

Aide-Mémoire

Oral health service improvements – further information

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Purpose

1. This aide memoire provides you with additional information on oral health services for 0–18-year-olds, following previous advice on this topic (HNZ00091681), specifically:
 - a) The reasons why costs have increased under the Combined Dental Agreement (CDA).
 - b) What is being done to address access issues and improve the number of children utilising oral health services.
 - c) Potential new models of care and timeframes for analysis of the combined investment across community-based oral health services.

Discussion

Increased costs under the CDA

2. The CDA funds oral health services for adolescents and special dental services for children, who receive treatment from private providers in the community (HNZ00091681 refers). In that paper, we advised that funding for the CDA had increased by 47% since 2022/23, from around \$47 million to \$70 million in 2024/25.
3. Three main factors have contributed to this cost increase:
 - a) Volumes have increased: The volume of claims has increased between 2017/18 and 2024/25; however, the rates of access have not changed due to population growth.
 - b) Cost pressure adjustments: The total cost pressure adjustments to CDA fees between 2021/22 and 2024/25 were 9.36%. These increased volumes and cost pressure adjustments account for around half of the total increase in budget (\$11.5 million).
 - c) Average cost per patient: The remaining increase in budget has been due to a 30% increase in the average cost per patient from \$230 to \$300 over this period (2021/22-2024/25). The CDA contains 47 codes each with its own fee for services provided under the CDA. Analysis of the claiming against codes indicate the increase in average cost per patient is not driven by an increase in acuity¹, but is due to increased volumes and price for the annual consultation fee code. In 2022/23, the fees paid for the annual consultations, extractions and root canal treatment codes were increased 24-50%, instead of increasing only by the general cost pressure adjustment. These increases were a result of annual review of the CDA in response to concerns raised by the New Zealand Dental Association that utilisation of CDA services remained low and there could be unmet demand due to low fees paid for these treatments.
4. Further analysis of the funding and cost increase under the CDA, including trends and forecasting will be completed as part of the review of oral health services (see paragraphs 19-23).

¹ Claim volumes for fillings, extractions, root canal treatment and costly codes have remained static.

Access to community-based oral health services

5. Service capacity and historic models of delivery are limiting the ability to increase the number of children accessing oral health services.
6. The Health New Zealand (Health NZ) Community Oral Health Service (COHS), which delivers oral health services for children aged 0 to around 12 years, is funded and provided through Hospital and Specialist Services. The COHS budgeted workforce has remained unchanged for over 15 years. However, the population of children has grown by almost 50,000 over that time. In recent years, there have also been high vacancies in some districts, which has added to service capacity constraints. Similarly, the population of adolescents aged 13 to 17 years has grown by almost 50,000 since 2010, while the CDA budget and capacity of providers has not grown to match the population.
7. With little change in the rates of decay in children and adolescents, there is insufficient capacity within the oral health system to provide the current services universally. However, there are actions underway to address access issues and improve the capacity of the current services.

Districts are working to solve workforce and operating hours challenges to improve access to services

8. Our previous briefing highlighted two key access issues: workforce shortages and operating hours. Districts are working to address these challenges in ways that meet the needs of their populations.
9. Vacancies in oral health and dental therapist roles in COHS have increased in recent years and some districts (Tairāwhiti, Taranaki and West Coast) report longstanding vacancies of over 50%.
10. The New Zealand Health Workforce Plan 2024 included actions to improve the pipeline for oral health therapists. Since 2023, the number of people enrolled and training to be oral health therapists has grown 10% (to 279) and the number completing the Bachelor of Health Science (BHSc), (Oral Health) increased 6% (to 72).
11. There have also been bespoke workforce solutions in response to local needs. Te Tai Tokerau – Northland established a satellite training hub, in collaboration with Auckland University of Technology, to support improved access to BHSc (Oral Health) and the ability for dental assistants to work and earn locally while they complete their qualifications. The programme has 21 students enrolled and around 50 percent are Māori. The first six students graduated at the end of 2024, with four employed by the COHS.
12. Operating hours of COHS have historically been limited due to access to school sites during holidays and collective agreement conditions on working hours. Most COHS now have alternate delivery sites, for example early childhood centres, marae and other community sites, to offer services from throughout the year. Some COHS have trialled weekend and evening clinics to increase access, particularly in high needs areas. However, limited available workforce is a barrier to further expanding operating hours in most districts.

District have local actions under way to improve access to community oral health services

13. Individual districts are taking actions to improve access to community oral health

services for children and adolescents, based on their local challenges and needs. Several examples of these are outlined below.

14. In response to high numbers of children overdue for an oral health assessment, many services have reviewed the frequency and mode of services, and prioritised groups of children based on need. For example, the MidCentral COHS has shifted from annual visits to an 18-month recall at their fixed clinic for children attending decile 5 and above schools, and 12-monthly mobile clinic visits to decile 4 and below schools.
15. COHS have also implemented actions to improve awareness of and enrolment in their services, for example working with Well Child Tamariki Ora and immunisation teams. Access to appointments and telephone advice has also been improved. For example, in Auckland and Wellington calls to the 0800 TALK TEETH line are answered during office hours (rather than the previous answer phone service).
16. Some districts with long-term workforce shortages have put in place arrangements for younger children to be referred to private dentists with a CDA (rather than through COHS). For example, in Taranaki and Blenheim they are referring all school year 7 and 8 children to be seen under the CDA, and in Tairāwhiti they have previously referred all children living on the East Coast to be seen by a mobile CDA provider.
17. The new mobile clinic service models developed under the Budget 22 investment also provide opportunity to increase access to oral health services for children and adolescents. For example, collaboration between the Fono and Auckland Regional Dental Service will see up to 3,000 children in South Auckland referred from the COHS to receive oral health care from The Fono's new mobile clinic.
18. The Northern Region has established a regional oral health system improvement group and similar groups are planned in Te Manawa Taki and Te Waipounamu. These forums provide an opportunity for discussion on regional actions that can be taken to address the dental surgical waitlist and improve access to oral health services, for example, sharing of workforce or facilities across districts and regions.

New models of care will be pursued through the review of oral health services for children and adolescents

19. Improving access rates and equitable oral health outcomes requires new and more flexible models of service delivery and an increased focus on preventative measures.
20. Health NZ has committed to reviewing community-based oral health services provided to children and adolescents (the Review). This includes the COHS delivered through Hospital and Specialist Services to children aged 0 to 12, the services Health NZ funds under the CDA for adolescents aged 13 to 17, and special dental services for children. It will also include other oral health promotion and services delivered by providers in the community through Health NZ funding contracts for the 0–17-year age group.
21. The Review will focus on two key areas – recommendations for the model(s) of care for delivery of oral health services and subsequent recommendations for how to contract, fund and monitor the services. Health NZ intends to contract with an external supplier to support the Review.

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Next steps

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