Comment

Public Sector Oral Health Service Provision for High Needs and Vulnerable New Zealanders: An Executive Summary

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Introduction

The Strategic Vision for Oral Health in New Zealand identifies vulnerable New Zealanders and those who have high needs as priority population groups. High needs and vulnerable people are disproportionately impacted by poor oral health, a situation that is likely attributable to the difficulties they face in accessing and affording dental services, and their poorer access to other social determinants of health. In New Zealand, ethnic differences in oral health are also evident, with Māori and Pasifika having poorer oral health and access to oral health care than other ethnic groups. Moreover, they are overrepresented in the vulnerable population because they are more likely to live in poverty and be affected by material disadvantage.

While the treatment needs of high needs and vulnerable populations may be met in primary care, the complexity of treatment and patient management for this population group often requires care delivered by appropriately skilled and trained personnel in a hospital setting. Relatively recent epidemiological and demographic changes in the New Zealand population — an ageing population, greater life expectancy, increased multimorbidity prevalence and improved tooth retention — place considerable demand on the nation's hospital dental services. Such changes are expected to continue, suggesting that the high needs and vulnerable proportion of the population will increase in the near future, further pressuring hospital dental services.

The poor oral health experienced by high needs and vulnerable New Zealanders suggests that the group's oral health needs are not being met. To better understand the reasons for this unmet need, and for planning their future oral health needs, it is critical to explore, and identify the gaps in, the current hospital dental services.

This report presents the executive summary of findings from such investigations with key informants from New Zealand's hospital dental services and recommendations for service improvements. In doing so, it provides a thorough understanding — from the participants' perspectives — of the national situation concerning the hospital-based dental services for New Zealand's high needs and vulnerable population. Such information is urgently needed to inform actions to improve oral health service provision to high needs and vulnerable New Zealanders, and ultimately improve their oral health.

The reader seeking more detail is referred to the fully referenced report at https://www.otago.ac.nz/sjwri/otago719588.pdf

This research aimed to:

- gain an in-depth understanding, from the perspective of key informants, of the oral health services provided by the public sector for high needs and vulnerable New Zealanders;
- bench-mark the services currently provided by hospital dental services in each DHB against the Ministry of Health's Hospital Dental Service Tier Two (HDS T2) service specification and the Hospital Dental Services Minimum Eligibility and Level of Service Matrix (the Service Matrix); and
- provide recommendations to ensure the equitable provision of oral health services to high needs and vulnerable New Zealanders.

Method

This research used a mixed methods approach. It used:

- routinely collected hospital dental service utilisation data provided by the Ministry of Health, primarily National Minimum Dataset (for inpatients) and the National Non-Admitted Patient Collection (for outpatients);
- a structured questionnaire to collect quantitative information on key aspects of each DHB's hospital dental service, including: facilities, workforce and capacity, outpatient and inpatient services, services for high needs and vulnerable patients, tertiary services, and those for low-income adults and emergency care; and
- a semi-structured interview schedule to collect key informants perspectives on the hospital dental service, in relation to the HDS T2 service specifications and the Service Matrix.

Data collected from the Ministry of Health and some interview data were analysed descriptively and tabulated according to elements of the Service Matrix. Free text data from the interviews transcripts were analysed using thematic analysis.

In total, 20 interviews were conducted with 22 key informants, including Oral Health Clinical Directors, Heads of Department, Principal Dental Officers and Hospital Dentists Senior Medical Officers, and/or Senior Dentists and Special Needs, Paediatric, Oral Maxillofacial Surgery (OMFS), Public Health dental and Oral Medicine

specialists; and oral health managers, and planning and funding advisors. Data were collected from May to August 2018. The response rate was 100%. All DHBs were represented.

[Since data collection, there have been changes to some DHBs' hospital dental services, e.g., workforce capacity or service provision. Changes that we have been made aware of are acknowledged.]

Results

Hospital dental services – facilities and workforce

Sixteen of New Zealand's twenty DHBs provide hospital-level dental services; the exceptions are Waitemata, Lakes, Wairarapa and West Coast DHBs. Of those that provide hospital-level dental services, fourteen have dental facilities located in their hospital(s) (i.e., have hospital-based services) and four also operate at multiple sites; and two (Bay of Plenty and Hauora Tairawhiti DHBs) employ local, community-based oral health care providers who provide the required outpatient services in their private surgeries or, when necessary, in their DHB's hospital operating theatres. Almost half (typically provincial) of all DHBs also have the use of mobile surgical services, albeit not typically operated by the hospital dental service, a few up to four times a year, to treat some adults and children.

Thus, about one-third (6/20) of DHBs either do not provide hospital-level dental services or do provide such services but not in hospital-based dental facilities.

Seven DHBs are regional centres providing a range of tertiary and other dental services for their own population and (their typically neighbouring) less well-resourced provincial DHBs. Auckland DHB Oral Health Service – Regional Service (hereafter Auckland Regional Service), which has recently been split into two separate services, one providing hospital dental services and the other OMFS services, incorporates three DHBs (Waitemata, Auckland and Counties Manukau); people who live in the Waitemata DHB region are able to access hospital dental services at Auckland and Counties Manukau DHBs. Southern DHB contracts the University of Otago School of Dentistry to provide hospital-level care for the Otago region.

Capacity (based on the number of dental chairs and dental personnel (full time equivalent (FTE)) to manage and deliver hospital dental services varies widely across the country. Among DHBs with a hospital dental department, the number of dental chairs/100,000 per regions' population ranged from (1.1 (Auckland Regional Service) to 4.5 (Northland DHB) (median 2.4). Among DHBs with salaried hospital dentists or a hospital-based facility, the FTE/100,000 per regional population ranged from 0.3 (Bay of Plenty) to 6.2 (Southern (Southland)) (median 2.1).

Hospital dental services – services provided

Inpatient services

Annual hospital dental service inpatient visits/100,000 (120 to 810) and inpatient visits per 1.0 FTE (44 to 782) differ across DHB. About half of all services have an established inpatient referral pathway within their DHB; the remaining DHBs appear to have well-established *ad hoc* systems.

Outpatient services

Almost all DHBs provide dental treatment for medically-complex patients and those requiring pre-surgery assessment. A common additional patient group is those receiving intravenous bisphosphonates for cancer-related conditions (but not for osteoporosis). Nationally, there is substantial variation in annual hospital dental service outpatient visits/100,000 (110 to 3776) and outpatient visits per 1.0 FTE (132 to 2315). In accordance with the HDS T2 service specifications, almost all DHBs provide continuing dental care for core hospital dental service outpatients: severely physically and intellectually disabled people, those with complex comorbidities, children and adults attending special schools, and with congenital conditions. About half of DHBs provide continuing dental care for those in residential care and long-term mental health units; the remaining DHBs provide dental care episodically. Dental care at most DHBs for children and adolescents with uncontrollable caries, and treatment under general anaesthesia (GA) is episodic. In general, service eligibility criteria and acceptance into the hospital dental services appear consistent across DHBs.

Tertiary services

Patients appear to have access to the majority of tertiary oral health services, either in their DHB of domicile or by referral to a DHB with such services.

Services as capacity allows

The eligibility criterion for hospital dental services for low-income adults is, at minimum, the possession of a Community Services Card (CSC); several DHBs also require the card holder to have at least one comorbid condition. About half of all DHBs provide emergency dental care services for low-income adults; all charge a co-payment of $35-$50. Of the remaining half, some contracted local community-based primary oral health care providers to provide emergency dental care. Over half of all DHBs provide basic dental services for low-income adults.

Hospital dental services – Key informant perspectives

Key categories discussed in all interviews were the changing nature of patients referred and treatment need, resources and capacity, low-income adults, lack of visibility and prioritisation of oral health and the hospital dental service, DHBs without hospital dental services or services with limited capacity, and successes within hospital dental services. South Island participants were also asked about the South Island Alliance among DHBs and those from North Island DHBs were asked about the possibility of forming similar collaborations.

Changing nature of patients referred and treatment need

Almost all participants thought that the nature of the patients referred to, and treated by, hospital dental services had changed. They said they had noticed

that greater proportions of people with co-morbid conditions and older people now present to the hospital dental service than ever before, and increasingly, those groups are dentate. Consequently, patients' oral health management has become more complex. The majority of participants also said that, in recent years, more children are being referred by the Community Oral Health Service (COHS) for treatment under GA.

Resources and capacity

In the majority of DHBs, the changes in the nature of patients had consequences for the management and provision of hospital dental services. Staffing levels and workload were of particular concern to almost all participants. Most clinical leaders thought that, to appropriately meet the complex needs of their high needs and vulnerable patients, experienced dentists, especially senior dentists, and specialists, were required in the hospital dental service. Several participants were particularly concerned about the oral maxillofacial surgery (OMFS) and oral medicine workforces, citing challenges in the training and recruitment of New Zealand OMFS clinicians, and in recruiting overseas-trained oral medicine specialists because of registration challenges. Suggestions participants made to address those issues included undertaking OMFS workforce planning, establishing an OMFS centre of excellence, ensuring each tertiary centre had oral medicine specialists, instituting career progression processes in DHBs and providing more opportunities for distance specialist training.

Several participants also said that, to accommodate the increased workload in their hospital dental service, the recall periods for core hospital dental service patients receiving continuing care are being extended or rather than seeing some high needs and vulnerable patients for continuing primary care, they were referred back to their community-based primary oral health care providers. Almost all participants said that their service lacked the capacity to provide emergency and/or basic dental care for low-income adults. In several DHBs, 'low-income adults' were provided with a one-off episode of treatment or the option of a full dental clearance. Those patients, and those people declined access to the service, were then typically returned back to their community-based primary oral health care providers.

Some participants highlighted the contradiction in the HDS T2 service specifications between the 'mandatory' requirement and the 'as capacity allows' clause. Several were of the view that the latter introduces inconsistencies among DHBs in the services provided and data collected.

Hospital dental services in which the clinical leaders who were allocated non-clinical time appeared to have greater capacity to advocate for, and participate in, their DHB's strategic planning of their service than those who did not. In turn, their hospital dental service seemed better resourced than services in which the clinical leaders' time was purely clinical. Hospital dental services' interaction with planning and funding services within DHBs appeared mixed; some clinical leaders said they had little contact with planning and funding, whereas others had a good relationship with them. Overall, all participants said they enjoyed good working relationships within their team, and with other hospital services. Nevertheless, the majority of participants said they received inpatient referrals very late, which they said was frustrating and placed unnecessary pressure on the hospital dental service.

Participants' responses when asked about the credentialing processes in their hospital dental service indicated that they varied among DHBs, with some having regular formal processes while others were more informal or minimal. Further, several participants also said that their service's external providers are not included in the process.

Comments from a few clinical leaders indicated the lack of meaningful reporting requirements for the hospital dental service. They also appeared unaware of funding and planning arrangements, their comments suggesting that there is little data to inform business cases and decision-making for clinical leaders to monitor and improve resourcing and services for patients and to reduce staff workloads.

Clinicians' access to patient records was mixed. Typically, participants described fragmented systems within the DHB and between the hospital dental service and the COHS. Almost all clinical leaders agreed that, to assist them in appropriately diagnosing and planning the treatment of their high needs patients, they need to have all of their patients' medical records available to them.

Low-income adults

According to most participants, it was likely that not all high needs and vulnerable patients were being seen by the hospital dental service. The most commonly mentioned groups missing out on services were older people, low-income adults, mental health patients and those in residential care. The majority of participants said they would like to improve or increase their service; however, doing so would increase workload beyond the services' current capacity. Almost all participants agreed that, to address this issue, more resources — staffing and funding — would be required.

All clinical leaders were able to identify the hospital dental services' priority groups and thought that, generally, they were providing an adequate service for those patients. There was less certainty among almost all participants on the eligibility of those people who did not clearly fit within the core patient category for the hospital dental service, described by several participants as a 'grey area'. Typically, they were patients who were categorised as 'as capacity and funding allows', usually low-income adults. The eligibility of those groups of people appeared to be more arbitrarily determined, and thus differed by DHB.

In all DHBs, the criterion for 'low-income adult' was a CSC, although many DHBs also required the presence of a co-morbid condition. A common theme raised by the majority of participants was the inadequacy of the CSC to identify low-income adults. Most participants had observed that people who were just above the

threshold for a CSC but could not afford oral health care in the community — 'the working poor' — struggled to access any oral health care. Almost all participants acknowledged there is considerable unmet oral health need among low-income adults in New Zealand. To address the issue, several called on central government to act.

According to almost all participants, low-income adults were the most impacted by the increased workload generated by the greater complexity in treating patients who required hospital-level care. Almost all participants thought that low-income adults (and some patients with higher health needs) could, and would, be more appropriately treated by primary oral health care providers in the community. They said that doing so would reduce pressures on the hospital dental services and other hospital services, such as Emergency Department, and allow the hospital dental service to focus on treating their core patients. However, they also thought that shifting oral health care back to the community providers would be challenging. Many clinical leaders were of the view that, in general, community providers likely lacked the capacity, and/or confidence, skill and experience, and/or motivation and interest to treat patients with more complex health conditions.

Several clinical leaders said that some of their service users have difficulty physically accessing or attending the service. Comments from clinical leaders who operated out of multiple sites and/or mobile surgical services indicated the benefits of those facilities in improving physical access to the service, and reducing waiting times and pressure on the service. Very few hospital dental services provide domiciliary services. While most participants said that providing such services would be beneficial, staffing and resource constraints prevented them from doing so.

Lack of visibility and prioritisation of oral health and the hospital dental service

The lack of visibility of the hospital dental service and the importance of oral health within the DHB was a key focus in almost all interviews. Most participants' comments indicated that their service's low profile made it more difficult to obtain support for greater resourcing of the hospital dental service.

DHBs without hospital dental services or with services of limited capacity

The hospital dental services in seven DHBs are of considerable or critical concern. Five[1] either do not provide a hospital dental service or do not have hospital-based dental facilities in which to provide hospital-level care: Lakes, West Coast and Wairarapa, and Bay of Plenty[2] and Hauora Tairawhiti, respectively. The latter each employ (on a part-time basis) a local, community-based primary oral health care provider as a hospital dentist; Lakes contracts a community provider. Several of those DHBs serve regions with populations smaller than (or of equivalent size to) others that have hospital dental services with hospital-based dental facilities. Whanganui and Waikato have limited workforce capacity. In addition, the Auckland Regional Service has workforce, facility and funding constraints that are of concern.

Bay of Plenty

Overall, given the available resources, the hospital dental service in the Bay of Plenty is being delivered to the best of the incumbent's capacity and capability. However, the lack of adequate facilities and resources means the service provided is not equitable to that provided in almost all other regions in New Zealand. In addition, it is likely that many of the hospital dental service objectives and service specifications are not being adequately met in the Bay of Plenty region. Moreover, the service is not prepared to address the region's future oral health needs. The hospital dental service in the Bay of Plenty DHB is of critical concern. [At the time of writing, plans are underway to establish a dental department in Tauranga Hospital.]

Lakes

Although most hospital-level dental presentations at Lakes DHB were being addressed, either by the contracted community provider or referral to neighbouring DHBs, there were gaps in the hospital services for oral health. Of most concern was the lack of services for mental health patients, along with emergency dental services. The hospital dental service in the Lakes DHB is of critical concern.

Hauora Tairawhiti

Ultimately, Hauora Tairawhiti hospital dental service was in a similar position to Bay of Plenty and Lakes DHBs, in that a physical presence within the region's hospital(s) was needed, with increased FTE and good oversight. Aspects of the hospital dental service in Hauora Tairawhiti DHB are of considerable concern. [At the time of writing, there had been some increase in FTE.]

Wairarapa

There is no dental facility at Masterton hospital and Wairarapa DHB does not employ a dentist. The only adult oral health service in Wairarapa DHB is a full clearance service under GA for CSC holders with comorbidities. For all remaining adult hospital dental needs, the service relies on local practitioners, together with the neighbouring DHBs. It is likely that there are oral health issues with the high needs and vulnerable population in the region; however, those issues appear to lack visibility and in turn, are likely not being addressed. Aspects of the hospital dental service in Wairarapa DHB are of considerable concern.

West Coast

The West Coast does not have a hospital dental service. Transportation is likely a substantial barrier for West Coast patients accessing hospital-level care, undoubtedly, compounded by patients' medical

[1] Waitemata not included as services are provided as part of the Auckland Regional Service.

[2] At the time of publication, hospital dental services were being instituted in Bay of Plenty DHB.

comorbidities. Dentists are contracted to provide dental treatment under GA for some adults and children. Aspects of the hospital dental service in West Coast DHB are of considerable concern. [At the time of writing, concerns about the oral health services in the West Coast DHB are in the process of being addressed.]

Whanganui
The lack of workforce capacity and, in turn, the current workload of the hospital dentists at Whanganui DHB is of considerable concern.

Waikato
The hospital dental services at Waikato DHB have a strong surgical focus; there is limited hospital dentistry workforce capacity.

Auckland Regional Service
The organisational structure of the hospital dental services within the Auckland Regional Service, and its relationship with OMF is complex. The Service faces considerable resource limitations and constraints, including funding, workforce and facilities. Consequently, it has difficulty meeting the demands of its diverse, large and increasing population. Such constraints also limit the delivery of tertiary services to those within the Service's region and from referring DHBs.

Successes
All participants were asked to provide some examples of activities or aspects of their service that were working well or that benefitted their patients. Positive aspects of their service mentioned included HealthPathways, relationships within hospital dental departments and with other hospital services, the combined hospital dental and community oral health services clinical director roles, community care and a range of smaller initiatives to improve services.

HealthPathways is a tool used to facilitate the relationship between primary and secondary care. Only a few participants said they were currently using HealthPathways for oral health referrals and treatment in their DHB. Those participants thought that oral health HealthPathways improved the visibility of oral health and their service within their DHB and other hospital services. It also improved referral quality, assisted in managing workload and supported community-based primary oral health care providers when treating more complex patients. They also thought the differing treatment philosophies and models of oral health care delivery between hospital and community-based primary oral health care providers had the potential to challenge greater use of oral health HealthPathways.

Regional DHB Alliances
Regional Alliances are seen as an essential strategy for improving coordination and consistency in service provision. According to the South Island participants, the benefits of the South Island Alliance include: improved communication; providing a forum for problem-solving and opportunities to advocate for the resourcing of hospital dental services in neighbouring, less well-resourced (and smaller) DHBs.

While some loose, regionally-based alliance groups among some North Island DHBs have been formed, they have not been formally established; most do not have service management, and funding and planning representation, and some groups focus only on the COHS. In general, there is support among the North Island DHBs for a similar arrangement to that in the South Island, with the formation of three or four alliance groups, based on typical or usual regions. The regional arrangements used by the Electronic Oral Health Record (EOHR) Programme could form the basis of the hospital dental services' North Island Alliance groups.

Key findings
1. The nature of the patients being referred to (and treated by) the hospital dental service has changed. More than ever before, greater proportions of high needs and vulnerable people have multimorbidity and retained their natural teeth. In addition, more children are being referred for dental treatment under GA. These changes place a substantial burden on hospital dental service resources and those of some other hospital services.
2. The provision and resourcing of hospital dental services lacks national consistency. Some DHBs have limited or no hospital dental services. In about one-third of DHBs, the provision of oral health services for their region's high needs and vulnerable population is of considerable or critical concern.
3. For the most part, hospital dental services appear to be adequately meeting the 'must do' service specifications for the majority of core service users. However, the complexity of many hospital patients' oral health and overall health management means that many hospital dental services find it challenging meeting all the core patients' oral health needs, particularly ongoing primary oral health care. Increasingly, because of limited capacity, hospital dental services are less able to provide oral health care, including relief of pain treatment, for low-income adults.
4. The HDS T2 service specification's 'mandatory' requirement and the 'as capacity allows' clause are contradictory. The lack of consistency in the application of the 'as capacity allows' clause by DHBs likely contributes to inequalities in access to care and oral health among the high needs and vulnerable population nationally, and between Māori and Pacific peoples, and the overall population.
5. Overall, the Hospital Dental Service lacks sufficient staff resources, and/or the appropriate mix of skilled and experienced staff to meet the current and future oral health needs of the high needs and vulnerable population. Particular concerns include workload, training, career progression and succession planning of hospital dentists and some specialties.
6. The determination of some patients' eligibility to access the hospital dental service among DHBs is mixed. Eligibility is very clear for some high needs and vulnerable groups; for other groups it is arbitrarily

determined, and consequently, the services provided to them differ by DHB. In all DHBs, the criterion for eligibility as a 'low-income adult' was the possession of a Community Services Card. However, this criterion does not adequately identify all adults on low incomes. Although the Service Matrix is used by some DHBs to triage patients into the hospital dental service, its use is not universal across the hospital dental services.

7. The oral health care needs of some high needs and vulnerable people, particularly low-income people, are more appropriately addressed by primary oral health care providers in the community. The hospital dental service should only provide primary-level health care for those who have high health needs and whose treatment can only be provided in a hospital setting.
8. Hospital dental services lack visibility within DHBs, and oral health stands alone from general health and health care. Consequently, the hospital dental services and oral health typically lack prioritisation within the DHB, and within the overall health system. Overall, collegiality and relationships within hospital dental services and with personnel from other hospital services are positive. However, in many DHBs, there is a disconnect between the hospital dental and community oral health services; those DHBs in which the two services have a common clinical director role appear to have a more seamless service. There is also a disconnect between the hospital dental service and the community-based primary oral health care sector.
9. Data collection within the hospital dental services is limited. There is a lack of meaningful data, and monitoring and evaluation of hospital dental services, to usefully inform their management, resourcing, performance and planning. Data management processes not only lack consistency among hospital dental services, but also between hospital dental and community oral health services, and between hospital dental and other hospital services.
11. Differences in the hospital dental service likely contributes to the poor oral health of the high needs and vulnerable population, and to oral health disparities between high needs and vulnerable people and the overall population.
12. There are benefits to the regional coordination of hospital dental services.

Recommendations

1. Establish a working/reference group to develop an implementation plan that includes a set of feasible and acceptable strategies to operationalise recommendations 2-14.
2. Review the definition of 'high needs and vulnerable' in the context of the hospital dental service and the HDS T2 service specifications 'mandatory' requirement, in particular, those who are eligible service users 'as capacity and funding allows'. Address the contradiction between 'mandatory' and 'as capacity allows' in the HDS T2 service specification.
3. Update the Service Matrix and require its use in all hospital dental services.
4. Review the eligibility criteria for 'low-income adult'.
5. Reorient some oral health services to accommodate the outcome of Points 2, 3 and 4. In particular, oral health services for low-income adults should be shifted from the hospital dental service to primary care (when clinically appropriate).
6. Deal with those DHBs in which the hospital dental service is of critical or considerable concern.
7. Institute Community and Hospital oral health HealthPathways nationally.
8. Review the oral health workforce plan, developing a strategy that will adequately address the current and future demands of the high needs and vulnerable population.
9. Institute meaningful reporting requirements, and require all DHBs to support and adopt the EOHR programme.
10. Investigate and implement strategies to improve timeliness of service provision and physical access to hospital dental services, particularly those DHBs with widely dispersed population.
11. Ensure that all hospital dental services' clinical leaders have allocated non-clinical time.
12. Institute a universal credentialing process – for all services, providers and external contractors.
13. In the North Island, establish, or review and formalise current, dental service alliance groups.
14. Invest in oral disease prevention throughout the life course.

Further research

The findings of this research are limited to the perspectives of hospital dental services' clinical directors and leaders, or other DHB personnel. To provide a comprehensive view of New Zealand's hospital dental services, and inform practice and policy, further research is required, including the following:

- Gathering the perspectives of all those involved in the delivery and receipt of hospital dental services, particularly service users—patients—and their whānau and supporters. Such investigations must be led by, or be conducted in partnership with, Māori and Pasifika, so that the planning and implementation of interventions are relevant to both groups. Most importantly, doing so would ensure the obligations to health equity and protection for Māori under Te Tiriti o Waitangi are met. Research with the high needs and vulnerable population should align with the research priorities identified and outlined in Oranga Waha[1] and any subsequent Māori oral health research agenda.
- An in-depth investigation of tertiary oral health services capacity, particularly oral medicine and OMFS services.
- Investigations to plan services and formulate strategies to address the oral health needs of low-income adults.

- Gather the perspectives of the primary oral health care providers and determine the capacity, skill, confidence, cultural competence and willingness within the sector to manage high needs and vulnerable patients. Data will usefully inform the reorientation of services for low-income adults.
- Monitoring and evaluating any service changes or interventions implemented in the hospital dental service.

Conclusion

Inconsistencies in the provision and delivery of hospital dental services likely contribute to the poor oral health and access to services experienced by high needs and vulnerable New Zealanders, and likely perpetuate oral health inequalities.

Addressing the gaps in the hospital dental service is a collective responsibility, requiring a coordinated and collaborative response from the whole of the oral health sector, guided by national leadership. Achieving equitable hospital-level care and seamless service for the high needs and vulnerable population requires increased resourcing and workforce planning, reorientation of some oral health services, meaningful monitoring and evaluation of services, implementation of systems to break the silos between oral health and general health, and development of a national strategy to plan oral health services and coordinate hospital dental services and other facets of the oral health sector.

Recent demographic and epidemiological changes in New Zealand's population have placed considerable pressures on the hospital dental service. Given that such changes are predicted to continue into the future, so too are the pressures on the hospital dental service; indeed those pressures are likely to worsen if the underlying causes are not addressed.

The government is currently exploring how to provide a *"sustainable and forward-looking Health and Disability System that is well placed to respond to future needs of all New Zealanders"*. Urgent action is required to ensure the hospital dental service has the capacity to provide high needs and vulnerable New Zealanders—now and in the future—with services that adequately and appropriately respond to their oral health needs. Only then will New Zealand's most vulnerable people enjoy good oral health, for life.

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