greater mobility, as it has the potential to provide to diverse rural

[6] Previously known as the Oral Health Services Agreement (OSHA), or General Dental Benefit (GDB).

populations and for service delivery in a variety of community settings, such as marae, kohanga reo, kura kaupapa, health clinics for delivery of both treatment and preventive care programmes.

Access to oral health services for tamariki and rangatahi are mostly delivered from a mobile dental unit, in a school setting. Services for adults are best delivered from a fixed dental surgery, ideally co-located with other health and social services, which a Provider may already be offering to whānau. However, a mobile dental unit can also allow for provision of preventative care, oral health screening and treatment services in diverse community settings, such as marae.

Fixed facilities should be available 5 days a week, 8 hours a day (minimum) but this will depend on the business model and factors such as workforce capacity and service demands. Whānau preferences should be incorporated into the model of care as evening and Saturday appointments may suit whānau who are unable to get time off work to attend during the day. Mobile dental units, if operating from schools, usually only operate for 32 weeks, 5 days a week and for 5 hours a day. Some current Providers have been able to secure arrangements with their DHB to utilise the DHB mobile dental unit during school holidays, with great success. Mobile dental units also require to be relocated during the year, there are additional costs for relocation and site preparation.

Major Dental Supply Organizations

Many businesses exist to offer a vast range of dental equipment, materials and supplies to an organization providing oral health services. Dental suppliers tend to specialize in narrow lines of specific products, often from one manufacturer. Whilst other businesses potentially can supply everything from the; dental surgery design, supply of dental surgery equipment, fit-out and the supply of ongoing consumables, the major dental supply organizations which current Māori Providers tend to use for both surgery equipment and consumables, include;

- Henry Schein Dental
- Ivoclar Vivadent
- Aluro Healthcare NZ
- Gunz Dental NZ
- Oraltec

Dental Equipment

The next step is to determine what type and quantum of dental equipment and supplies will be required to enable the chosen services to be delivered. Several considerations need to be assessed, such as;

- what type of dental equipment - purchased or leased?
- equipment will vary depending on the age
- how many items should be obtained?
- ongoing operational cost, such as insurance, servicing, spare parts commonality, usage
- capital budget availability - leased or owned?
- clinician recommendations
- new or secondhand equipment

There are several New Zealand-based suppliers of new dental equipment, however there are also an increasing number of dental equipment suppliers for dental clinic items, such as dental chairs, x-ray units and autoclaves. Local DHBs also have access to preferred suppliers of most dental surgery equipment, providing the dental equipment is used to provide services under Crown funder agreements e.g. toothbrushes/toothpaste.

Depending on the policies and business practices of a Provider, it is recommended that a Request for Proposal (RFP) for the supply of dental equipment is considered as the most transparent approach when acquiring such expensive equipment. The RFP would include a full specification of the dental equipment to be supplied, including;

- installation and ongoing warranties
- maintenance agreements offered
- reference sites of installed equipment
- supplier and business profile of agencies
- performance

- payment terms expected
- supply dates
- training and support - including any special Provider requirements, date for submission, no commitment to award tender, confidentiality clauses etc.

The Provider may consider it appropriate to have proposers visit to make formal presentations in person, as part of the RFP process. A minimum of three tenders should be sought and once responses have been received each should be evaluated against a set of criteria, which rank the proposals in terms of technical best match to requirements and tender affordability.

Further discussions may then be undertaken with the proposers to clarify any points in respect to their bids, after which a formal recommendation as to the preferred supplier should be made to governance, presented by the RFP panel. That decision should then be communicated to each proposer and the necessary contractual supply documents executed in accordance with the Providers policy.

Subsequently, a further option may be that the subcontracted clinician enters a rental of equipment arrangement, if that is the delivery model option preferred by Provider. Such an arrangement may require an independent assessment of the market value for rental items attached to the dental equipment to be provided.

Information Technology and Patient Management Systems

Most MOHP operate under either a mix of the CDA, ACC, and MSD funded service arrangements. The preferred patient management system EXACT has been identified as the most commonly used IT package by private dental practices in New Zealand Aotearoa.

Furthermore, DHB run a customized variation of EXACT, namely Titanium. This patient management system is used within Community Oral Health Services for patient information and clinical data. Currently, the MOH is leading a sector-wide project to establish a common electronic patient management system and for Titanium to be reconfigured to match this common record and for all DHBs to use this in the future. Importantly, QIG represent Māori Oral Health Providers views on the EOHR national committee. Updates from QIG or via respective DHBs can provide more information on the implementation of Titanium.

Access to incorporate other patient management systems such as MedTech or Whānau Tahi database warehouses may also be worthy of consideration by Providers, for reasons such as most x-ray units now have digital capability for both x-ray and pictures, for which data can also be stored electronically.

Treatment Room

The treatment or operation room configuration is essential to ensure maximum efficiency. The arrangement of the unit, the patient's chair, hand instrument table and worktop are the key to improving productivity. Choose a trusted dental equipment supplier to help design a fit for purpose space for the dental practice.

- Patients Chair
- Dentist's Chair
- Assistants Chair
- Overhead and Ceiling Light
- Delivery System
- Dentist and Assistant Computer and Screen
- Patient Monitor
- Tirturator
- Autoclave
- Compressor
- Vacuum
- Water Filler
- Remote Control Panel

Waiting Room

The provision of a comfortable waiting room within the dental practice helps ease dental anxiety and fear patients may be experiencing while they wait for their dental appointment. This is easily obtainable and can be put together by using inviting furniture and entertainment. When selecting furniture for the waiting room, themes that have local cultural significance can be incorporated. Colours are important for warmth, ideally the waiting room should feel more like a living room than an office and incorporate elements like plants and natural lighting.

You do not have to spend a fortune to provide entertainment for patients. Reading materials like magazines and newspapers can help pass the time. For younger patients, a collection of games and puzzles are also an excellent idea for distraction. You may want to consider innovative approaches such as, digital eyewear which appeals to all age groups, with research showing they have a positive impact on the overall experience and reduction in the patients dental fear and anxiety.

Staff

First, the quality of oral health care delivered by a MOHP is strongly determined by the quality of the team providing care to an individual and their whānau. Therefore, it is critical that a Provider has a process in place to clearly identify the essential qualifications and characteristics required for each member of its oral health team, whether they are employees or contractors.

The success of a positive oral health experience is closely linked to the effective engagement of the dentist and dental staff, with the interpersonal behaviour of staff impacting on a positive experience. In this context, cultural competence is just as important as clinical competence. Importantly, dental auxiliary staff need to be employed not only on their clinical skills and knowledge but more importantly on their cultural responsiveness, positive attitude and passion to work with tamariki and whānau.

Second, the starting point of this process is the clear definition in the position description of each role which the Provider is seeking to fill, to include mandatory clinical specifications, appropriate experience, references, aspirations, and team record. Additionally, a Provider should also use a suitable interview panel, comprising both internal and external members to meet and assess the suitability of the applicant to provide the services in a manner which acknowledges the tikanga of the Provider.

It may be appropriate to also conduct a chairside assessment of applicants for clinical positions as part of this process, with an independent clinical assessor. Typically, a standard Individual Employment Agreement (IEA) or Independent Contractor Agreement (ICA) can be applied, which includes specific mandatory requirements for a person joining the organization.

These documents, together with a profile of the Provider and the Position Description should be made available to applicants, as part of the position advertisement process. Options to source possible clinical staff can be via;

- general job websites
- recruitment agencies, specializing in dental staff countries such as New Zealand, United Kingdom, Australia, other overseas countries
- approaches to staff at DHBs, existing dentists
- approaches to professional bodies and listing, via their websites, publications, meetings
- approaches to oral health tertiary training organizations (through promotional visits and recruitment packs)
- approaches to Te Ao Marama; other MOHP
- through word of mouth, upskilling current staff

In respect to clinical staff, a critical step in the assessment of any applicant is an online check via the DCNZ website (www.dcnz.co.nz) to ensure that the applicant has a current practicing certificate, with attention to scope of practice limitations. It is also important to the extent possible, to carefully assess referee check comments on any clinical applicant, noting any gaps in employment which may require further investigation or clarification from a previous employer.

In regard to remuneration there is appropriate information publicly available on which to base an offer to a suitable applicant. The exact pay package arrangement will depend on whether the staff is ; full time, part time, level of experience, employee or contractor, salaried or commission based.

The Association of Salaried Medical Specalists (ASMS) sets the award in respect to employment agreements for dental staff in New Zealand. The DHB Award set out the basic scale for dental therapists, with a guidance for salary scales for other auxiliary dental staff. Providers should refer to the ASMS award and where appropriate, seek guidance from Māori oral health providers.

For dentists there are a variety of options from salary to commission, with market guidelines to assist in the negotiation with the preferred candidate, such as DHB dentists. For dental therapists and dental hygienists, a similar market model of pay levels is also accessible as guidance. Oral health educators and support staff (dental assistants, receptionists, kaimahi) salaries are occasionally covered by allied health awards, or by local practice and assumed to be at a minimum set at the national minimum wage rate level.

Orientation and Training

Professional development may be sought from a number of events, training days and seminars provided by oral health professionals and industry providers. Te Aō Marama annual conferences provide clinical and non-clinical oral health professionals with oral health education and network opportunities. For many, this may be their only contact with other oral health professionals, as many such as tamariki ora nurses have limited opportunity to network in oral health. Te Aō Marama is a valuable collective of kaimahi committed to Māori oral health improvement and provide a united voice of Māori oral health professionals to advocate for Māori oral health, and are a key stakeholder for MOHP.

Scopes of Practice

Dentist

- The Dental Council defines the practise of dentistry as “the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures within the scope of the practitioner’s approved education, training and competence”.

Oral Health Therapist

- Oral health degree graduates from 2008 have a new dual scope which basically contains both dental therapy and dental hygiene scopes. These new scopes include diagnosis and treatment of dental cavities for patients up to the age of 18 and carrying out dental hygiene treatments on adults (including scaling).

Dental Therapist

- Scope of practice that evolved from the original school dental nurse role which includes oral health promotion, diagnosing and treating dental cavities for patients up to the age of 18 and extracting primary teeth.

Oral Hygienist

- Scope of practice is largely focused on the prevention and non-surgical treatment (e.g. removing tartar) of periodontal disease.

Dental Assistant

- Assistant trained to support dentist in their practice

Recommended Practicing Ratios

Practicing ratios will depend on the service configuration including capacity, number of chairs, type of clinical service, and community need. Providers would benefit from visiting other Māori oral health providers to help determine appropriate ratios for the type of service that the Provider is looking to deliver.

Essential Requirements

There are a number of areas that must be considered to ensure Providers are meeting appropriate and relevant requirements. These can generally fall under three categories:

Table 3: Essential requirements

Patient safety and standards	Clinical and service standards	Local standards
Patient Privacy Privacy Act Patient Rights Health & Safety Regulations	Infection control Practitioner registration, scope, and annual practising certificate Contractual obligations Indemnity insurance and professional liability Radiology	Electrical systems Security Access and mobility Fire requirements Water and waste Heating, ventiliation, and air conditioning Lighting

For further information, refer to Māori oral health providers, and/or refer to the Ministry of Health, Community Oral Health Facility Guidelines (2006).

Building a Client Base

Providers will often have an existing client base from other health and social services offered. The Provider may choose to automatically enrol these clients and expand to new clients. But this will ultimately be determined by the business model that the Provider has previously determined in the planning phase. Generally, clients can be categorised according to the funding and support provisions available.

Low Income Adults

People receiving welfare support through Work and Income New Zealand (WINZ) or who are regarded as low income earners with a Community Services Card are considered low income adults in the provision of dental care. Low income adults are undoubtedly a group worthy of targeting for treatment services because they often have high and unmet dental needs, but traditionally they are the least financially viable.

Whānau typically don't have the financial means to pay for dental treatment and are entitled to only limited financial support via WINZ or DHBs provisions. To cater for this population group the Provider needs a sustainable business case that usually involves obtaining a Relief of Pain or Low income adult contract arrangement with a respective DHB, with MSD and WINZ for approved quote payments for clients. The Provider will need to carry out an assessment and provide a quote to the local WINZ office for dental treatment. WINZ will make an assessment based on a criteria, and if approved, will grant a $300 one-off, special needs grant for dental treatment. The special needs grant for dental treatment is usually only approved once per year, for emergency treatment only, and depending on previous grants approved, may be repayable.

Tamariki and Rangatahi

The first two tamariki groups are usually served by the DHB through the community oral health service model, employing dental therapists, whilst the rangatahi group are usually enrolled with a private dentist with a CDA contract with a local DHB. Annual basic capitation fees for both these groups are in the $150+ pp/pa range.

Negotiations with the local DHB are required if the Provider is looking to secure a sustainable contract. Other MOHP have been successful in obtaining contracts with DHBs to provide such oral health services to tamariki, especially in high-need, rural, non-fluoridated areas. Where there is clear unmet need and whānau experiencing barriers to access to dental care, DHBs should consider Providers to provide these services.

As to adolescents, if the Provider employs a dentist, the DHB will need to approve an CDA contract to enable provision of care and payment. Information on this patient group to assess the viability of servicing them would

need to be obtained from the DHB. The information required includes, number of dentists with contracts in area, number of enrolled adolescents, details of treatments and high school rolls.

Promotion and Launch of Oral Health Services

Having arrived at the point where all decisions have been taken to enable a Provider to deliver a range of oral health services, a final consideration is the launch of the oral health service and how it will be communicated to whānau and community. Most Providers will have established channels for dissemination of information on a range of services to whānau, how services can be accessed, locations of services and a clear description of what is to be provided. It will further require the disclosure of ancillary matters, such as fees, registration and expectations.

Accordingly, a communications plan which provides clear messages for staff and whānau for positive engagement with the community. In addition, the use of media channels, websites and other social media platforms should all be included as part of a comprehensive communications package.

Professional Partnerships

Te Aō Marama; The New Zealand Maori Dental Association

Te Aō Marama, was formed on 26 May 1995 to address concerns over the state of Māori oral health, as highlighted by research. The Association was founded by dental therapist Mrs Inez Kingi, Kaumātua Mr Pihopa Kingi and Patron Professor John Broughton.

Te Aō Marama is now an organisation of around 100 members, who represent the Māori oral health workforce, including clinicians, specialists, health promoters, support staff, researchers, teachers and students. The membership remains committed to its vision of 'Hei oranga niho mo te iwi Māori'.

Te Aō Marama is an important forum for members to support each other while showcasing and sharing information about new initiatives that contribute to positive outcomes for Māori oral health. Te Aō Marama is also a professional body that acknowledges and celebrates members who are driving positive change, optimising leadership potential and working towards reducing inequalities in Māori oral health.

Future work includes supporting the professional development of the Māori oral health workforce and developing career pathways, building research capability to conduct significant Māori research projects and working closer with iwi and Māori communities to ensure the best access possible to the best services available.

Ministry of Health, Oral Health

The MOH is the principle advisor to government concerned with the health and disability of all New Zealanders. Check out their website for resources on oral health such as pamphlets and posters. The recommended approach to access the information about oral health and related matters is via the MOH website https://www.health.govt.nz.

Locating oral health information and data

The opening page on the Ministry site shows several "tabs" each of which can be further interrogated for more detailed information. The main tabs, for example, provide "drop downs" with menus on specific items;

- Your Health – (i) tab steps to "Healthy Living" then to "Teeth and Gums" which opens a tile with five more topics; (ii) tab steps to "Services and Support" then to "Māori Health Providers", or "visiting a dentist" etc.
- Our Work – tab offers menu to access; child health, Māori health, oral health, fluoride and oral health etc.
- New Zealand Health system –tab allows access to menus with further details on key organizations, health targets, eligibility for public health services, claims and payment processing
- Health Statistics – tab lists statistics (and data sets) by topic, series, publication, with both "oral health" and "Māori health" as topic choices along with host of other data, including DHB oral health service delivery reports by DHB
- Publications - is the next major tab on the main website pane; the best approach is to type in "oral health" to the search box, which will deliver (currently) 45 documents, all available as website downloads

University of Otago – Faculty of Dentistry

Providers can be part of the University of Otago BDS student outplacement programme which provides valuable community based dental training for final year students. Providers have over 10 years of experience as training sites and can provide new Providers with information and insights into the programme to determine possible participation. In recent years, the Otago Faculty of Dentistry has embarked on several initiatives, including;

- establishment of a program to train dental therapists and hygienists
- a new $130 million teaching school in Dunedin (2019) to increase student places
- plans to open a large community dental unit in Tamaki (2020) for treatment and training

- increasing the number of Māori students for both dentistry (BDS) and dental therapy/hygienist (BOHS) programs
- community placement of undergraduate BDS/BOHS students with MOHPs, under "Memoranda of Understandings" with existing MOHP
- joint research projects with MOHP on various topics of relevant to Providers
- provision of research data to MOHP for specific issues
- annual hui with MOHP to support clinical workforce recruitment

In addition, the University of Otago, Dunedin provides a degree course for dental therapists and hygienists. Full information about the University of Otago Dental School, including its programmes, key contacts and plans can be accessed via https://www.otago.ac.nz/dentistry.

The Auckland University of Technology (AUT)

AUT provides a Bachelor of Health Sciences (Oral Health) qualification for dental therapists and hygienists from its North Shore campus. The AUT Oral Health Department conducts research on oral health issues and provides support to Māori students wishing to explore the BHS (OH) degree option. AUT also has a Māori Health Department, which teaches Te Ara Hauora Māori and has close links with the AUT Oral Health and Public Health departments. From 2018, AUT expects to increase its intake in the number of oral health students from 45 to 90 and is also exploring the matter of adult scope certification for dental therapists.

New Zealand Dental Association (NZDA)

The NZDA was established in 1905, the organisation holds a voluntary membership which represents dentists in Aotearoa New Zealand. The association advocates and supports the interests of the dental profession through advocacy and the provision of services. The organisation provides up to date information such as guidelines on food, nutrition and oral health for infants, toddlers, children, teenagers and adults, reviews, journal articles and reports. Information on oral health problems such as orthodontics, fissure sealants, trauma, tobacco, gum disease, erosion, tooth whitening, dry Mouth, tooth Sensitivity, amalgam and oral piercings is also available.

The organization represents the interests, professional, business and other, of all dentists in Aotearoa New Zealand, whether in private practice or in employment, education and research. In addition to a National office based in Auckland, local branches of the NZDA operate in most provinces, with a focus on more local topics of interest to dentists. The NZDA also provides ongoing professional education for its members, through a variety of avenues, including an annual conference and local branch seminars. Members can also access relevant documentation from NZDA about;

- practice management,
- employers' guides,
- purchasing schemes,
- professional indemnity insurance,
- a host of other initiatives promoted by NZDA, such as world dental day, school's sponsorship, young dentists, fees free days, Wrigley's Foundation grants, etc.

The website provides information specifically for members, but via its "Public" tab a significant amount of information on oral health advice, initiatives, media releases, find a dentist, resources, careers, dispute resolution are available.

A set of recommended (but not mandatory) best practice guidelines are also produced by NZDA for its dentist members. The NZDA also have position statements, videos and pamphlets on key oral health issues, such as fluoridation, sugary drinks or adolescent care that are of interest to Providers.

Additionally, the NZDA also runs accredited courses for dental assistants, carers for older people, dentist fees survey information on a regular basis, administers scholarships and a Research Fund both of which may have appeal and relevance to Providers and publishes a quarterly journal, and NZDA News to its membership.

Dental Council New Zealand (DCNZ)

The DCNZ is the regulatory body that regulates dentists, dental hygienists, dental therapists, dental technicians and clinical dental technicians. The dental council is constituted under the Health Practitioners Competence Assurance Act 2003 to protect the safety of the public by ensuring all clinicians are safe and competent to practice. All practicing clinicians must be registered with the dental council and ensure continuation of professional development and maintain high standards of practice.

Their current website www.dcnz.org.nz allows for both members of the public and oral health professionals to interact in order to obtain information about registered practitioners, scope limitations and annual practicing certificate status. The site also has 'drop down" tabs which enable access to information about DCNZ, resources and publications, complaints process, patients, the public and employers' rights and information on the registration process and its requirements.

New Zealand Dental Therapist/Hygienist Association (NZDTA)

The NZDTA established in 2012, is a voluntary membership organisation which represents and supports the dental therapy and dental hygiene profession to ensure members provide a high standard of quality and ethical oral health care for the public. Continuing professional development is also encouraged and facilitated by the association.

New Zealand Institute of Dental Technologists (NZIDT)

The NZIDT was incorporated in September 1977, following a merger of the New Zealand Dental Technicians Society and the Dental Laboratories Association. The NZIDT is a professional network which facilitates the advancement of dental technology. There primary aim is to support the professional development of clinical and non- clinical dental technicians, and students.

National Radiation Laboratory

The MOH Office of Radiation Safety administers the Radiation Safety Act (2016), which amongst its statutory duties is to ensure that all devices which emit radiation are regularly tested and certified. Which includes the x-ray units operated by oral health service Providers, although emitting very small amounts of radiation, are required to be included in this certification process.

Although Section 21 within the Act stipulates that a health practitioner, as user of such a device for dental diagnostic purposes must have a license from the Office, schedule 3 exempts dentists, dental therapists and dental hygienists from such a requirement, providing they are registered with DCNZ and hold a current Annual Practicing Certificate. Further details can be accessed via the Ministry of Health's website, follow the path of "home/our work/radiation safety/users. /licensing…/ exemptions.

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