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New Zealand private practice dentists' views of oral health injustice: A qualitative investigation

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Abstract

Objectives: Most adult oral healthcare in New Zealand (NZ) is provided in private dental practices on a fee-for-service basis, funded directly by the patient. The cost of dentistry means that low-income New Zealanders have inequitable access to regular oral health care. We investigated how private practice general dentists within two NZ regions view the current oral healthcare funding model and its influence on oral health inequalities.

Methods: Eight general dentists currently working within the Bay of Plenty and Lakes District Health Board regions participated in semi-structured interviews. Transcripts were analysed using a general inductive thematic approach.

Results: Three main themes emerged: education/prevention, funding, and commercialisation. The importance of preventive interventions for reducing the population burden of oral disease and associated inequalities was highlighted. Low-income adults were recognised as a priority group requiring additional assistance. However, the dissatisfaction of most participants with the current Government-funded oral healthcare contracts meant that planning and developing any future contracts to address their needs should involve consultation with private practice dentists, in order to improve on the shortcomings of previous contracts.

Conclusion: To improve oral health and reduce injustice and inequities for vulnerable groups in the population, dentists need to be encouraged and supported to practise in a way that balances their commercial needs and their responsibilities as healthcare professionals.

Introduction

Funding for oral healthcare in NZ comes from a mixture of private and public sources (Smith et al. 2020). Until July 2022, the NZ healthcare system comprised 20 District Health Boards (DHBs) that exercise regional management of funding, planning and provision of healthcare services for their geographic areas. DHBs contributed a large proportion of the publicly-funded dental care provided. However, the services provided, the manner in which they were provided, and the extent of funding all showed considerable variation among DHBs. Those younger than 18 years are entitled to free basic dental treatment (Smith et al. 2020). Up to age 13, this care is provided through the Community Oral Health Service (COHS), which historically involved an oral health therapist based in a permanent facility at many schools (Moffat et al. 2017). In recent years, the COHS has moved to a predominantly mobile-caravan-based system, whereby oral health therapists move around schools in a mobile facility, spending an allocated amount of time at each school (Moffat et al. 2017). For adolescents up to 18 years of age, publicly-funded oral healthcare is provided by private dental practitioners working under the Government-funded Adolescent Oral Healthcare Contract (AOHC). By contrast, most adult dental treatment is provided through private practices, usually on a fee-for-service basis and paid for by the patient (Smith et al. 2020). Publicly-funded dental treatment for adults is usually provided through hospitals or by private practices contracted under DHB[1] funding schemes to assist particular population subgroups such as low-income adults or those on a government benefit (Smith et al. 2020).

Aside from DHBs, other Government agencies providing some public funding for dental care in NZ include the Accident Compensation Corporation (ACC), Work and Income NZ (WINZ), the NZ Defence Force, the Department of Corrections and the Ministry of Health (MoH). Collectively, however, these enable only a small proportion of oral healthcare. ACC provides a part-payment for dental treatment required because of trauma; it is universally available to the NZ population. WINZ funds a limited range of dental treatment for some low-income individuals. In essence, though, most adult oral healthcare in NZ remains privately funded on a fee-for-service basis (Smith et al. 2020).

Unlike other NZ regions, hospital-based general dental departments do not exist within the Bay of Plenty (BOP) and Lakes areas (Smith et al. 2020). Instead, basic emergency dental treatment for adults who are community services card (CSC) holders is funded by the BOP and Lakes DHBs, provided by private practices holding a low-income adult (LIA) contract with their respective DHB (Smith et al. 2020). CSCs are held by people whose income is below a threshold which entitles them to receive subsidised healthcare services[2]. Patients requiring dental or maxillofacial surgical treatment beyond the scope of those community-based private practices are either referred to a neighbouring DHB for care or can be seen in the general hospital theatres managed by BOP DHB (Smith et al. 2020).

1 In July 2022, the 20 DHBs were combined into a single nationwide health provider, Te Whatu Ora (https://www.futureofhealth.govt.nz/health-nz/). To date funding for oral health remains the same under Te Whatu Ora.

2 https://www.workandincome.govt.nz/products/a-z-benefits/community-services-card.html

This means that low-income people in the BOP and Lakes area cannot simply walk into a hospital emergency department and receive free emergency treatment for oral problems as can be done in other areas of NZ. Instead, they must find a dentist holding a LIA contract and receive only subsidised care.

The most recent national oral health survey, conducted in 2009, showed that dental caries was the most prevalent chronic disease in NZ, with one in three adults having untreated coronal decay, and one in ten having root surface decay (Ministry of Health, 2010). Most adults used oral health services episodically rather than for routine check-ups, a pattern of utilisation known to be associated with poorer oral health (Thomson et al, 2010). Nearly half of the adults surveyed reported that they currently needed dental treatment, and a similar proportion reported avoiding oral healthcare because they could not afford it. Poorer dental attendance and oral health were typically seen in men, young adults, Māori, Pacific peoples, and those in deprived areas (Ministry of Health, 2010). This considerable unmet oral health need within the NZ population has raised questions about the efficacy and justice of the current oral healthcare funding model in providing care, particularly for those most vulnerable to poor oral health.

Dentists' opinions of the current system's effectiveness in providing oral healthcare to the NZ population are highly relevant because of their central role in service provision. Their views on the desirability and feasibility of universal publicly-funded dental care for adults have recently been reported (Cheng et al. 2021), with one third not perceiving cost to be a substantial barrier to dental care for adults. Those findings underline the need for a more focused, in-depth examination of private-sector dentists' views on such issues. Accordingly, we investigated how private practice general dentists in the BOP and Lakes regions view the efficacy of the current oral healthcare funding model and its influence on oral health inequalities. The BOP and Lakes DHB regions serve a population of greater-than-average deprivation.

Methods

Ethical approval for this qualitative study was obtained from the University of Otago (Reference Number D20/248). A sample of dental practitioners was recruited from within the BOP and Lakes DHB boundaries. All private dental practices listed on the NZ Dental Association (NZDA) website which fell within the BOP and Lakes DHB regional boundaries were contacted. Each practice was phoned and asked for the email address(es) to which an invitation, information sheet and consent form could be sent so that dentists at their practice could view the documents and opt into participating if they wished. Dentists who gave written consent to participate were recruited.

Eight dentists (seven males, one female) were interviewed on a first-come, first-served basis. Recruitment ceased once data saturation had been achieved (Grady 1998). Two participants had been practising for fewer than ten years, one for between 11 and 20 years, three for between 31 and 40 years, and two for between 41 and 50 years. Seven were practising within the BOP region, with the other practising within the Lakes region. All were general dental practitioners (GDPs) who worked either full- or part-time in private dental practice as an owner/operator or as an employee.

Each took part in one semi-structured interview. An interview guide was developed from similar research with Australian dentists (Holden et al. 2021). Although participants were aware of the general nature of the questioning, they were not given the interview questions prior to their interview, ensuring that their true, unpremeditated responses were recorded. All interviews were conducted by a single interviewer; seven were held in-person and one was held over Skype™ due to timetabling and logistical challenges. The interviewer was a dental practitioner who has lived in the Lakes and BoP region. Interviews followed the semi-structured interview guide, but further questions were asked—where necessary—to encourage responses or to further explore a response. Interviews were audio-recorded and then transcribed verbatim by a professional medical transcription service.

This qualitative research is underpinned by a social constructionist lens (Burr, 2015) which allows for multiple truths, readings, and interpretations. In line with that approach, the data were analysed using thematic analysis (Braun and Clarke, 2006; Thomas, 2006; Braun and Clarke, 2022), which allows identification of themes and patterns that indicate shared ideas, meanings, or concepts. These themes are actively produced by the researcher through systematic engagement with the data; they do not simply "emerge" from the data. The transcripts were read and re-read, recurring themes noted and refined, and evidential quotes grouped under each theme. Triangulation, whereby all three researchers undertook analysis, was used to ensure consistency and reliability of themes (Flick et al. 2004). The analyses of the three researchers were compared and refined until a consensus on themes was reached. The researchers' backgrounds are in general dentistry, qualitative health research, and public health respectively, meaning the analysis involved a broad range of perspectives.

Findings

Three main themes which emerged from the interviews were education/prevention, funding and commercialisation. These are represented in Figure 1, together with the sub-themes which fall under each. Inevitably, there was considerable intertwining and overlap of themes, but, for the purposes of organising and reporting the findings, each theme is presented, illustrated by quotes, and discussed separately below.

Education/Prevention

The education/prevention theme emerged where participants discussed their beliefs that additional oral healthcare funding should be put towards preventive measures in the first instance. Specific preventive measures that participants thought required more focus were expanding community water fluoridation

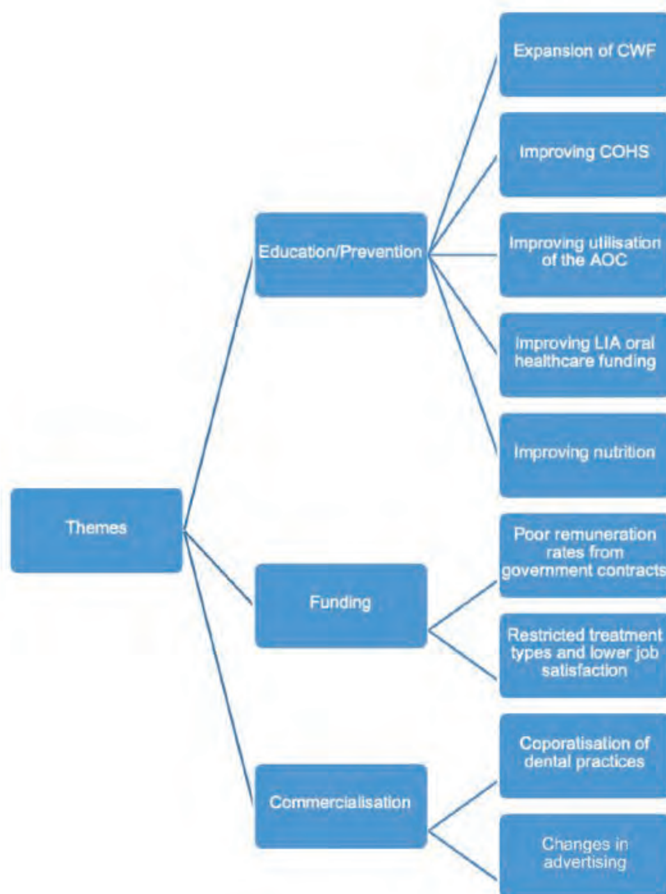

Figure 1. Themes that emerged from the interviews.

(CWF) to more areas, improvements in the COHS, improving utilisation of the adolescent oral healthcare funding scheme, improving access to preventive oral healthcare services for low-income adults (LIA), and improving nutrition.

All participants suggested that additional Government funding for oral healthcare should focus on preventing the development of oral diseases. One participant summed this up by saying, “the problem with the current funding model is that it’s based on the ambulance at the bottom of the cliff so you’re trying to fix surgical issues and you’re never gonna fix them.” Two participants suggested CWF as a preventive measure that is both economical and effective in reducing the oral disease burden.

Participants from fluoridated regions claimed that fluoridation of their water supplies had lessened the burden of oral disease within their community to levels where they could treat patients under poorly-funded Government oral healthcare contracts without too much financial loss. Participants also viewed CWF as essential to reducing oral health inequalities.

All felt that any additional Government funding for oral health should be focused on younger people, with specific focus on improving the COHS and utilisation of the AOC. Their reasons for targeting preventive and restorative interventions for younger age groups were rooted in their belief that it will encourage lifelong good oral hygiene practices and health for the next generation. One participant encapsulated this view with the statement: “we will be stopping all that stuff from happening in the first place, nipping it in the bud”. Most participants believed that, if children and adolescents are taught how to maintain good oral health prior to the age of 18 years, they should be able to maintain this for the rest of their lives, thus reducing the need for expensive restorative work for late-stage disease. Those suggesting this approach accepted that the positive impact would not be apparent instantly, but that the generational change would be worthwhile.

Most participants commented on the major shortfalls within the COHS and felt that addressing these should be a priority for improving population oral health. Most attributed the shortfalls to poor service funding. Many also commented on the reduction in the quality of service provided following the “reform” of the COHS into a hub-and-spoke model where services are provided by mobile caravans rather than permanent school-based clinics.

> *The Government in 2008 introduced this hub and wheel system where they reduced the number of clinics in schools, reduced the number of therapists and the theory was that this would lead to efficiencies, which would enable them to treat children with greater advocacy, but the reality is that this hasn’t happened. What’s happened is that the health boards have seen this as an opportunity where they can abdicate some of their responsibility, provide services which aren’t so regular nor so extensive and those children are now missing out.*

Most participants spoke about a considerable number of children not being seen annually under the COHS as they should be, resulting in extended periods without dental check-ups and referrals or treatment. Consequently, children are missing opportunities to be treated preventively, and then require restorative management.

> *Sometimes some of these kids haven’t been to the dentist for two or three years because they are visited by the caravan rurally and they weren’t at school that day or the caravan just didn’t have enough time to get through all the children and stuff like that.*

Many participants believed that the underperformance of the COHS was increasing population oral health inequalities.

> *Then we have a burgeoning young population that aren’t getting seen every year and the wealthier parents just take their children out of that system and take them to see a dentist and pay privately. I’ve seen quite a few families that have lost faith in the system and they want to take control themselves.*

Almost all participants mentioned difficulty in recruiting oral health therapists into the COHS as a major contributor to its shortfalls. Many thought that the lack of oral health therapists has increased since dental therapy

and dental hygienist qualifications were merged into a single oral health therapist qualification about a decade previously. Participants opined that, since the merger, graduates were favouring jobs in private practices as hygienists rather than working in the COHS as therapists, with working conditions being the major factor.

> *Commercially wise, hygienists get paid a hell of a lot more than oral health therapists. Since they have jammed the two degrees together, everyone wants to go and work for hygiene, get paid a hell of a lot more. So, the School Dental Service there's no one left to work in there. They're only the older ladies who are only single qualified as therapists who can't work as hygienists – they're gonna phase out and then what?*

Almost all participants expressed this belief, best represented by the statement, "the therapists definitely need more support and more funding, more of them."

One participant stated "I think the School Dental Service is underfunded and it needs a bit of imagination to try and bring it back to modern way of delivering the service." Another participant suggested that children should be treated in family-based private practices who hire oral health therapists to facilitate this, contracted by the Government.

Many participants also highlighted poor AOC utilisation rates as an issue. Many believed that improvements to the COHS would increase adolescents' familiarity with oral healthcare providers and thereby improve their attendance for care. Many suggested that there should be a better system for referring adolescents to dental practices contracted under the AOC. Suggestions included schools giving adolescents information about nearby providers and for social services to make referrals for adolescents no longer in school for general dental check-ups by these providers.

Three participants felt that low-income adults should also be a priority group for funding. Their concern was for low-income adults who do not have their oral healthcare funded by WINZ because they fall just outside the income limit, but who still struggle to afford basic oral healthcare. Currently, a low-income adult funding contract exists within the BOP and Lakes DHB regions to subsidise oral healthcare for this group, but very few private dental practices choose to work under this scheme due to the poor remuneration rates. The adult funding was described by one participant as, "Low-income adult system – haven't done it for 20 years, it's woefully underfunded. It's terrible."

Three participants expressed concern that the low-income adult contract funds treatment for only late-stage oral disease and dental emergencies, with little focus on prevention. They believed that the scheme needs to be changed to a preventive focus, in order to reduce the number of late-stage restorative interventions required. They believed doing so would improve remuneration rates for contracting dentists, thus improving the contract uptake among private practices. Some preventive measures suggested were periodontal management and simple restorations. These participants also advocated to maintain the low-income adult contract as a 100% payment to avoid imposing a financial barrier to oral healthcare services for patients who could not afford the co-payment.

> *The low income adult system, it's gotta be a full funding system because otherwise the co-payment is a barrier to them getting their treatment done. Then it should be full funding for a limited number of services.*

One suggestion for meeting the needs of low-income adults was to employ dentists under a Government salary to provide them with basic oral healthcare services including preventive treatment.

> *It would be very economical to salary dentists into positions that could provide basic dental care with oodles of preventive care and reap the rewards in five years' time with improved health of our dental community and less need for the ambulance at the bottom of the cliff.*

Almost all participants believed that the subsidised services available to low-income adults were an 'ambulance at the bottom of the cliff', encouraging episodic patterns of service-use. They believed this resulted in poorer oral health for this population, and that it was more costly to the Government than subsidising preventive oral healthcare for them.

By contrast, two participants stated there was no need for low-income adults to receive subsidised treatment. They thought that the disparity in cost between healthy and unhealthy foods/drinks needed to be addressed instead. If healthy food and drink options were made more accessible, affordable and desirable, it would avoid the need for further funding of dental treatments in the low-income adult group.

Funding

When discussing funding, participants talked about limitations with the current Government-funded oral healthcare contracts, along with their consequent disinterest in signing up to any future contracts that might become available to increase the scope of (and coverage by) publicly-funded dentistry in NZ. Two subthemes emerged within this theme: the poor renumeration rates when working under Government contracts; and the dentists' lower job satisfaction when working under restrictive Government contracts.

All participants commented on limitations in the current Government funding contracts for oral healthcare in NZ, particularly in respect of the adolescent and low-income adult contracts, as discussed above. The AOHC is a partial capitation system with a set per capita fee paid to the practice annually, enabling each adolescent enrolled to receive dental examinations, intra-oral radiographs, scaling, fissure sealants, single-surface restorations and topical fluoride applications at no charge to the patient (Ministry

of Health 2006). Additional treatment required by adolescents extending beyond those mentioned above can be provided with third-party Government funding on a fee-for-service basis. Under the scheme, the fee paid for any given service is set by the Government and is standardised for all practices working under this contract, with no option to request co-payments from patients (Ministry of Health 2006). Seven participants said they worked under the AOHC, while one did not. All commented on the poor funding. One participant pointed out, “the fees are crap, it’s literally charity, you lose money doing work for the kids. To put people in that position while you’re asking for good work is not fair.”

Three participants stated that the financial loss incurred by working under the AOHC was less pronounced in communities where adolescents’ dental needs were less extensive. They suggested that the capitation fee for maintenance and preventive management was more appropriate for patients with good oral health.

> *There are two ways to look at it. One is that if you see high need adolescents that require multiple treatment sessions, it can be quite damaging to your profitability as a practice because you get paid less than half the amount that you would privately for fillings, root canals, extractions. That just takes away all your profit so you’re just treading water but if you see a whole lot of adolescents that have good teeth, you can get them through, just take bite wings, and do a quick clean.*

Participants gave two reasons for their working under the AOHC despite its poor funding: (1) it acts as a good practice builder; and (2) it is a service to the community. They stated that the financial loss incurred by working under the Contract was manageable only because the patients they treated comprised a small proportion of their total patient base and workload. They used profit generated by the privately paying patients to cross-subsidise the financial loss incurred through working under the AOHC.

> *We do a service to the community is why we do it. You don’t get paid anything for it, at the end of the day, that is horribly underfunded but at least it’s something I suppose. Also, it’s a good practice builder – you’re getting the kids in and the parents come in. You’ve gotta look at the bigger picture from a business point of view.*

Most participants mentioned how the low-income adult contract is similarly underfunded, and said they do not work under it on this basis. Most were unwilling to tolerate the magnitude of financial loss caused by working under the low-income adult contract. They suggested that absorbing the financial loss of working under that was not worthwhile because the financial toll was great, and working under the contract came with few advantages for the practice.

> *For instance, we can’t take out wisdom teeth in Dental Benefit patients now ‘cos the fee for doing it sometimes is less than the cost of a dental exam and that’s for a surgical extraction. It’s just not worth us to do it.*

Participants stated that the high overhead costs of running a dental practice are not appropriately reflected in the renumeration rates provided under Government oral healthcare funding contracts. They also commented that the Government remuneration rates were not keeping up with inflation. The poor rates provided under the AOHC and low-income adult contract meant that that some practices signing up to these contracts were pressured to compromise the quality of their care for the sake of minimising the financial toll of working under them.

> *This happens a lot with the Adolescent Oral Healthcare Contract is that you get put in a situation where health care is weighed up against commercial and it’s like that kid needs free massive occlusal fillings and you don’t get paid for it. Dentists will just go, oh let’s just watch those teeth instead of filling them. That doesn’t happen with everyone, it definitely doesn’t happen all the time but it’s putting people in difficult situations.*

One participant mentioned that the financial loss incurred by treating patients under the AOC and low-income adult contract was also exacerbated by the greater time spent processing the required paperwork and documentation than for privately-funded patients.

> *It’s not all about the money. A lot of it’s about the bureaucracy. The reporting that is necessary for these contracts is onerous and costly and the more reporting we have to do, the less dentistry we can afford to do so whoever’s making this model needs to think about that.*

Participants said that they would be unwilling to opt into a Government adult oral healthcare funding contract providing care for the majority of the adult population if it was managed similarly to the current Government-funded oral healthcare contracts. All participants explained the reason was that running a practice where a large portion of the patient base were Government-funded patients was financially unviable.

> *I’ve seen over many years the gradual attrition of the level of funding given to Dental Benefit patients and we can operate under duress because they are a small section of the community… Does that mean I’m going to take on the treatment of every patient in the neighbourhood, in the whole town at a reduced fee when they don’t allow me to reinvest and improve my services and keep up to date with technology? I don’t think so. I’d rather do it privately, be compassionate, target the services we need and provide a better service. We have to, we’re under so*

many Government regulations that we have to provide a really good service and I don't know that the funding would keep pace with the cost of the changes we need to make.

Almost all participants thought that fully-funded oral healthcare was unachievable because the cost of running a comprehensive service would exceed what the Government would be willing to offer.

I don't think full payment is the answer because it's done on a fee for service basis and most dentists would struggle and wouldn't be able to operate because the funding will never keep up with the demand. Just the cost of materials alone, cost of providing equipment … The costs of running a dental practice are phenomenal … I can't even imagine the Government would want to pay for all of it. Part payment maybe but I think they're better to select their targets.

Some participants said they would consider working under a Government contract providing subsidised care to a greater proportion of the adult population if the contract was financially more aligned with private fees.

Many participants expressed concern that an oral healthcare funding contract extending to a wider range of the adult population might limit the range of treatment types they could provide. They thought Government contracts would exclude the same treatments excluded in the adolescent and low-income adult contracts, and that these were the most enjoyable treatments to provide. They stated that, as a consequence, their job satisfaction would be lower because their work would be mostly confined to less desirable treatments.

I like saving teeth with root canal treatments, and I like doing the odd CEREC or the odd gold crown or the odd treatment that wouldn't necessarily be covered, like a bonded bridge for a lower anterior, things like that. I don't think you'd get to do some of those more enjoyable treatments; I think it would be mainly be extraction after extraction and that's hard work physically and mentally seeing the really bad teeth.

Participants described the work they did under Government contracts (particularly the LIA contract) as challenging. The challenging nature of the work and the poor fees made working under these contracts undesirable. One participant suggested the need for incentives to entice dentists to do this more labour-intensive work.

In Australia, you get paid really well for going to the desert to work. Whereas, I know working in the NZ public system it can often be frowned upon, you're not going to make as much money or you're not gonna have the same kinds of opportunities.

Commercialisation

The commercialisation theme became evident when participants discussed NZ dentistry becoming increasingly commercialised. Two subthemes emerged under commercialisation: the increasing corporate ownership of dental practices; and the public's changing view of dentistry as a result of contemporary advertising.

Seven participants discussed the gradual movement toward increasing corporate ownership in NZ dental practices. One talked about the current development of several "mini-corporate groups" in NZ and how this is likely to facilitate the movement to one or two corporate companies owning most NZ dental practices in future. "You've almost got these mini corporates. I wonder if that's just a stepping stone towards eventually some company like BUPA buying everyone out."

All seven of these participants believed that increasing corporate ownership was causing dental care provision in NZ to become increasingly commercially focused.

The greater level of corporatisation results in a lessening of the professional ethic being dominant. It's more governed by commercial considerations rather than ethical and professional considerations and the dentist is subject to the requirements of the management so the profession is generally on a slippery slope downward, in my opinion, as a result of that.

Some participants commented that dentists working in corporate practices have less capacity to practise according to their own ethical judgements because many of their practising decisions are influenced by commercially-focused business managers.

At the end of the day, we train our dentists, and we encourage ethical behaviour and every dentist has to make their own choices about what they're doing from moment to moment and in their entire careers. Certainly, in the corporate world, these key performance indicators are aggressively schooled and managed and practice managers are usually non dental trained are pushing young new graduates and new immigrants to believing this is the way it should be done.

Corporate practices with owners who are not from the dental profession were described by one participant as being "run like a business and their first priority is to their shareholders, not to the dentist, the staff or the patient". Another participant stated, "you will always receive better care from a well-run private practice but that doesn't mean that you can't receive good care from a corporate practice because there's a tendency to drift on that scale towards business indicators, making the numbers fit."

A few participants suggested that, as the corporatisation of NZ dental practices increases, the commercial focus will increase, and this is likely to cause oral health within the population to worsen.

It may not necessarily cause a decline in the quality of care, but it is more likely health outcomes as a population will change for the worse because there will be smaller and smaller groups having more and more expensive cosmetic procedures and unnecessary procedures at the exclusion of people that need routine preventive care. Then they slip into needing casualty and emergency care.

By contrast, another participant believed that the quality of care provided by corporates was likely to be poorer due to the speed at which the dentists have to work within those practices to meet their key performance indicators. That participant believed that this poor care would adversely affect population oral health.

Several participants offered reasons for increasing corporate ownership in the NZ dental sector. The most common reason was that the new generation of young dentists lack the desire to enter into practice ownership as opposed to earlier generations of dentists.

Commercialisation in dentistry is probably going to increase as Lumino and other corporates take greater hold of the profession. I see this as inevitable because there are a lot more female graduates coming through or not even just female but male graduates who don't aspire to own a practice; they'd rather just work part-time and take what they can for themselves as a lifestyle rather than being completely dedicated to running a full-time practice.

Five participants commented that changes to advertising dental care have contributed to its commercialisation.

Changes to the Advertising Act and practices have been opened up to being owned by other than dentists. Before the establishment of the Commerce Commission, I established a new practice and I was allowed to advertise in the paper five days, no more than a two-inch column and I was allowed to say who I was, what my qualification was, address in which I was practising. It was forbidden under the rule of ethics of the Dental Association for any more information and for any longer period of time. That was harsh and the Commerce Commission changed that, but not necessarily for the better. Things have changed a lot and people have just come to see it as advertising for dental is like advertising for a hairdresser or something like that and it does kind of cheapen it in a sense, I think.

Five participants believed that some dental practices abused the more lenient advertising laws to oversell their services, causing the public to lose trust in the profession.

I think that there are certain practitioners who either insinuate or imply that their qualifications are other than what they are and also there are some who probably are giving false expectations to the public about what they can achieve for them. Cosmetic dentistry, among other things, or orthodontics, fast braces sort of thing.

Another participant thought that advertising pricing commercialises dentistry:

If you're competing on price, it's a race to the bottom… the advertising that happens tends to push dentistry towards looking more like a product. By some of the advertising that happens you know $69.00 for this or $59.00 for that, it makes it seem like it's more of a commodity and that everything's the same. Again, that's how the majority of the public will tend to view it.

These five participants thought that the current advertising in dentistry—particularly among corporate practices and practices in larger cities—is causing the public to view dentistry more like a commercial product instead of a healthcare service.

Discussion

This study investigated the views held by private practice general dentists within the BOP and Lakes DHB regions, of oral health injustice and the current funding system for oral healthcare in NZ. It replicated a similar qualitative study conducted in Australia, aiming to gather findings relating specifically to NZ (Holden et al. 2021). Specifically, this study was undertaken with dentists in an area where free emergency hospital dental care is not available to patients, meaning that the dentists had a good understanding of the oral health injustices suffered by low-income adults. Consistent with the nature of qualitative research, the findings of this small study are not necessarily generalisable to other areas in NZ or to other countries, but they do highlight a range of ideas on why inequities in oral healthcare in NZ exist, and how equitable access might be enabled.

Participation in Government-funded contracts for oral healthcare was felt to be based on goodwill rather than obligation. Consistent with findings from a similar qualitative study conducted with Canadian general dentists, participants in the current study felt that efforts to reduce the burden of oral disease were best achieved through planning, advocacy and preventive measures rather than providing universal subsidised oral healthcare services under Government contracts (Quiñonez et al. 2009). International comparisons of different healthcare systems found that those that are most effective and efficient in reducing the burden of oral disease had philosophies and policies with a preventive focus (Saekel 2016). These comparisons suggest that oral health services for all ages should be aimed at reorienting the focus of services from disease-finding to risk-finding and oral health guidance (Saekel 2016).

Participants thought prevention measures should firstly be focused towards children and adolescents. This is consistent with the *Child Health Strategy* established by the NZ Government in 1998, which outlined that, when trying to improve population health, children should be a priority group for healthcare interventions (Ministry of Health 1998). Participants also commented on the current ineffectiveness of the COHS in its provision of oral healthcare services to children

under 13 years of age and the staffing issues this service is likely to face in the future if changes are not made. They indicated that making improvements to the Service—which is designed to be universally accessible to all children in NZ—should be a high priority when attempting to improve population oral health through preventive interventions. Participants also expressed concern for the low utilisation rate of the AOHC scheme, last reported to be 65% (Birch and Anderson, 2005), and thought that more attention needed to be devoted to improving this. Consistent with other research, participants believed that, by ensuring all NZers are routinely using oral healthcare services up to the age of 18 years, good oral health and healthy habits will transfer into adulthood. Regular attendance for oral healthcare is associated with profoundly better oral health outcomes (Saekel 2016; Thomson et al, 2010).

Participants also advocated for universal preventive interventions, such as CWF and increasing the affordability of healthy foods, as ways to reduce the burden of oral disease (and oral health inequalities) in NZ. CWF is a universal preventive oral healthcare intervention that can reduce dental decay by up to 40% for children and adolescents, and by 20-30% for adults (Moore and Poynton 2015). Universal preventive interventions such as that have also been shown to reduce ethnic and socio-economic inequalities in oral health (Moore and Poynton 2015). Currently, 85% of the NZ population are on reticulated water supplies, and 56% of those people receive fluoridated water (Moore and Poynton 2015). Participants in the current study believed that CWF needed to be expanded to reach a larger proportion of the population. Participants all acknowledged their obligations to reduce oral health inequalities but thought that this was best managed by planning and advocacy for universal preventive interventions.

Current oral healthcare expenditure in NZ comprises 25% Government, 5% private insurance, and 70% private funding contributions. Of the 25% that is Government-funded, most is for those younger than 18 years (Birch and Anderson, 2005). An investigation of NZ dentists' views on universal publicly-funded dental care for all ages found that nearly two-thirds believed cost to be a barrier to dental care access for many NZ adults (Cheng et al. 2021). This is consistent with the current findings, whereby some dentists were concerned that many adults—particularly low-income adults ineligible for WINZ subsidies—were unable to afford access to oral healthcare services. Cheng *et al.*[5] revealed that nearly two-thirds of NZ dentists thought that the provision of cheap oral healthcare services to the adult population under Government-funded contracts would be ineffective at addressing oral health need within the population (Cheng et al. 2021). Our participants demonstrated similar disinterest in taking up future Government-funded oral healthcare contracts, and suggested that focusing on preventive measures would be a more effective and efficient way of improving oral health in NZ. Similar to Holden et al. (2021), they felt that the burden of excessive administrative work and poor renumeration rates for the treatment provided under Government contracts made them untenable. Consequently, participants were distrustful of those contracts and hesitant about engaging with any future ones. These findings emphasise the importance of involving dentists in the development of any future funding contracts to ensure that they are practical. This includes making sure that the contracts enable dentists to receive reasonable financial renumeration for treatments provided and to provide the scope of treatments that they enjoy.

Some participants—despite being dissatisfied with previous Government-funded oral healthcare contracts—thought that additional effort and funding needed to be directed into making a greater range of preventive and restorative treatments accessible and affordable to low-income adults who were ineligible for WINZ dental funding. They believed that they needed additional assistance beyond the preventive approaches discussed earlier. This could be achieved by introducing a fully-funded Government contract for low-income adults to receive comprehensive stabilisation treatment and ongoing preventive and maintenance care. Participants who advocated for such an arrangement thought that those being treated under the contract needed to express a degree of personal responsibility to be eligible for the funding. They thought this should involve the requirement that the recipients of care under this contract must regularly attend oral healthcare services, as per a set schedule, for check-ups and any required restorative work. Inability to adhere to routine attendance to these services would make them ineligible for further funding under the contract. Since routine attendance for oral healthcare has been shown to be associated with better oral health (Thomson et al, 2010), a contract that promotes this pattern of service utilisation will likely improve outcomes (Saekel 2016). However, routine attendance can be precluded where transport, inability to get time off work, or childcare responsibilities are an issue. Making a contract that is (beyond the period of initial stabilisation) focused on prevention and management of early-stage disease would make it more viable for private practices to work under because Government remuneration rates for this type of work are more reasonable than those for treatments required to manage late-stage disease (Saekel 2016). Despite suggesting the introduction of such a contract, participants still commented that they would only be willing to work under a contract like this if it was designed in consultation with the NZ Dental Association and had sufficient remuneration for any services provided. In contrast to this perspective, two participants had an opposing view, believing that there was no need to provide any subsidised care to low-income adults. There is some guidance for practitioners in the DCNZ standards framework (https://www.dcnz.org.nz/i-practise-in-new-zealand/standards-framework/).

There was concern over the future direction of the profession as corporate ownership in dental practices increases and a commercial imperative becomes more dominant in the way those practices operate.

Participants commented that many dentists working for corporate practices are unable to practise according to their own ethical and professional principles due to close oversight by commercially focused (and non-dentally trained in many cases) practice managers. This is similar to the findings of Holden et al. (2022), whose participants commented that many corporate groups run their practices in a manner where commercial gains are prioritised at the expense of adherence to professional obligations. In the current study, participants believed that the increasing corporatisation of the NZ dental sector was attributable to the increasingly unaffordable cost of owning and operating a practice, making entering practice ownership progressively more difficult. They speculated that the culture among the younger generation of dentists may be driving the corporatisation of the profession as few younger dentists wish to enter into practice ownership. They recommended that, if non-corporate practices are to endure into the future, ways to improve the feasibility of (and motivation for) young dentists entering into practice ownership must be considered. The increasing commercialisation of dental care is likely to drive treatment costs up and create further inequities in access to care for low-income New Zealanders. Moreover, the increasing commercialisation means fewer practices might take up government contracts for subsidised treatments, again worsening inequities.

Similar to the findings of Holden et al. (2022), participants also highlighted their concern that modern advertising in dentistry is causing patients to perceive oral healthcare treatments as commodified products, further driving the commercialisation of the profession. Participants were concerned that some modern dental advertising in NZ is dishonest or incomplete in its disclosures of practitioner qualifications, services provided and the outcomes that can be achieved with the treatments being advertised. Holden et al. (2022) suggested that many dentists in Australia perceive that their professional obligation to provide information to patients in a way that is not misleading applies only when the patients are in the clinical setting. This suggests that they viewed sales tactics which advertise oral healthcare using dishonest or incomplete information to attract patients into their clinics as being acceptable. Although not investigated in the current study, this attitude may also underpin the current poor ethics of much dental advertising within NZ. Participants in both studies expressed concern that modern advertising of oral healthcare services by some practices has cheapened the services provided and damages the reputation of the profession (Holden et al. 2022). Some participants compared the strict advertising laws of the past with the lenient ones now and suggested that some middle ground between the two needs to be considered in the near future. Managing advertising will be important for ensuring that the public's trust in the dental profession is maintained.

The generalisability of the research findings to the population of general dentists in NZ is also limited because the sample was from private practices from a small geographical area of the country. This is supported by recent research, which showed that dentists working in institutions—such as hospitals and universities—were more likely to support Government subsidisation of adult oral healthcare services than their private practice counterparts (Cheng et al. 2021). The comparabiliity of the findings with those from other countries is limited to countries with non-subsidised adult oral healthcare. However, the findings provide other countries with insight into where focus should lie when trying to plan an oral healthcare system that will be effective in improving and maintaining oral health.

Our sample contained participants from a wide variation of practice types and locations within the BOP and Lakes DHB regions in NZ. This is likely to have enhanced the findings' trustworthiness, since participants' experiences covered both rural and urban practice. The wide variation in length of practising career among research participants was another strength, given that career length is known to be a major influence on dentists' opinions on Government-funded oral healthcare (Cheng et al. 2021).

Conclusion

This research highlights dentists' views of the shortfalls in oral disease prevention within NZ and how future funding into oral healthcare should be best focused towards addressing these issues. Some thought that introducing a Government funded contract to provide a wider range of subsidised preventive and restorative treatments to low-income adults was important, but most participants were dissatisfied with the current Government-funded oral healthcare contracts, indicating that planning and developing future contracts should involve the private dental sector. Greater participation of dentists in Government-funded oral healthcare contracts would likely require improvements in remuneration rates and conditions of contracts. To improve oral health and reduce injustices and inequities for vulnerable groups in the population, dentists need to be encouraged and supported to practise in a way that balances their commercial needs and their responsibilities as healthcare professionals. Regulatory bodies such as the NZ Dental Council could also consider how their regulations on ownership of dental practices influence dentists' freedom to practise within the ethical boundaries expected of healthcare professionals.

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Conflicting interests

The authors declare that there is no conflict of interest.

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News from the School of Dentistry

Staff changes at the Faculty

Professor Alison Rich and Associate Professor Geoffrey Tompkins have retired from the Faculty of Dentistry following long and distinguished service.

Staff Promotions

The Dean, Professor Paul Cooper, has advised that Associate Professor Andrew Tawse-Smith has been promoted to Professor and Senior Lecturer Susan Moffat has been promoted to Associate Professor, with the appointments taking effect on 1 February 2023.