

## **Rationale for Change Community Oral Health Project Good Oral Health For All, For Life**

### **Strategy**

In August 2006 the Ministry of Health (MoH) released the Government's strategic vision to promote, improve, maintain and restore good oral health for all New Zealanders. The Ministry of Health vision is for an environment that promotes oral health, whether through fluoridated water, a healthy diet, or publicly funded services staffed by a multidisciplinary workforce that actively addresses the needs of those at greatest risk of poor oral health. In this future, oral health is recognised as an important part of general good health. Links between oral health services and other health care ensure that oral health is promoted, improved, maintained and, where necessary, restored at the earliest opportunity.

Good oral health for all, for life, starts with promoting oral health for the youngest and most vulnerable members of our society. Ensuring that oral health services are accessible and responsive to the needs of children and their families and whānau is the first step in accomplishing that objective. For this reason, the Government is investing in a strengthened, community-based oral health service for young people. The new Community Oral Health Service will make oral health a more visible and integrated part of primary health care.

### **Why Change**

Over the last 50 years of the school dental service, responsibility for the costs associated with running school clinics have been assigned to either Education or Health depending on the policy at the time. Currently school clinics are owned by education; the right to use the clinics by health is historical rather than contractual and incurs no rental or lease charges. In today's environment maintenance and upgrading of school dental facilities has lagged with Boards of Trustees indicating they would prefer flexibility to decide how clinics were used.

Recent reviews of the School Dental Service showed that services are often hampered by ageing equipment and buildings, and models of service delivery that are no longer meeting communities' needs. Secondary services are under pressure from larger case loads of patients requiring more complex treatment. Barriers to oral health facing older adults, who are increasingly keeping their own teeth, are also presenting a challenge at the other end of the age spectrum.

Fixed clinics some up to 40 years old, have not kept pace with developments in the practice of dentistry and surrounding regulatory environment; Many of the on-site school facilities need to be renovated or rebuilt or otherwise enhanced to comply with standards and legislation to enable the provision of modern, high quality dentistry and to fulfill the health and safety needs of school dental service and patients; the imperative to move to electronic records and high speed medical data and information transmission poses additional demands on facilities and space. Modern practice especially in remote or rural areas will increasingly require sophisticated imaging and communication systems for appropriate diagnosis, patient care and referrals.

Our therapists are working in a complex field as sole practitioners without peer support, often isolated and the restricted clinic space precludes the use of a full time assistant.

Equipment used has advanced progressively over time and the size and layout of most clinic facilities are now inadequate to house the modern equipment, such that the cluttered workspaces may pose health and safety hazards to workers and patients. A large proportion of the equipment is old/ outdated or replacement parts are unable to be sourced.

### **Inequalities**

The current service delivery model does not meet the needs of all children eligible for care from the school dental service.

Changes in service delivery are necessary to make child oral health services more accessible to disadvantaged groups.

### **Future**

The Community Oral Health Service will replace the current School Dental Service. The new service will focus upon prevention of oral health disease, reducing inequalities in child oral health, and education to improve the health status of children in our community.

This will be achieved by widening the catchment of children who attend clinics from the current 2.5 years to 0 years for at risk children, and up to year 8. Attendance will be by appointment and it is expected that parents/guardians/whanau will accompany the children so that health promotion and education can be undertaken at the one session.

The service will be delivered from a range of facilities in the NMDHB region, with the Ministry of Health providing funding for 5 fixed and 2 mobile clinics.

Mobile units will provide a full service in some of the more rural locations.

The key aims of the new service are:

- Prevention of oral disease
- Improve oral health outcomes
- Health promotion and education
- Modernising oral health delivery;
- Investing in the workforce to ensure sustainability

The new fixed clinics will be placed on schools sites and building will begin later this year.

- Henley
- Parklands
- Nayland Primary
- Innes House Blenheim
- Nelson City area (TBA)

The new clinics will be opened in March next year with a phased closure of the old clinics. The first mobile clinic is due May 2011 the second mobile is due April 2012.