

Oral Health *consultation*

ADDRESSING THE ORAL HEALTH NEEDS OF
OUR CHILDREN & ADOLESCENTS

Greater Wellington Oral Health Consultation Document

Consultation Period
25th June – 17th August 2007



Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

HUTT VALLEY DHB



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Purpose of This Document

The objective of this document is to invite input from the wider community which will inform the development of a joint Capital & Coast and Hutt Valley business case to the Ministry of Health that:

- Promotes a new model of oral health services for the greater Wellington region with a strong patient focus
- Improves working relationships and conditions for clinicians
- Provides purpose-built facilities and modern equipment that allows for a more efficient and effective service
- Makes the best use of resources and funds by working collaboratively across both Capital & Coast and Hutt Valley district health boards (DHBs)
- Meets the requirements of the Ministry of Health as set out in the “Business Case Guidelines for Investment in Child and Adolescent Oral Health Services”
- Gains Ministry of Health support and approval.

Together, the district health boards have developed options that meet clinical and operational needs. However, the impact on the community cannot be appropriately ascertained without extensive consultation.

This document, combined with the summary and supporting questions and answers, is designed to give all interested parties information upon which to comment.

The two district health boards are aware that the proposals set out in this document represent significant change from the status quo, and therefore, they require real and considered input from the community.

The district health boards are seeking submissions from affected and interested parties in order to inform and develop their business case that will be presented to the Ministry of Health in order to secure funding for the redeveloped service.

The Ministry of Health Vision

The Ministry of Health's strategic vision for oral health "***Good Oral Health for All, for Life***" was launched in August 2006, following the national School Dental Service Review and the National Maori Child Oral Health Review (2004). This vision is for 'quality oral health services that promote, improve, maintain and restore good oral health, and are proactive in addressing the needs of those at greatest risk of poor oral health'.

The Minister's vision includes the following:

- Community based dental services with strong links to schools, Maori oral health providers and primary care providers (replacing single-practitioner dental clinics at schools)
- A seamless 0-18 year-old service structure (currently the links between early childhood services and the school dental service are tenuous, and the adolescent service is run separately as is the health promotion and education service)
- Delivery through a hub and spoke model with a mix of fixed and mobile facilities (this means having a larger central clinic in an area, with mobile clinics going out to schools)
- A focus on prevention and very early intervention (the intent is to strengthen services for children in the zero to two year age group in order to prevent problems later)
- An appropriate and skilled workforce (the school dental service, in particular, has long suffered from workforce shortages)

It is expected District Health Boards will implement the full strategic vision over the next ten years. To support implementation the Government made funds available in its 2006 budget. District health boards have to apply for those funds and in doing so they have to present business plans to the Ministry of Health that show how they will turn the vision into reality in their districts.

Capital & Coast and Hutt Valley district health boards have worked in collaboration to develop a regional business case, taking into account:

- Improving oral health is one of the 13 health priorities identified in the New Zealand Health Strategy and one of the 12 in the Maori Health Strategy
- The Ministry of Health's strategic vision for oral health, ***Good Oral Health for All, for Life*** (August 2006) calls for 'quality oral health services that promote, improve, maintain and restore good oral health, and are proactive in addressing the needs of those at greatest risk of poor oral health'
- Reducing inequalities in child oral health and improving child and youth services are priorities included in the Minister of Health's 2006 priorities and expectations for district health boards.

Oral Health Goals and Objectives

Alignment of Capital & Coast and Hutt Valley district health boards with the Ministry of Health Vision for Oral Health

Both district health boards have included the development and reconfiguration of oral health services for young people from 0-18 years, as outlined by the Ministry of Health vision, in their District Strategic Plan and District Annual Plan goals.

Methodology

In the process of developing a Business Case, Capital & Coast and Hutt Valley district health boards have undertaken a review of the current School Dental Services and other oral health services currently available to children and adolescents aged 0-2, 3-12 and 13-18 years.

In working towards a business case, we have undertaken an assessment of this population's oral health needs, and identified different options for the configuration of services to meet these needs.

Having completed the options analysis, we have identified a recommended configuration of oral health services that we believe will best meet the needs of our diverse populations. It is this proposed configuration of services on which we are inviting public input in order to identify outstanding issues. Extensive consultation with all service providers and stakeholders is vital for us to be able to conclude development of a business plan for the future.

The Current Oral Health Service

The geographical area served by the two district health boards and subject to this proposal includes:

- The Kapiti Coast including Waikanae
- Porirua City
- The Hutt Valley - Upper Hutt and Lower Hutt
- Wellington City

Currently a range of different services cover elements of oral health for young people aged 0-18 across this area. These services have grown over the years to meet varying demands and are, consequently, fragmented through a range of independent providers. This section outlines the different services.

Well Child Service Providers

There is currently no dedicated oral health service for the 0-2 year age group. Promotion of dental health and enrolment with school dental services is included in the Well Child/Tamariki Ora national schedule as a key topic for Well Child providers from the time a child is 15 months old. Plunket is the main Well Child provider through a national contract with the Ministry of Health, although both district health boards have several other Well Child providers covering smaller numbers of children (primarily Maori and Pacific). Part of this dental health education and promotion role includes the requirement that Well Child providers give parents and caregivers information about enrolling their child with the School Dental Service and stress the importance of the child having an assessment by the School Dental Service before starting school.

As families may have a limited level of oral health education and little information about services available, the current system is dependent on the Well Child provider promoting the importance of dental health and encouraging early enrolment with the School Dental Service.

Although the School Dental Service is available to treat children from 2½ years, the burden is on the parent to arrange the enrolment and it is often overlooked. Enrolment figures indicate no children under 2 are currently registered with the school dental service to be seen once they turn 2½.

Children who establish poor oral hygiene habits are more likely to have dental problems and caries in the future. Pre-school children assessed with significant oral health problems are referred to hospital dental services if they are beyond the capacity of the School Dental Service to treat.

School Dental Service

The School Dental Service provides a regional oral health service to Capital & Coast and Hutt Valley district health boards, comprising a school-based examination and treatment service to children aged 2½ to 12 years. Services are provided to 180 schools using 89 school-based clinics across the region and four mobile units in Wellington City. The four mobile units in Wellington replaced the service provided by the Willis Street dental therapy training school clinic.

The school dental service aims to provide an annual examination and provision of a range of treatments and/or referral on to more specialist dental treatment (i.e. public or private dentist), where required.

Dental therapists staff the service. There are currently 31 full-time-equivalent dental therapists, consisting of 40 staff in total. The dental therapists are rotated around the clinics to provide the service. Many clinics are only open part of the year, and, as many dental therapists work part-time, many of the clinics are also staffed part-time. This has resulted in some clinics being empty for long periods of time. Many clinics are in isolated areas and many dental therapists do not have easy access to clinical and professional support. Because

of the low staffing levels, patients often have had to travel to a different clinic for appointments.

Currently, approximately 48% of children enrolled with School Dental Service (58% in Capital & Coast, 38% in Hutt Valley) are required to go to clinics at another school to access services at a school dental clinic.

The responsibility for maintaining clinics currently rests with the schools. This has led to varying levels of maintenance standards across the combined Capital & Coast and Hutt Valley regions and many of them need replacement or substantial renovation. Even then, they would still struggle to meet the demands of modern dentistry techniques, and the estimated cost of refurbishing them is far in excess of available capital funding.

Currently Dental Assistants undertake clinic cleaning and most of the administrative tasks required for the clinics.

Private dentists, contracted through the national Combined Dental Agreement treat children aged 3-12 years who cannot be treated by the School Dental Service. There are currently 16 private dentists contracted through the Combined Dental Agreement to provide these services for Capital & Coast district health board, and 13 for Hutt Valley district health board. Some of these dentists restrict their access to the children of existing adult patients (2 for Capital & Coast, 2 for Hutt Valley).

In addition to this, treatment that involves general anaesthesia of paediatric patients, and/or children with special needs and/or complex treatment needs, is performed in hospitals.

The number of children enrolled in the School Dental Service as at December 2006 was 50,985 (30,837 Capital & Coast and 20,148 Hutt Valley). The service is currently in significant arrears, with over 30% of enrolled children not being seen within the target of one year. To manage the needs with limited staff, the service currently gives priority to examinations and treatment to high-needs children.

The School Dental Service operates a risk assessment system to identify and prioritise children's oral health needs and treatment. The School Dental Service acknowledges the risk system is flawed, as this system applies to children that are actually recalled and examined by the service, and does not account for children who have not been seen by the service since their enrolment.

Adolescent Oral Health Services

Publicly funded dental care for adolescents from Year 9 until their 18th birthday is available from private dentists who have chosen to contract with their local district health board.

The Combined Dental Agreement is a national contract for district health boards to use for delivery of oral health services for adolescents, although some boards already have other contracts with dentists to provide oral health services to ensure accessibility to treatment.

This contract or Combined Dental Agreement is a fee for service agreement, which encompasses a range of dental services for eligible adolescents.

Not all dentists are contracted and not all contracted dentists are able to provide care to all. Of the 28 contracted dentists within Capital & Coast district health board, 8 have restricted their services to adolescents of existing adult patients only and of the 22 Hutt Valley district health board dentists, 3 have restricted their service.

As many dentists choose not to contract with district health boards, dental services for adolescents are insufficient in the Wellington region overall, and in some parts, non-existent.

Adolescent Oral Health - Regional Coordination Service

To support the Combined Dental Agreement that district health boards have with contracted dentists, an Adolescent Oral Health Coordination service is provided. The role of the coordination service is to support and advocate the utilisation of publicly funded dental care for adolescents, consistent with national, regional and district health strategies.

Combinations of factors contribute to the low utilisation and service provision for adolescents in the region. Known factors are:

- Limited contracted providers,
- No knowledge of the free service available for adolescents by adolescents, their families and communities,
- Problematic access to service, prevention and treatment information
- Inconsistent or unavailable data for this age group.

Utilisation is gauged by three measures:

1. Enrolments with the adolescent service;
2. Completion of treatment within a 12-month period;
3. Non-completion of treatment within a 12-month period.

Contracted providers can only claim for dental care once an adolescent has enrolled with the service.

Oral Health Promotion

Regional Public Health currently provides oral health promotion services to both Capital & Coast and Hutt Valley district health boards. Regional Public Health's Oral Health Promotion Team provides information and education on oral health services for children aged 0-12 years to a wide range of organisations serving that age-group, including the Community Dental Service, Early Childhood Education Centres, Public Health Nurses, the Oral Health Regional Coordination Service (OHRCS), Primary Health Care Organisations (PHOs), Plunket and other community providers.

Issues affecting the Current Child and Adolescent Oral Health Service

Workforce Issues

Workforce shortages have existed in the Wellington region School Dental Service for several years, resulting in significant delays in the routine examination and treatment of enrolled children. The following issues have been highlighted:

- The current dental therapist and dental assistant workforce tend to be older and committed to the service, however there is concern about the low number of young therapists coming through. The current average age of dental therapists and dental assistants is 47 years, and 25% of staff is aged between 52-64 years.
- The current part-time nature of the dental therapist workforce is expected to continue, and adds to the complexity of modelling a new service.
- The current service has been understaffed for some time, as identified in the School Dental Service Review.
- Nationally the availability of the dental therapist workforce is limited - numbers graduating are small.
- The current service has a scholarship programme, which will need to be maintained to continue to attract graduates.
- The high level of demand for treatment leaves dental therapists unable to devote significant time to health promotion activities

Facilities

There are currently 89 fixed and 4 mobile school-based clinics across Capital & Coast and Hutt Valley district health boards, covering 180 primary and intermediate schools. Table 1 breaks down the facility allocation.

	Total	CCDHB	HVDHB
No of primary/intermediate schools	180	114 (63%)	66 (37%)
No of schools with clinic on-site	89	48 (42% of CCDHB schools)	41 (62% of HVDHB schools)
Mobile units		4	

Table 1: School Dental Service – school-based clinics, March 2006

The Facilities Review undertaken as part of the Wellington School Dental Service Review found that the majority of facilities are outdated in design, in poor repair, and, in many cases, do not comply with practice standards and guidelines. The review included recommendations for remedial work in the following areas:

- access for people with disabilities
- floor coverings
- hot water cylinders
- improved electrical safety and lighting
- clinic temperatures
- isolation switches
- additional doors
- locked records facilities
- bench space (for infection control).

In conclusion, most of the clinics require major renovation or rebuilding to comply with the health and safety legislation when more than one clinical operator is on-site. The findings indicate that the current facilities are inappropriate for providing modern dentistry where a therapist and assistant are working together on a patient. The cost of refurbishing existing fixed clinics to meet required standards and the ability to provide modern dentistry was assessed. The costs of refurbishing existing facilities to the required size and standard would be higher than the cost of the service being proposed in this document.

Another key issue around facilities is that the funding regime between schools and the Wellington School Dental Service for maintaining school dental clinics, in many cases, is not working. Schools receive very little funding to maintain underused clinics, resulting in sub-standard facilities for staff and patients.

School dental facilities are generally only open for a limited period each year, and due to staff shortages, in some cases, this has been reduced even further, resulting in a highly inefficient use of resources.

Clinic utilisation rates (that is, the proportion of a year a clinic is operational) is on average around 31 percent, which is not cost effective. The Ministry of Health's *School Dental Service Facilities: Discussion document* (2004) noted that '[d]ue to the low utilisation rates of school dental clinics, it would not be cost-effective to simply renovate, rebuild and upgrade all operational fixed school dental clinics and to replace all old equipment. An alternative solution is necessary'.

Access

School Dental Service

Staff shortages have compounded the school clinic utilisation problems, so children often receive their examinations and treatment at different clinics. This can cause confusion and failure-to-attend. Figures at December 2006 indicate a 10% failure-to-attend rate.

A high percentage of children are currently travelling to access School Dental Service services (58% in Capital & Coast and 32% in Hutt Valley). Due to limited staffing resources and workload pressures, a third of children (30% Capital & Coast; 33% Hutt Valley) have had to wait for more than a year for their annual examination.

In Wellington City, School Dental Services are provided from four mobile treatment units, which travel around to various schools. However, several schools are unable to accommodate the current mobiles on their sites and so this limits access for some children to services on their school site.

Although the Wellington School Dental Service is based in an urban environment, children and families who are disadvantaged still face barriers to access with a lack of adequate transport. These issues are compounded by the high mobility of dental therapists around the clinics and the frequent changes of address for some families.

Adolescent Service

Limited providers, restriction to services, and inadequate 'teen-friendly' environments are key access issues hindering adolescents from seeking dental care.

Currently a low number of the adolescents in the district utilise publicly funded oral health care, with 2005 Combined Dental Agreement enrolment rates indicating 62% enrolment of 13 to under 18 year olds for Capital & Coast and 57% for Hutt Valley (see Table 2).

13-17y enrolled with Dentist providing service	CCDHB	HVDHB
Number of adolescents enrolled	11,377	6,374
Percentage of 13-17y enrolled	62%	57%
Number of Maori enrolled	862	706
Percentage of 13-17y Maori enrolled	25%	24%
Number of Pacific Island enrolled	368	269
Percentage of 13-17y Pacific Island enrolled	14%	21%

Table 2: 13-17y Enrolments with CDA Dentist 2005, CCDHB, HVDHB

The Way Forward – The Oral Health Strategy For Children And Adolescents Aged 0 – 18 Years

Planned Outcomes

By implementing the national vision in the greater Wellington region we aim to achieve the following outcomes:

Service Improvement

- Increased oral health promotion, oral health education, and co-ordination for all age groups
- Improved oral health status for 0-4 year olds from increased prevention efforts
- Improved uptake and participation in the free adolescent oral health service
- Improved service coverage for the 0 - 13 age group through increasing the number of dental therapists.
- Improved efficiency, increased collegial and professional support and reduced isolation of dental therapists by developing teams of therapists.
- Better use of new clinic sites.
- Reduced number of sites and district health board ownership of the facilities will simplify management and ongoing maintenance.
- An increased number of examinations and treatments for all children

Changes in Access

- Access to health promotion and disease prevention services for preschoolers
- Improved access for the 3-12 year population by providing more regular visits at fixed clinics
- Reduced arrears because there would be more dental therapists working together in multi-chair clinics to see more children each year.
- Access for the 13-18 year-old population improved by supporting current private provision with the addition of public dentists in areas where there are few private providers.

Better Outcomes

- Universal access to oral health services for children and young people aged 0 to 18.
- Reduced inequalities between Maori, Pacific and other children aged 0 to 18 years
- Improved oral health status for all children and adolescents within the Capital and Coast and Hutt Valley district health boards' regions
- Improved understanding of the importance of good oral health in families and whanau/parents/caregivers

Options for the Proposed New Service

Two options have been designed to address issues with the current service. Each of the options would provide the same number of examinations and treatments, but the way in which the services are delivered to the community will differ slightly.

The proposed options are based on the following elements:

- The Ministry of Health's vision for centralised clinics being combined with mobile outreach services (known as the hub and spoke model)
- Eight geographical zones across the greater Wellington region being the basis for siting of the centralised clinics to which mobile services will be aligned.
- Within those eight zones, eleven community-based clinics replacing the current 89 school-based dental clinics
- Increasing the workforce from 31 full-time equivalent (FTE) dental therapists and 31 FTE assistants (no dentists) to 42 FTE dental therapists, 48 assistants and 6 FTE dentists
- Establishing a 5.5 FTE Early Intervention team undertaking oral health promotion and education, coordination and liaison. (This brings together a number of existing but fragmented functions and increases the number of people undertaking them from 1.5 FTE).

The proposed service options, would target:

0-2 years

- Ensuring 50% of children are enrolled and examined before they are three years old.
- We estimate that 25% of the enrolled population would require follow-up treatment by the age of three.

3-12 years

- Ensuring examination of **ALL** children in this age group within each calendar year (This is not currently being achieved)
- We estimate that 75% of those examined in this age group are likely to require, and would receive, follow-up treatment.

13-18 years

- Ensuring 85% of young people in this age group are enrolled with a dentist (currently approximately 55-60% are enrolled)
- We have estimated that the addition of six contracted dentists would be required to reach the target.

Option One

The first option the two options that the district health boards are considering would mean **ALL** annual examinations of 0-12 year olds would be delivered by mobile examination facilities on school grounds. This would mean planning for. -

- All 3 -12 year olds being examined in mobile facilities.
- All enrolled 0-2 year-olds also being examined in mobile facilities.

Once they had been examined all other treatment would be provided at centralised clinics. Additionally. -

- Capacity would be built into facilities for coverage of adolescents aged 13-18 by contracted dentists in areas where private dentist cover was either low or not available.
- Treatment would continue to be supported by private dentists and hospital based services where necessary.

Based on current population and expected growth, this option has been calculated to require 11 centralised clinics with 16 supporting mobile units. That would mean a total of 33 fixed chairs at the centralised clinics.

Option Two

The second option that the two district health boards are considering would mean that mobile examination units on school grounds would deliver most initial examinations. This would mean planning for. -

- All initial examinations of 5-12 year old children would be delivered in mobile units on school grounds. The other 25% of the initial examinations would be delivered at the centralised clinics.
- All enrolled 0-4 year olds would be examined at centralised clinics (not in the mobile units as proposed in option one).

As in Option One, once they had been examined all 0-12 year-olds would receive treatment at centralised clinics. Additionally. -

- Capacity would be built into facilities for coverage of adolescents aged 13-18 by contracted dentists in areas where private dentist cover was either low or not available.
- Treatment would continue to be supported by private dentists and hospital based services where necessary.

Based on current population and expected growth this option requires 11 slightly larger centralised clinics supported by 11 mobile units (instead of 16 as in Option One). This would mean a total of 39 fixed chairs at the centralised clinics (compared to 33 in Option One).

Preferred Option

There is no difference in the number of young people seen in either option but at this stage the two district health boards prefer Option Two because:

- The district health boards believe that babies and their parents are likely to receive better health promotion support and would begin to develop a better rapport with the service if their initial contacts are at the centralised clinics. This is considered important in reducing fear associated with dental services from a very early age.
- Fewer mobile units reduce the on-going costs (e.g. storage, fuel, parking, etc.), which we believe is a wiser way of spending the health dollar.
- In terms of maintaining and increasing the valuable oral health workforce, the district health boards believe it is important for them to have a greater proportion of their time spent in clinics that offer collegial support. In turn this offers patients and their families an increased assurance of service quality.
- The mobile units provide an efficient and flexible service for initial examinations and some preventative care. However, they are not equipped for treatment and the combination of examinations and treatment in centralised facilities, in some pre-arranged cases, would result in greater efficiency, reduced waiting times and less impact on the children and their families.

Zones and Chair Configuration

The proposed new service would have eight geographical zones, five for Capital & Coast and three for Hutt Valley (refer to Map page 16). Some zones would have more than one centralised clinic to allow for improved access for children and their families should they require treatment after being assessed, as well as providing improved administrative, professional and clinical support to dental therapists across the region.

How Zones Were Established

The zones have been established based on a combination of the population and geography of each area. The district health boards have endeavoured to ensure that they reflect the natural flow of people and services in the community.

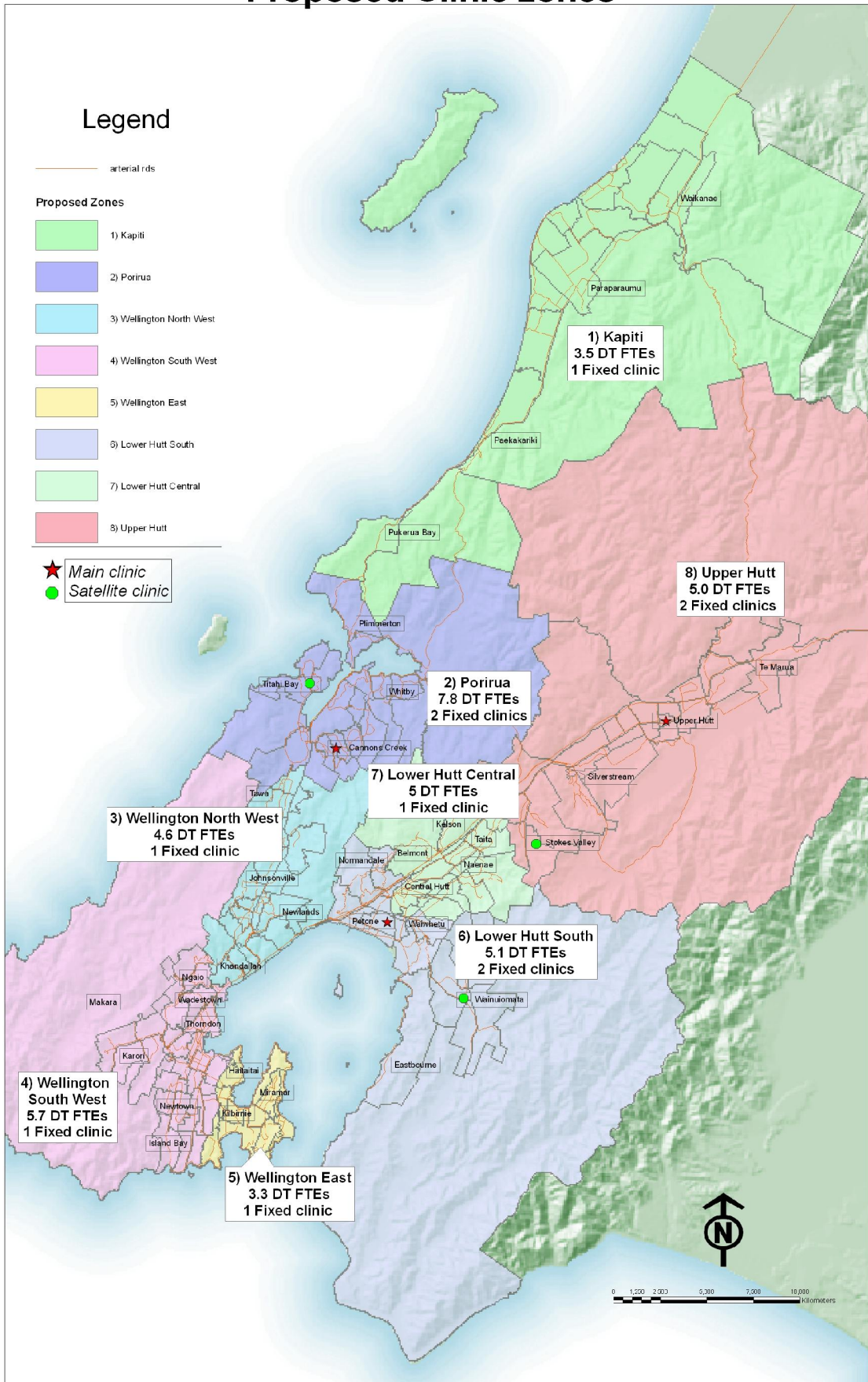
The Ministry of Health has advised all district health boards that the centralised clinics should be built on crown owned land, as opposed to leased commercial sites.

So, while the district health boards have indicated the number of clinics in each geographical zone, the exact location of the clinics has not yet been explored. Dependant on feedback from the community consultation process sites will be scoped based on availability of land, access to public transport and central location within each geographical zone.

Currently the Ministries of Health and Education are working towards an agreement that will outline ownership, lease and building improvements for all clinics sited on Ministry of Education land.

Tables 3 and 4 outline the recommended zones and chair configurations. These figures have been calculated according to population requirements for each community. -

Proposed Clinic zones



Option One

16 Mobiles and 33 Fixed Chairs

Phase	Zone	Sub Zones	Mobiles	Fixed Chairs Dental Therapist	Fixed Chairs Dentist	Total Fixed Chairs (rounded)
One	Porirua					
	Main Clinic	Porirua East	2.2	4	1	5
	Satellite Clinic	Porirua West	0.5	1	1	2
	Hutt Central					
	One Clinic	Hutt Central	2.0	3	1	4
Two	Wellington South West					
	One Clinic	Karori/Newtown	2.5	3	1	4
	Hutt South					
	Main Clinic	Petone	1.1	2	1	3
	Satellite Clinic	Wainuiomata	0.9	1	1	2
Three	Kapiti					
	One Clinic	Kapiti	1.5	2	1	3
	Wellington North West					
	One Clinic	Johnsonville	2	3	0	3
	Wellington East					
	One Clinic	Miramar	1.4	2	1	3
Two*	Hutt North					
	Main Clinic	Upper Hutt	1.5	2	1	3
	Satellite Clinic	Stokes Valley	0.4	1	0	1
Totals			16			33

*Stokes Valley is a current one-chair clinic, which only requires refurbishment, therefore can be undertaken during Phase Two

Option Two

11 Mobiles and 39 Fixed Chairs

Phase	Zone	Sub Zones	Mobiles	Fixed Chairs Dental Therapist	Fixed Chairs Dentist	Total Fixed Chairs (rounded)
One	Porirua					
	Main Clinic	Porirua East	1.3	5	1	6
	Satellite Clinic	Porirua West	0.3	1	1	2
	Hutt Central					
	One Clinic	Hutt Central	1.3	4	1	5
Two	Wellington South West					
	One Clinic	Karori/Newtown	1.7	4	1	5
	Hutt South					
	Main Clinic	Petone	0.7	2	1	3
	Satellite Clinic	Wainuiomata	0.6	2	1	3
Three	Kapiti					
	One Clinic	Kapiti	1	2	1	3
	Wellington North West					
	One Clinic	Johnsonville	1.3	4	0	4
	Wellington East					
	One Clinic	Miramar	0.9	3	1	4
Two*	Hutt North					
	Main Clinic	Upper Hutt	1	2	1	3
	Satellite Clinic	Stokes Valley	0.3	1	0	1
Totals			11			39

*Stokes Valley is a current one-chair clinic, which only requires refurbishment, therefore can be undertaken during Phase Two

Phasing In of New Service

Exact time frames cannot yet be determined and will be subject to the findings of the consultation phase and the approval of the subsequent business case for funding.

However, the intention is to phase the implementation of a new service over five years, in line with the Ministry of Health's funding indications.

The draft phasing in of the new service has been based on the district health boards' current clinical statistics, and reflects the communities with the most clinical need, but, this is subject to this consultation process.

Background Information

Population Estimates

In 2006, there were an estimated 108,726 children and adolescents aged 0-18 years living in Capital & Coast and Hutt Valley DHBs (see Table 3). Sixty-five percent of the children and adolescents aged 0-18 years lived in Capital & Coast DHB and 35% lived in Hutt Valley DHB. The 0-18 year population in the two DHBs is estimated to decrease by 3,909 by 2012 when it is anticipated that the model proposed in this strategy would be fully implemented.

Age group	2006			2012		
	CCDHB	HVDHB	Total	CCDHB	HVDHB	Total
0-2 years	10,882	5,882	16,765	10,613	5,381	15,994
3-12 years	35,618	20,863	56,481	35,558	19,323	54,882
13-18 years	22,318	13,162	35,480	21,788	12,153	33,941
Total	68,818	39,908	108,726	67,959	36,858	104,817

Table 3. 0-18 year population estimates 2006, 2012 CCDHB HVDHB

Ethnicity

In 2006, the 0-18 year population living in Capital & Coast DHB was 17% Maori and 12% Pacific. In the 0-18 year population in Hutt Valley DHB, 25% were Maori and 10% were Pacific (See Table 4).

	CCDHB	HVDHB	Total
Maori	17%	25%	20%
Pacific	12%	10%	11%
Other	71%	64%	68%
Total	100%	100%	100%

Table 4. Ethnicity as percentage of total 0-18 year population in each DHB, 2006

Figure 1 shows the proportion of children in each age group that are Maori, Pacific or Other ethnicity in Capital & Coast DHB and Hutt Valley DHB.

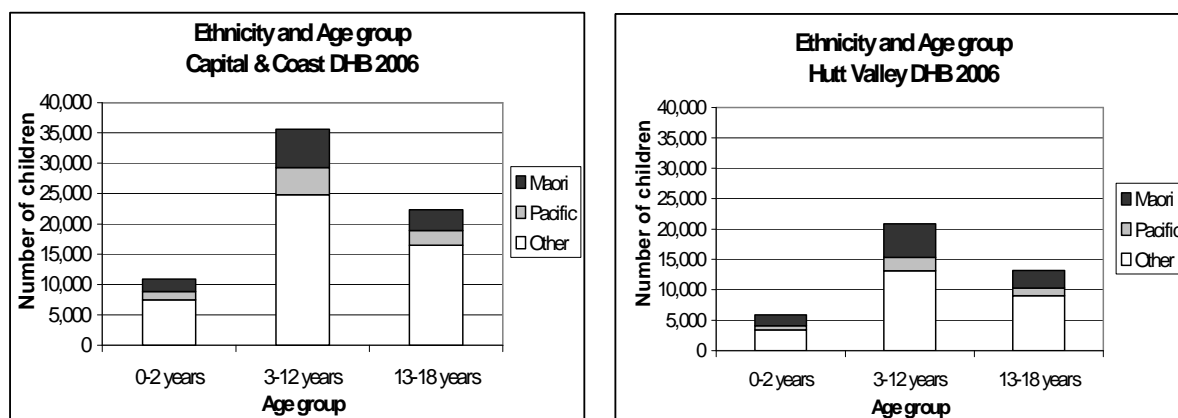


Figure 1. Number of children in 0-18y population 2006, ethnicity and age group, CCDHB, HVDHB

Deprivation

Deprivation and living standards have a major impact on children's health including their oral health. The oral health of people living in more deprived areas (NZ Deprivation 7-10) tends to be worse than those living in less deprived areas. Therefore, the deprivation profile of the population is an indication of the oral health and level of need for oral health care services.

2006	CC DHB		HV DHB		Total	
NZDep	Number of children	% of DHB total	Number of children	% of DHB total	Number of children	% of regional total
1-2	24,037	35%	9,834	25%	33,871	31%
3-4	15,338	22%	4,778	12%	20,116	19%
5-6	9,871	14%	7,908	20%	17,779	16%
7-8	5,663	8%	10,345	26%	16,008	15%
9-10	13,909	20%	7,042	18%	20,951	19%
Total	68,818	100%	39,908	100%	108,726	100%

Table 5. Deprivation profile of 0-18 year population 2006

There are 36,960 (34%) children and adolescents aged 0-18 years living in the more deprived areas (NZDep7-10) across both Capital & Coast and Hutt Valley DHBs (see Table 5 and Figure 2). In Capital & Coast DHB, 28% of the 0-18 year DHB population lives in the more deprived areas. In Hutt Valley DHB, 44% of the 0-18 year DHB population lives in the more deprived areas.

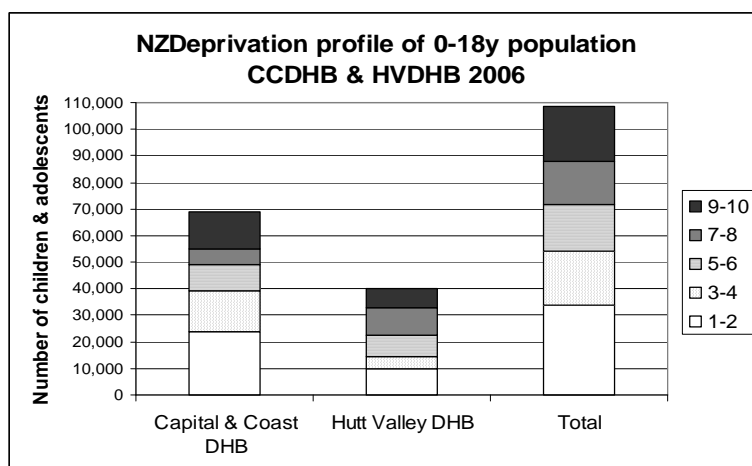


Figure 2. Deprivation profile of 0-18 year population, 2006 CCDHB, HVDHB

Current Oral Health Status

Currently, the oral health status of children in Capital & Coast and Hutt Valley DHBs is better than the New Zealand average at ages 5 and 12. However, there continue to be significant disparities between different ethnic groups within these DHB areas.

Current dental services collect data on the oral health status of the children that they cover. The key points are highlighted below.

0-2 years

There is a low level of enrolment of pre-school children in the School Dental Service, currently 45% (7,485 children out of an eligible population of 16,765). Historically, this has been disproportionately lower for Pacific and Maori children.

3-12 years

Compared to 2005 national averages, figures indicate that Capital & Coast and Hutt Valley DHB children have better oral health status at ages 5 and 12, but there are significant inequalities in oral health between different groups in the region.

Figures 3 and 4 show the mean number of decayed, missing and filled teeth (dmft) by ethnicity at age 5 and (DMFT) age 12. It can be seen that the mean dmft is significantly higher for Maori and Pacific children. Also mean dmft at age 5 is higher than mean DMFT at age 12.

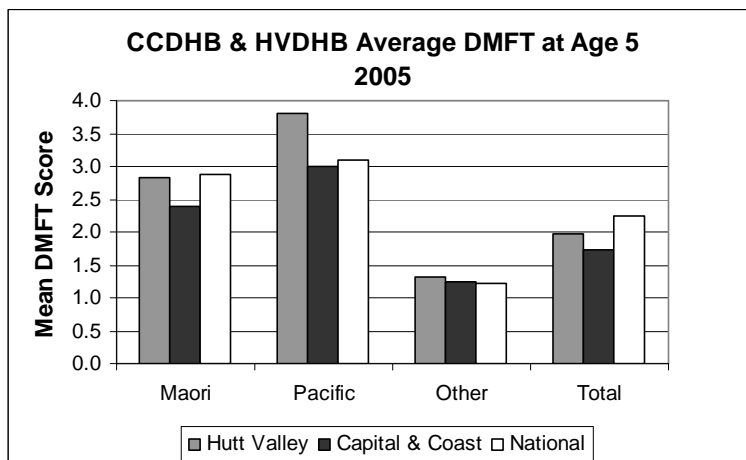


Figure 3: Average dmft at Age 5

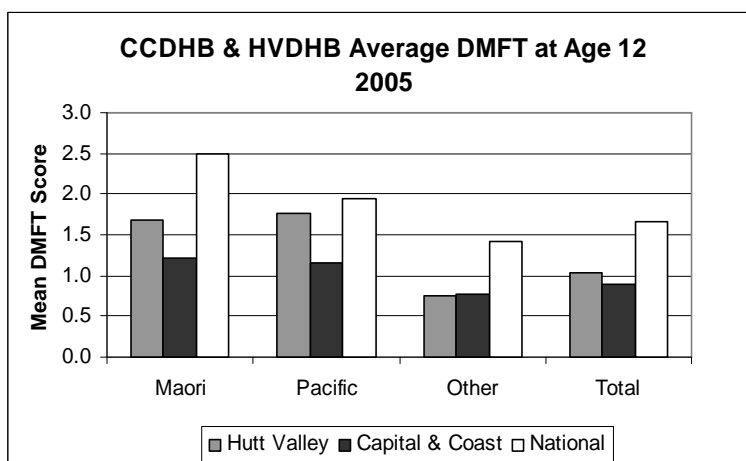


Figure 4: Average DMFT at Age 12

Arrears rates for the School Dental Service at December 2006 indicate that 31% of all enrolled children are not being seen within the target recall period of one year.

13-18 years

The oral health status for adolescents is typically unclear. Data has not been uniformly collected by all DHBs; or has been collected adhoc by various DHBs. This issue has been addressed for publicly funded services with the implementation of the Combined Dental Agreement on the 1st January 2006 and elimination of past agreements such as the General Dental Benefit and Adolescent Oral Health Service Agreement. Data to date can only show utilisation of the Adolescent Oral health service, using treatment completion and non-completion within a calendar year, combined with the number of new enrolments.

In 2005, 44% of the population aged 13-17 years in Capital & Coast and Hutt Valley DHB combined were recorded as having treatment completed (38% for CCDHB; 53% for HVDHB). (see figure 5).

Figure 5 shows completion rates in 2005 for Capital & Coast and Hutt Valley DHB compared to the national average. The national completion rate average is 54%, showing that Capital & Coast DHB rate is low compared to the national average, and the Hutt Valley DHB rate is almost the same as the national average.

The national goal is to achieve and maintain an 85% utilisation rate.

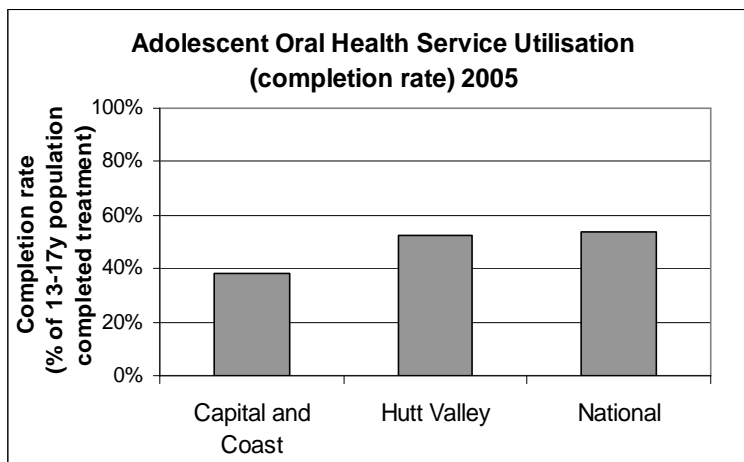


Figure 5: Adolescent Oral Health Service Utilisation (completion rate) 2005, CC, HV DHBs, and National