People who had input or were consulted on the Oral Health Plan.

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Sue Dasler	Service Manager, School & Community Dental Service
Carole Stuart	Practice Manager, Hospital Dental Service
Gordan Carter	Clinical Director, Hospital Dental Service
Janice Donaldson	Manager, Maori Services, CDHB
Janelle Mackie	Health Promoter
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Manu Sione	Manager, Pacific Trust Canterbury
Sandy Adams	Unit Manger, Intellectually Disabled Persons Health, CDHB
Murray Cameron	Consumer Advisor, Mental Health Division, CDHB
Amanda Cooke	Work and Income New Zealand
Mark Harris	General Dental Provider
Steve Simmons	General Dental Provider, President NZDA, Canterbury
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Tahi Takao	Kaumatua
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John Burton	Regional Adolescent Oral Health Coordinator – Southern Region

Appendix 2

MEMORANDUM

Community and Public Health, Christchurch Office

To:	Planning and Funding, Canterbury District Health Board
From:	Daniel Williams
Date:	July 8, 2003

Subject: **ORAL HEALTH STRATEGY**

Thank you for the opportunity to comment on the revised version of this Strategy from a "reducing inequalities" perspective. Overall, I think the Strategy does a good job of outlining oral health inequalities, and of suggesting strategies which address both underlying oral health determinants and problems in access to treatment. The issues I commented on in the initial draft of this document have largely been addressed in subsequent drafts. In particular, a number of initiatives are now specified which particularly target Maori oral health needs, and other strategies which are targeted at high risk groups, especially Maori and Pacific peoples, are now highlighted.

The following checklist has been applied to ensure the work carried out is aimed at reducing inequalities in health: (from Tackling Inequalities: Moving from Theory to Action, Ministry of Health workshops for District Health Boards 2002)

a) What health issues is the policy/programme trying to address?
b) What inequalities exist in this health area?
c) Who is disadvantaged and how?
d) How did the inequality occur?
e) What are the determinants of this inequality?

These questions are addressed clearly in the document. A number of "priority groups" are identified for action.

f) Where/how will you intervene to tackle this issue? Use the Ministry of Health's Intervention Framework to guide your thinking

Specified in final section of the document. The Strategy refers to the Ministry's Toolkit for Oral Health and He Korowai Oranga: the Maori Health Strategy. It also emphasises joint planning with Community and Public Health teams.

g) How will you address the Treaty of Waitangi? How will you ensure governance by, self determination by, and equity for Maori?

Maori are identified in the Strategy as a priority group. While access to dental care is clearly an important issue for Maori it is, as noted in the document, only one of the determinants of the poorer oral health status of Maori. Fluoridation could be expected to have a disproportionately large benefit for Maori, but barriers to implementation are noted in the Strategy. The need for other oral health strategies to be incorporated into existing health care or health promotion programmes which appropriately target Maori is acknowledged, particularly in *Actions 6.2*, but also in other sections throughout the document.

Planning and delivering these programmes in consultation and partnership with Maori will clearly be important to their success. It will also be important to have clear responsibilities within the DHB for ensuring these programmes are delivered and reported on.

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h) What effect will this policy/programme have on health inequalities (and C&PH have added: is it evidence based?)
i) Who will benefit most?
j) What might the unintended consequences be?

Improvements to the School and Community Dental Service are given some emphasis in the Strategy. They can be expected to benefit some of the people with poorest oral health, as the service specifically targets high-needs groups.

The Strategy notes the importance of promotion and prevention. Unless specifically targeted at the priority groups identified in the Strategy, education strategies may increase inequalities, as the people whose oral health is poorest may be in the worst position to respond positively to education messages. These issues can be addressed by emphasising education and promotion initiatives which specifically target groups with poorest oral health, and by increasing the emphasis on "environmental" initiatives in the community (eg working towards healthy food and fluid strategies in all schools; addressing cost barriers to regular brushing for people on low incomes etc).

"Interim alternatives to fluoridation" do have the potential to weaken the case for fluoridation of water supplies (which are the most effective and cost-effective means of delivering fluoride to the community). However, this must be weighed against the evidence that alternatives targeting high needs groups could considerably benefit those groups.

k) What will you do to ensure it does reduce/eliminate inequalities?

l) How will we know if the inequalities have been reduced/eliminated?

The Strategy emphasises joint planning between the School and Community Dental Service and Community and Public Health. Both services now include consideration of health inequalities as part of their planning processes. Information iniatives are clearly outlined in the Strategy, and would support an analysis of its impact on oral health inequalities.

Responsibilities for undertaking such an analysis and reporting on it will need to be clearly specified.

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New Zealand Health Strategy 2000

13 Population Health Objectives

- Reduce smoking.
- Improve nutrition.
- Reduce obesity.
- Increase the level of physical activity.
- Reduce the rate of suicides and suicide attempts.
- Minimise harm caused by alcohol and illicit and other drug use to individuals and the community.
- Reduce the incidence and impact of cancer.
- Reduce the incidence and impact of cardiovascular disease.
- Reduce the incidence and impact of diabetes.
- Improved oral health.
- Reduce violence in interpersonal relationships, families, schools and communities
- Improve the health status of people with severe mental illness.
- Ensure access to appropriate child health care services including well child and family health care and immunisation.

Maori Health Gain Priority Areas

- Immunisation
- Hearing
- Smoking cessation
- Diabetes
- Asthma
- Mental Health
- Oral Health
- Injury prevention

Submission from Hospital Dental Service on the Oral Health Plan

Oral health is one of 13 named priorities in the New Zealand Health Strategy. Oral health is named as part of 'Ongoing Work' in CDHB's strategic plan. The Hospital Dental Service has a fiscally small but clinically essential role in oral health care for the people of Canterbury.

In Canterbury general dental practitioners who are paid directly by the patient provide most dental care. School and Community Dental Service provides publicly funded care for children up to 13 years.

The Hospital Dental Service provides partially publicly funded care for those people who can not be treated by general dental practitioners, private dental specialists or the School and Community Dental Service. In simple terms the Hospital Dental Service (HDS) provides a clinical support service for all other providers. This is possible because of the specialist and team skills of the staff.

Specifically the Hospital Dental Service cares for patients referred for treatment by medical and dental practitioners in the community and by medical and surgical services within CDHB. People in the community with special needs directly access HDS.

We treat over 25000 out patients and approximately 2000 in-patients annually with 28 part time dentists and dental specialists and 25 support staff. Because we are at the end of the referral line, the people we treat take more time, are technically more complex, and may require additional resources – there is a higher degree of difficulty in the treatment of patients who attend the HDS.

HDS is funded in 6 different ways:

D01001	Case weighted Discharges.
D01002	Out patient treatment – referrals, special needs, pain relief.
D01003	Dental Benefits – support for children - often requires an anaesthetist and GA facilities.
D01005	Emergency treatment for low-income adults- 143 patients treated, no publicly funded payments received.
ACC	Patient co- payments – associated with D01002 and D01005 only.

Each contract has different requirements, scope and eligibility. Contract D01003 is unsuitable for HDS. It is written for straight forward treatments which can be carried out in general dental practice – it takes no account of the degree of difficulty of patients referred to HDS, for example there is no payment for the cost of providing an anaesthetist or anaesthetic facilities.

A substantial amount of work is unfunded and there is no provision for this work in the operating budget viz: 1960 out-patients, contract D01005 not paid for the past 6months, construction of artificial eyes for ophthalmology, over 0.5 EFT Dental Technician, sleep apnoea devices for respiratory medicine, etc.

When constructing any plan it is hard to see into the future. We know that the use of fluoride in the drinking water and in toothpastes will reduce the incidence of dental caries. Sealing fissures in the teeth soon after they erupt will also provide some

benefit. Other oral public health and preventive measures have an uncertain outcome. We speculate that any oral health promotion excluding the three mentioned above will increase the demand for HDS services because HDS is at the end of the referral chain. The ability to service altered expectation created by promotion must be considered at the time of any promotion.

Although HDS cannot foretell the future it is easy to identify 3 external drivers for change which will impact on the ability of this service to continue to function. Following a decade of apparent scandal two external drivers have been created by public and government concern about the safety of patients in a medical environment. This external climate of concern in the medical arena has also impacted on the provision of dental services in general and specialist dental practice and the HDS. The third external driver is the consequences of resettlement of patients with special needs in the community.

The drivers are:

- The need for accountability
- The need for ensured patient safety
- Resettlement of patients with special needs in the community.
- In addition HDS must be able to recruit and retain staff who can work with people who have complex conditions and problems which may be difficult to treat.

The need for accountability.

HDS – over 25000 outpatients, 1960 in-patients, 6 contracts over 55 part time staff, 4 operating sites and a domiciliary service. Patients are booked using 28 paper appointment books. Outputs are recorded each day using pencil and paper. Clinical records and prescriptions are handwritten.

About 90% of dental practices have electronic chairside data entry and centralised appointment keeping. They are able to account for the activities that they carry out and audit them. Without computerised recording of clinical indicators clinical audit is nonsense. In addition current dental graduates are trained in chairside data entry. They expect to be able to continue to do this when they commence work. None are prepared for the Dickensian accounting methods at the Oral health centre. The HDS needs fiscal support in introducing current methods of accounting and clinical audit.

The need for ensured patient safety.

Thirty years ago anaesthetics for dental procedures were given in private dental surgeries by dentists and general medical practitioners. In the Canterbury region there is now only one private dental practice, which will provide a GA on site. In addition the number of dentists who are willing to provide conscious sedation to patients in their surgery has diminished. These changes are because of the higher standard of care that can be provided by a specialist anaesthetist. The need for general anaesthetics and sedation has not reduced in the population. At the end of the referral line are dentists in HDS who, need anaesthetic support: to treat all the little children referred; and to provide conscious sedation for patients undergoing dental treatment; and to provide medical safety for frail patients. There is need for support to fund up to one full time anaesthetist (an increase of 0.6 FTE) to support and provide medical safety for the work of the hospital dental service.

Resettlement of patients with special needs in the community.

Changes in medical treatment and social philosophies have resulted in more people with disabilities living in the community. These emerging disadvantaged groups have special needs. Special Needs Dentistry is that part of dentistry concerned with the

oral health of people adversely afflicted by intellectual disability, medical, physical or psychiatric issues.

The treatment of this population group is unattractive to general dental practitioners because treatment is more difficult and may take more time. Few people with disabilities are rich. Many are unable to pay for dental treatment from general dental practitioners or traditional dental specialists. For these reasons most people with disability are treated as part of a hospital dental service.

The Hospital Dental Service in turn has much difficulty in retaining dentists past the first 2 years post-graduation. The staff of the service is composed for the most part of recent graduates, part time specialists and a smattering of people at end of career. There are few full-time, or even more than half- time, dentists employed who are mid-career. This is because there is no training path available to advance dentists, to specialist status and salary scale, within the major hospitals. There is no post-entry clinical training available in special needs dentistry

The integration of treatment required for people with special needs in Dentistry is best seen at Christchurch Hospital and Greenlane and Middlemore Hospitals in Auckland.

Hospital Dental Services will in 2003 propose a training programme for specialists in Special needs Dentistry in Christchurch. This will be the first time that a complete postgraduate course in dentistry using the medical model will be run outside Dunedin.

Support is sought for this initiative.

Frail Elderly in rest homes or hospitals receive ‘on demand’ care from a domiciliary service of HDS. The first project in a programme to examine the oral health needs of the elderly in Canterbury has been completed. We examined the oral health status and needs of over 200 dependent elderly (average age 84). Up to 1000 variables were recorded for each resident.

We found there is a large need in this group and risk of disease and death because pneumonia in this group has been associated with the number of carious lesions (rotten teeth). Of the 68 residents who had teeth on average each person had more than two carious teeth and one of those teeth was so carious it could not be saved and required extraction. We plan to extend this work into the elderly in rest home care, the independent elderly and the rural elderly to obtain a complete picture of this enlarging sector of the population. Working to determine the oral health needs of the elderly is a stated aim in CDHB plan. HDS requires support to continue with this worthwhile programme.

In summary the Hospital Dental Service treats patients other dentists can not treat and provides support to medical and surgical specialities which, seek to treat the whole patient. Change will occur in clinical practice in the Hospital Dental Service because of changing demographics, changed social attitudes, a public and government requirement for accountability, and rigorous levels of safety. If the income earned by staff of Hospital Dental Services were to be reinvested in the service over the next 4 years then the above government directives and local initiatives would be self funding with some residue available to support less productive services. The Hospital Dental Service would like Board support to move clinical dental practice and training into the new millennium.

HEARTBEAT CHALLENGE – WORKPLACE HEALTH PROGRAMME

Copied from National Heart Foundation website (www.nhf.org.nz)

What is Heartbeat Challenge?

Heartbeat Challenge is a workplace health programme that:

- Provides opportunities for healthy food choices at work.
- Encourages physical activity.
- Encourages a smokefree environment.

Why you should take up the challenge?

Research shows that companies that encourage workers to improve their health:

- Improve staff morale.
- Reduce absenteeism.
- Increase productivity (and increase presenteeism).

A healthier workplace is a happier workplace.

The aim

Create and sustain healthy lifestyle choices and improvements in the areas of healthy eating, physical activity and fostering a smokefree environment.

Enable people to increase control over and improve their own health in a supportive, informative environment.

Benefits for Employees

- Better health.
- Greater personal wellbeing.
- Improved self image and self esteem.
- Lower risk of contracting major diseases.
- General improvement in happiness and eagerness to work.

The Heartbeat Challenge process

Registration.

Follow-up

- Your Local Health Promotion Co-ordinator will follow-up within 3 weeks.

Interim audit

- If the company has not achieved a Heartbeat Challenge award after 12 months an interim audit is completed by your Local Health Promotion Co-ordinator.
- The company sends a completed assessment form to the Heart Foundation.

Assessment

- Heartbeat Challenge award is dispatched.

What Heartbeat Challenge can do for you

- It can be an effective team building tool.
- It can encourage healthy competition and co-operation between departments.
- It can make health education fun.

Information makes healthy choices, easy choices.

Why is Heartbeat Challenge a workplace health programme?

- Workplaces are potentially the single most effective place to reach adults.
- Two thirds of New Zealand adults over 15 are employees.
- 60% of waking hours are spent in the workplace.
- At least one meal is eaten at work.
- Work is a supportive environment.

Healthy choices do not have to be boring choices (treats are allowed!!!)

How to develop a workplace nutrition policy

The food New Zealanders eat has a major influence on their health. The workplace provides an opportunity to promote employee health by providing consistent messages and practices related to nutrition. Food and nutrition guidelines have been developed to help New Zealanders eat for health.

- Eat a variety of foods.
- Eat foods low in fat and salt.
- Keep yourself in shape with regular exercise and healthy eating.
- Have plenty of water and other drinks every day.
- If you drink alcohol drink only a little.

A Workplace Nutrition Policy based on these offers individuals the opportunity to make choices in line with the guidelines while they are at work. A policy may be developed by an individual or a team of employees in conjunction with management. Developing the policy in consultation with employees leads to wider acceptance on implementation. These steps will assist you in developing a policy which meets your individual workplace needs.

Set a workplace nutrition goal

Example:

Company X shows a commitment to the health and wellbeing of its employees and their families by following the NZ Food and Nutrition Guidelines in any initiatives involving food.

OR

To act as a role model with a commitment to the promotion and provision of healthy food choices in the workplace.

Identify scope of policy

Example:

This policy covers any provision of food to staff including work functions, the workplace cafeteria, provision of food for nightshift employees, vending machines, snack boxes, social functions.

Set strategies for implementation under areas identified in the scope
Examples:
Food and drink provided at work functions (e.g. board lunches) will meet the Food and Nutrition Guidelines (resource: *Function Catering Guidelines*).

Food choices will be provided at the workplace cafeteria that meet the Food and Nutrition Guidelines and all food will be prepared using safe food practices (resource: *Heartbeat Challenge Notes for Cafeteria*).

Vending machines and fundraising boxes will offer a choice of foods that meet the Food and Nutrition Guidelines (resources: *Vending Machine Ideas and Snack Box Ideas*).

At workplace social events, moderation will be encouraged with the consumption of alcohol, and food will be provided that meets the Food and Nutrition Guidelines (resources: *Function Catering Guidelines* and *Host Responsibility Kit*, kit available from the Alcohol Advisory Council).

If food is sold in the lunch room there will be some choices available that meet the Food and Nutrition Guidelines (resource: *Lunch Room Ideas*).

Trim milk will be available with tea and coffee and water will be available for drinking.

Education and information will be provided for staff to support the principles of the policy, e.g. pamphlets, posters, talks from dietitians, nutritionists or occupational health nurses.

Develop methods of monitoring and evaluation

Before initiating the policy, take a record of the current status of each area listed in the strategies.

Set a date to review and evaluate the appropriateness and success of the policy.

Establish a small team which will meet to do the regular review and evaluation. The team needs to ask these questions:

- Is the policy working?
- What do people think of it?
- Do any changes need to be made?

Information regarding changes may be gathered through:

- Regular staff questionnaires/surveys, e.g. ask staff if they liked the food at the last social function; sales records from the cafeteria - are the healthy choices selling well?
- Increased knowledge of staff as noted by a health nurse or health worker; e.g. evaluate with a questionnaire or nutrition visual evaluation, e.g. fruit basket available.
- Staff suggestion box.

In the end, a policy alone makes no change.

Only individuals, who take personal initiatives in the spirit of the policy, can make it spring into life.