



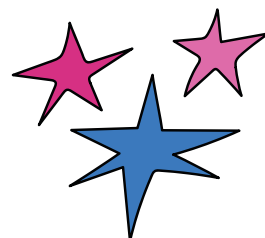
CHILDREN'S ORAL HEALTH WORKERS: VOICES FOR DENTAL FOR ALL

October 2026

Public Service Association
Te Pūkenga Here Tikanga Mahi

TABLE OF CONTENTS

FOREWORD	01
EXECUTIVE SUMMARY	03
Key findings	04
Recommendations	05
FREE PUBLIC ORAL HEALTHCARE FOR CHILDREN IS THE FOUNDATION FOR BUILDING DENTAL FOR ALL	07
Community dental services balance ease of access and parental involvement when providing care to children	11
Community dental services work hard to improve care and increase access	16
Māori oral health workers improve services to kura kaupapa	19
INVEST IN THE FOUNDATIONS OF PUBLIC ORAL HEALTHCARE	23
Lack of investment in equipment and infrastructure leads to children not being seen and their dental health getting worse	25
Vacancies in clinical roles reduce children's opportunity to be treated	28



Vacancies in non-clinical roles, such as data and digital, lead to equipment breakdown and clinical workers having less time to see children 32

Relying on clinicians to do substantial, manual administrative work is inefficient and lessens the time they can spend with children 34

USE THE EXPERTISE OF COMMUNITY DENTAL SERVICE WORKERS WHEN DESIGNING AND IMPLEMENTING DENTAL FOR ALL 41

Make existing services the starting point for dental for all 44

Expand the workforce while keeping specialist children's roles 45

Provide accessible oral healthcare for adolescents and young adults 46

Ensure parents have access to care to improve children's oral health 49

Include education and prevention in dental for all 52

Provide free, public, universal, Te Tiriti o Waitangi-consistent oral healthcare in Aotearoa 54

ACKNOWLEDGEMENTS 60

APPENDIX 1: METHODOLOGY 61

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FOREWORD

During the First World War, large numbers of men were rejected from the armed services because of problems with their teeth. In response, New Zealand set up a world-leading school dental service.

In the 1970s, dental nurses had to fight hard to protect their pay after a government-instituted wage freeze. After lodging a pay claim, stop-work meetings and power-building with meat inspectors at the freezing works, who threatened to go on strike unless dental nurses got their pay increase sorted – dental nurses went on strike.

When on strike, dental nurses marched in their uniforms down Lambton Quay to Parliament. After an hour and a half of face-to-face negotiations at Parliament, the dental nurses secured their pay increase. This is the only time that a protest at Parliament has won its aim before it left Parliament grounds.¹

The fight continued with the PSA 2018 Allied Health equal pay claim that covered dental assistants, dental therapists and oral health therapists. After five years of campaigning an equal pay settlement was won in 2023. The Government's subsequent attack on pay equity in 2025 was an attack on these workers. Like

other workers with settled claims, oral health workers lost the ability to have their settlement reviewed to maintain pay equity. Community dental workers continue to fight to have their work valued and represented.

For over a hundred years, community dental service workers have protected children's teeth, while adult dental care has remained out of reach for many. The work community dental service workers do to care for children's teeth provides a foundation that all too often gets eroded away because they cannot afford to access healthcare as adults. Adults' lack of oral healthcare leads to decay, pain and health problems, at a huge cost to both individuals and society.

As the union for community dental service workers, PSA is a member of the Dental for All coalition that is determined to change the current situation and build an oral healthcare system based on the following three pillars:

Oral healthcare should be provided universally and free

Oral healthcare should honour and uphold Te Tiriti o Waitangi

Bring oral healthcare into the public system

1. Noel O'Hare, *Tooth and Veil*, Massey University Press, 2020.



This report contributes to the work that Dental for All and allies have done showing the importance and urgency of changing adult dental care.² Previous reports in the Dental for All campaign have outlined the problems with the current provision of dental healthcare for adults,³ used overseas examples to show that changes to oral healthcare are necessary,⁴ and put forward a model for an Adult Community Oral Health Service, based on universal free care, Te Tiriti consistency, public provision, salaried workforce, community clinics, mobile services, tino rangatiratanga, and strengthened Te Whatu Ora capacity.⁵

This report focuses on the voices and experiences of workers who are already providing free public oral healthcare for children. Workers in community dental services are experts on the public provision of oral healthcare and have intimate knowledge of the importance of free, public oral healthcare.

This report takes that expertise and those lessons to inform the growing call for

a free, universal public oral health service in Aotearoa.

Importantly, in this report oral healthcare workers describe their work to improve services and aspects of the current system that should be avoided with Dental for All. Individual Māori oral health workers are having to take the lead in ensuring appropriate services are provided to kura kaupapa. Underfunding means delays to children being seen, which leads to preventable decay, pain, and the need for more intensive treatment.

The importance and potential of community dental health service is seen in the stark contrast between children's and adults' access to oral healthcare. It does not have to be like this. Community dental services for children provide the foundation for building a free, universal public oral health service in Aotearoa.

Duane Leo & Fleur Fitzsimons

National Secretaries,
Public Service Association
Te Pūkenga Here Tikanga Mahi

2. See: <https://www.dentalforall.nz/research>

3. Frank Advice, 'Adult oral health in Aotearoa: The costs of inaction? The social, economic, and fiscal costs of the current settings for adult oral health', 2024 (https://static1.squarespace.com/static/6716db8303911558a264cee/t/6893fb04bd24865e5ef-a7e1f/1754528521108/FrankAdvice_report_for_Dental_for_All_Coalition.pdf)

4. Anne Campbell and Abigail Thompson, 'There Are Alternatives: Analysis of Overseas Models of Expanding Access to Oral Healthcare within Public Health Systems', 2026, (<https://drive.google.com/file/d/1G29aZ-0FKbYIDDxSFFeX0e6jAt0rYx2/view>)

5. Dental For All, 'Fixing Oral Healthcare in Aotearoa New Zealand: A Costed Policy Plan for Delivering Dental for All', April 2026, Dental for All Policy Paper April 2026.pdf (<https://drive.google.com/file/d/1vBYUTru-dcAF7aCCzANbBFgWp7Bn6oBA/view>)

EXECUTIVE SUMMARY

Community dental workers already deliver free, public oral healthcare to thousands of children across Aotearoa. Their experience shows both how Dental for All could work and what mistakes must be avoided when building it.

Community dental service workers are experts on providing public oral healthcare and have thought deeply about how their service could be improved if it were available for all.

I would really love a facility where a whānau could come as one together into a clinic and have all their dental needs met. That's actually been a dream of mine for a long time. I would love to see that.



Based on in-depth interviews with 19 workers from community dental services across the country, including dental therapists, oral health therapists, dental assistants, an oral health promoter, a receptionist and a service desk analyst, this report brings together the expertise and experience of providing free public oral healthcare to children to set the direction for expanded access for everyone. It reinforces the Dental for All policy proposal with the lived expertise of workers already delivering free public oral healthcare to children, showing that building a free, universal public oral health service in Aotearoa is as practical as it is necessary.

KEY FINDINGS

The report is organised around three key findings:



Free public oral healthcare for children is the foundation for building Dental for All

Free public oral healthcare already exists for children in Aotearoa and provides a practical model for expanded service. Community dental workers described the strengths of the current system, the ways they improve access for tamariki and whānau, and the lessons that can be learned from more than a century of public dental provision.



Invest in the foundations of public oral healthcare

Workers consistently described the impact of underinvestment in equipment, infrastructure, workforce, digital systems and administrative support. These experiences demonstrate the risks that must be avoided when expanding free public oral healthcare to adults.



Use the expertise of community dental service workers when designing and implementing Dental for All

Community dental workers are experts in providing universal public oral healthcare. They have practical ideas about expanding services, improving access, supporting prevention, extending care to adolescents and young adults, and providing care for whole whānau. Their knowledge should help shape the future of public oral healthcare in Aotearoa.

Oral health workers' dreams do not have to remain just dreams. We can have free, universal, Te Tiriti o Waitangi-consistent oral healthcare in Aotearoa; it just takes political will.

RECOMMENDATIONS

These recommendations arise directly from the interviews. They support and operationalise the Dental for All policy proposals.

Free public oral healthcare for children is the foundation for building Dental for All

1. Recognise that community dental services are the foundation for building free, universal public oral healthcare.
2. Recognise community dental service workers as experts in the design and delivery of public oral healthcare.
3. Recognise Māori oral health workers' expertise as a starting point for Te Tiriti-consistent oral healthcare.

Invest in the foundations of public oral healthcare

4. Fund sufficient capital investment to ensure equipment and facilities can be properly maintained, repaired and replaced.
5. Fully fund national information technology systems that support efficient and consistent delivery of care.
6. Remove barriers to hiring and retaining clinical staff.
7. Employ sufficient support staff, including administrators and data and digital specialists, so clinicians can focus on patient care.

8. Leverage government procurement power when building a free, universal public oral healthcare system to ensure quality equipment is available across the entire system.

Use the expertise of community dental service workers when designing and implementing Dental for All

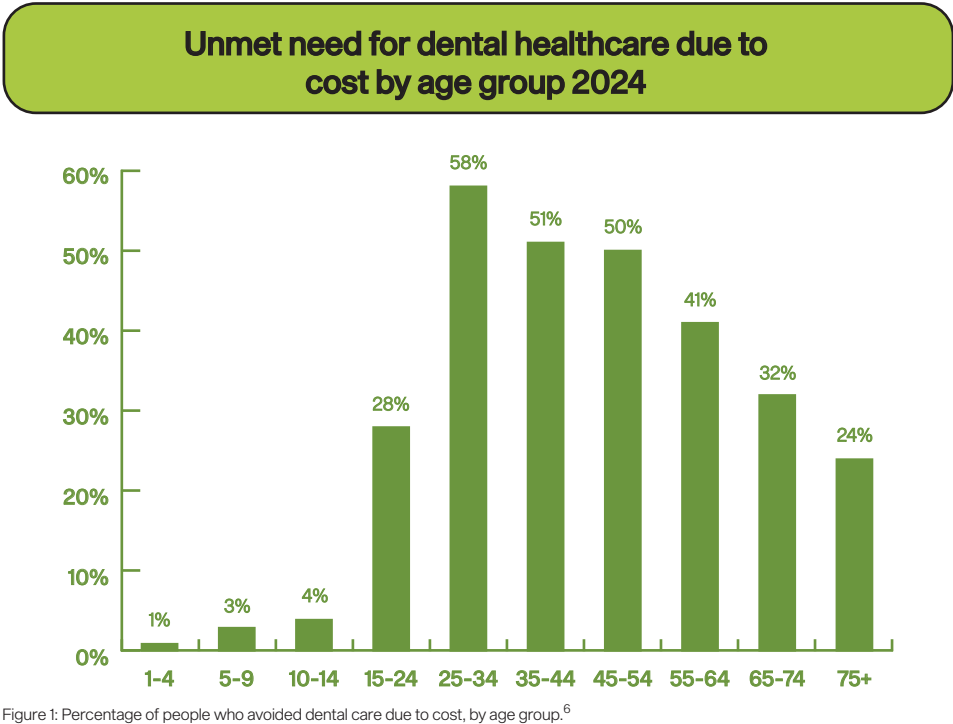
9. Establish a reference group from the existing network of community dental clinics and mobile services to support the build out of an expanded public oral health system with practical knowledge and advice.
10. Embed community dental service worker expertise in national governance, planning, monitoring and implementation of the Adult Community Oral Health Service.
11. Maintain school-based services and enable whānau to receive care together through integrated community dental services.
12. Support therapists who wish to expand to an adult scope of practice, while maintaining and valuing children's oral health roles.
13. Ensure prevention, education and health promotion are core parts of any expanded public oral health service.



Part One: Free public oral healthcare for children is the foundation for building Dental for All

Every day, thousands of children visit public dental services for the examinations, prevention, and treatment they need. Free public oral healthcare for children provides a practical model for expanded service. Community dental workers described the strengths of the current system, the ways they improve access for tamariki and whānau, and the lessons that can be learned from more than a century of public dental provision.

The community dental service is free, so all children can access dental care, no matter the circumstances of their whānau. At the same time, hundreds of thousands of adults avoid the dentist, because they cannot afford it. The community oral health service for children contrasts sharply with the oral healthcare of adults, which is almost entirely private and expensive. This can be seen in the oral health New Zealanders as a whole. Cost is a huge barrier for adults receiving dental care. Thanks to the hard work of community dental services, the same is not true for children, as the following graph shows:



This graph shows the ongoing harm of our current model of care for adults and the importance of the community oral health system protecting children’s oral health.

6. Data from 2020/21 New Zealand Health Survey Annual Data Explorer (<https://www.health.govt.nz/publications/annual-update-of-key-results-202021-new-zealand-health-survey>). Based on a graph from Ministry of Health, 'Unmet need for dental healthcare due to cost in the past 12 months' Unmet need for dental healthcare due to cost in the past 12 months | Ministry of Health NZ (<https://www.health.govt.nz/monitoring-statistics/surveys/new-zealand-health-survey/publications/202021-survey-publications/snapshots-from-the-202021-survey/unmet-need-for-dental-health-care-due-to-cost-in-the-past-12-months>)

When New Zealand's public health system was set up in 1938 dentists successfully lobbied to be excluded from it. This exclusion has never been corrected, but there is a small amount of public provision of dental care. This provision is fragmented, specific and not well known. Understanding the circumstances under which adults currently get public oral healthcare underscores the limitations of our current system.

Hospital dental units provide care for adults in very limited circumstances. There is some free provision for people who have Community Service Cards. Adults who have not had access to a dentist often need urgent oral healthcare in order to receive treatment for cancer or heart conditions. If someone has an infection in their gums then that needs to be addressed, because otherwise that infection will be a risk when someone has chemotherapy. This need is a result of the lack of oral healthcare provision.

The fragmentation of care provided in hospitals can be seen in the criteria for accessing maxillofacial surgery – surgery of head, neck, face, jaw and teeth. Some people need maxillofacial surgery due to conditions they have had from birth and this is provided free on the public system. However, if someone needs corrective surgery after cancer, for example if they have had to have part of their jaw removed, then they will have to pay. This disparity and the personal cost to cancer patients was very distressing to the interviewee who worked in this area:

There's no funding for the cancer patients, which I find horrendous. Absolutely horrendous. If the patient's a cancer patient and they're having implants placed, then they have to have a quote given to them. The implants will not be placed until the patient accepts and signs and pays half of what the treatment cost will be. But anyhow, it's not up to anyone here.

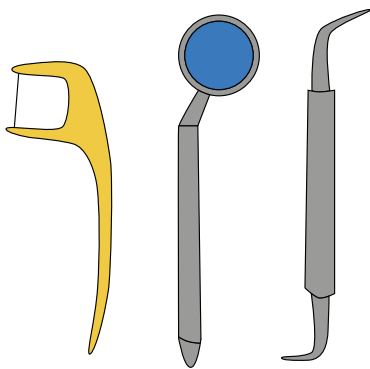
Capacity in hospital dental units is limited and disabled people and people who need oral healthcare before treatment are prioritised, so not everyone with a Community Service Card can be seen. Many people with Community Services Cards are turned away from the health system when they need oral healthcare, to the welfare system.

There's a dental provider here who's slightly cheaper than everyone else. Might be like \$50 cheaper or something for an exam and scale and that type of thing. I can't remember his prices, but we'll refer people out there, especially if they're on a benefit.

This limited and fragmented system is all the public provision of oral healthcare currently available for adults. In contrast, children's oral health is protected by free, public provision.

COMMUNITY DENTAL SERVICES BALANCE EASE OF ACCESS AND PARENTAL INVOLVEMENT WHEN PROVIDING CARE TO CHILDREN

Oral health workers describe the work they do each day caring for the teeth of pre-schoolers and school children:



I usually treat from the age of two, sometimes a bit earlier, up until the age of about 12. I fill teeth that need repairing, remove teeth that need to be removed. I care and provide information to parents and children regarding oral healthcare, how to avoid those kind of situations. The biggest part of my job is gaining small people's trust and getting their consent to provide any care that is needed or required by their oral health indicators.

The treatment options are very progressive. There's been a lot of changes. There would have been, originally, a lot of amalgam fillings, whereas now we've got a lot more treatment options, different materials we can use, different ways of looking at it. We've kept abreast of what is current and the service has moved along with the new science.

Workers in community dental services are well aware of the importance of their work, and what happens when children do not receive oral healthcare:

Getting children booked in and seeing them in a timely manner is so important because it can be the difference between saving a tooth and losing a tooth. If we can see them on time, getting the treatment they need, it can save space for their adult teeth and they're more likely to not have ongoing issues. And then they're proud of their teeth, like we want to be proud of their smile for their whole life.

Oral health workers take pride in their work and the difference it makes to the lives of children and their whānau:

The thing is that it's not money orientated to us, we are on salary. We can spend time on a nervous child. I think that



that's what's so strong about our service – we're treating the human.

We saw a mother with six children, at one of our marae that we had visited. Six children - I just applauded her because I have two and that's a lot. She was doing amazing. The majority of those children needed treatment and we were able to see all of them. Two of them were hospital referrals and four of them we completed all the treatment. That was just such a big one for me. I was so happy. And the family were happy. So that's what gives me joy. That's what I love about my job.

Community dental services' care of children is the foundation for free, public oral health services for everyone in Aotearoa. Free, public oral health services are being provided across communities every day. If 750,000 children can receive free, public oral healthcare then so can everyone else.

Community dental services are based in hubs and mobile vans. The hubs are fixed sites, usually in the grounds of a school or hospital, and the mobile vans travel to where children are, mostly schools but also other forms of outreach. This mixed model was developed in 2011. Previously, dental care had been more school-based.

Some children receive dental care at fixed sites by appointment or from school if the site is based in their school.

Other children receive dental care from mobile dental units that are fully equipped to do all the treatment that a child would receive at a fixed site.

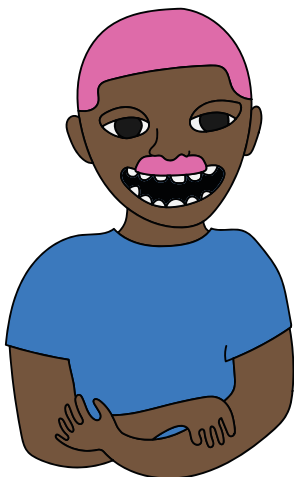
Providing dental services in schools has a long history in New Zealand, and it makes sure that dental services are very accessible for children. When children are seen in schools, parents do not have to take time off work to ensure children can get an appointment. Oral health workers are very aware that children were more likely to come to appointments if they took place in schools:

The main reason we want to finish every school is the child's way more likely to have an exam if we see them, then we can get them from class. That's the guaranteed exam, and any major problems are now picked up. Last year one of the schools, a big school here, had a new office put in, so our plug was taken out. We couldn't take the van to the school there last year, and they weren't able to have us there any other time. So we could only book the children in here. We would have seen less than half the children.

The downside of seeing children in school is that community dental service workers often did not talk with parents:

I think what's happened is in New Zealand, we've always taken care of it for the parents. We've always been in schools. There are more parents that do want to come now, but traditionally we've always kind of just done it. And I think actually that needs to change. It's like, would you let your child go to the doctor by themselves? You wouldn't. No one would. So why is it okay for them just to pop over to the dentist by themselves?

The idea of the parents coming is that the parents are there at the appointment. You're able to pass on messages and update them and inform them of oral healthcare of their child. That's a really good thing, but it's one of those perfect scenarios and we don't live in a kind of perfect world. And so that doesn't always work. That's why the access to schools came in.



Our system was to try and not be the ambulance at the bottom of the cliff. We're trying to get education into the families. So they wanted parents to be at the initial appointment so that we could get education into the home.

I think the model works okay. For 100 years we have been in schools and we have not actually changed New Zealand's oral health. Because when you talk to a child about what they're eating and drinking, the child can't make decisions. We wanted more parental contact. That's why we wanted the parents to come to appointments. It's very hard to shift entrenched things. But I think the model was a good model. Talk to parents.

Oral health workers were clear that the current model was a compromise between two different important priorities. One worker clearly laid out the situation:

There's very few children from a hub school that we don't get their treatment done. We can be quite assertive with teachers when the parents pick them up from school, can you just get them to sign this form? The hurdle is getting them into the hub. We brought in the hub model to get parent engagement, because an issue we have with our hub school children is we get all their work done, but we never see the parents. We're not able to like give the good oral hygiene information. We fix it in the background, but we're not making a change at home necessarily. Sometimes you need the parent there.

Community dental services are balancing making sure oral healthcare is as accessible as possible with ensuring parents are involved in their children's health. One of the reasons this balance is necessary is because adults do not have access to free public oral healthcare.

COMMUNITY DENTAL SERVICES WORK HARD TO IMPROVE CARE AND INCREASE ACCESS

One of the most striking aspects of interviews with community oral health workers was how hard they were working to increase access to care. Almost every interviewee described initiatives that were taking place in their clinic, or service, to improve access.

These improvements, however, are often ad hoc and service-based, rather than systematic. This was seen repeatedly in the interviews. A dental worker on a recently formed outreach team that went to ECE centres, marae and churches described the logic for her service:

Normally the vans go to primary schools, by the time we see them at primary school, many children have decay already. So another model of care was proposed and the outreach team was created. It's just been over three years. We visit different preschools and screen children on site and do treatment when required. We're hoping that this makes a difference, you know, trying to catch them early, educating parents earlier. Taking our service to them rather than trying to make them come to us.

In another region, an oral health worker described initiatives to ensure that children were not lost and got full access to care. The first was to ensure that children connected with the service:

We have Kaiāwhina. If people miss a couple of appointments in our area, the Kaiāwhina will visit them. They will offer them transport. For young women, you don't have to be Māori to have that support. We do go out of our way. Some districts, if you don't turn up for three appointments, they put you off the list and put you forward a year. We actually go after the lost sheep.

The second was improving the pathway from community dental services to more specialist services when needed:

If I came across something that's outside of my scope of practice we used to just write a form and tell them to take this to the dentist, the government will pay for it. Now,

quite often, they never got to the dentist and we just lost sight of them and the work never got done. We now can refer through our hospital dental department. It's a more seamless pathway. They're still within our service, so you can follow where they are.

As well as improvements being fragmented from district to district, there were also many temporary improvements that did not last, or could not reach their full potential because of lack of funding.

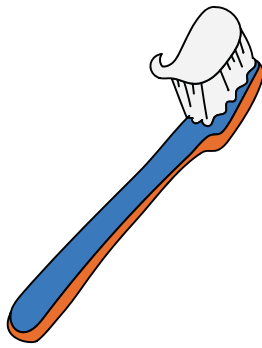
One worker described a pilot that had involved a treatment van and a dentist and greatly improved children's access to treatment:

They had some extra funding for one year and we had this wonderful dentist and she came and she did a Masters on treatment vans. She set it up, she went and it works. We know it works if there's funding for a van that can do treatment, we know it would work. And we can't get funding for her to come back. I saw her at the dental conference and she said, "I would come back any time if there's funding". Treatment vans can do some of the treatment for the kids that even if we're referring, they're not getting their treatment because no one takes them to the appointments. Then you're not going to have so many referrals to hospital to get things done under a general anaesthetic, which is so expensive.

The inability to continue pilots that intervened early and prevented problems later on were particularly frustrating for workers, who were seeing the impact that these pilots had and the money that would be saved in the long run:

We recognised about three years ago that the oral health of the children was really deteriorating. Some of the dentists and community dental and local iwi health services all came together and did a couple of pilots of toothbrushing in schools to see whether that would help. They supplied our toothbrushes to start with toothbrush holders, everything that schools needed to implement it. But then that funding ran out. We've been scrimping and saving and getting all that we can from Colgate or whatever to try and keep these programmes running.

MĀORI ORAL HEALTH WORKERS IMPROVE SERVICES TO KURA KAUPAPA



The current provision of community dental healthcare, like much of the health system, is not Te Tiriti-consistent.⁷ Māori oral health workers are having to work to change services to better reflect Te Tiriti and the needs of whānau, on top of their jobs. Their experience is practical evidence for Dental for All's commitment to tino rangatiratanga. One example of this is the essential work to improve community dental services at kura kaupapa and te reo Māori immersion schools. Māori oral health workers actions show a path to Te Tiriti-consistent oral healthcare, but change should not be dependent on individual Māori workers.

When one of the therapists interviewed moved to a new region, she realised that kura kaupapa and schools with the highest Māori rolls were not getting treatment vans to visit their schools:

We weren't going to Māori schools, but we were going to all the mainstream schools. There's Māori in all the schools we go to, but in some schools there's a lot higher percentage of Māori than others. It's taken me years to push and push and push and fight to get them seen in ways that minimise barriers to parents. And being on site is probably the best way to minimise that.

She worked for over a decade to ensure that kura kaupapa got visited by a mobile dental unit. This had involved very practical work with both kura and her service around access to utilities and space. But her work had paid off:

7. Courtney Harper, Kimi Tangaere, Lolhea Tongi, Brooke Hayward. *Preparing the soil for oral health equity: A think piece on a new mauri of care*. Ko Awatea; Counties Manukau Health, 2022.



I've just, for the first time ever, gone into a kura that we've never seen. They've always had to come and bring their kids to a fixed clinic. It was great to be able to get in there, but that took a lot of negotiating between both us, Te Whatu Ora, and the school. It's taken 11 years since I've worked here to get into that school and actually see the kids in the school, not just screen them, not just examine them, but also do the work that's necessary. It's amazing. Amazing.

One area had a te reo Māori-speaking oral health therapist and dentist working together. They visited kura kaupapa and provided treatment in te reo Māori:

You can see the results of a te reo speaking therapist and dental assistant working together. There's parents and families and the whānau that weren't engaging with the service, so they needed work done and they wouldn't come to appointments. The way that that therapist was able to work with them meant that they were way more likely to attend appointments. You see the results of it when that ideal is done.

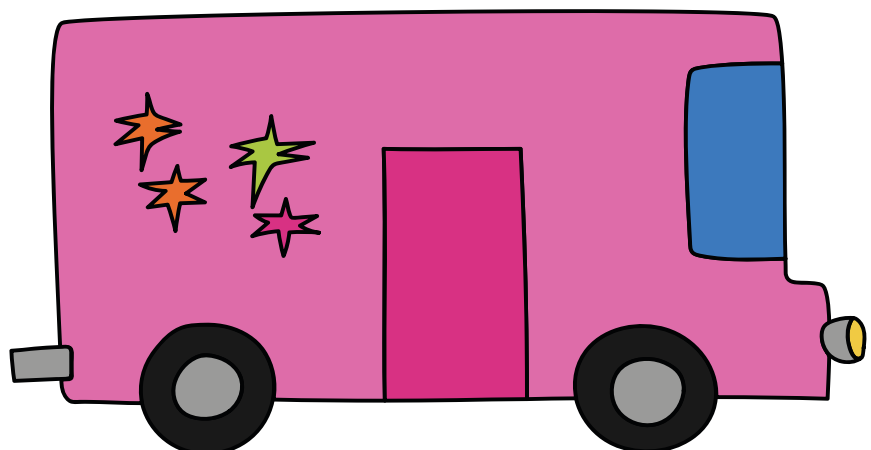
The enthusiasm for this initiative underlined how rare it was. As far as Wellington oral health workers knew this was the first time that a team working entirely in te reo Māori had been available for kura kaupapa.

RECOMMENDATIONS

1. Recognise that community dental services are the foundation for building free, universal public oral healthcare.

2. Recognise community dental service workers as experts in the design and delivery of public oral healthcare.

3. Recognise Māori oral health workers' expertise as a starting point for Te Tiriti-consistent oral healthcare.





Part Two: Invest in the foundations of public oral healthcare



Everyone here works really hard, and we all want to do the best for our patients and their families. You wouldn't work in this job unless that was part of your motivation. Because you are seeing people, sometimes in the hardest times of their lives, you do support them through things sometimes. We're right in the community, we're right in the schools we see things in schools that people wouldn't normally see. We want to be funded enough that we can do a good job, get in early, help people prevent problems. When they have problems, we want to catch it in a timely manner. We want kids to be able to do the treatments here whenever possible to not have to go on waitlists. We want the waitlist to disappear.

Underfunding is the biggest problem facing the community dental service, like much of the rest of the health system. Workers consistently described the impact of underinvestment in equipment, infrastructure, workforce, digital systems and administrative support. These experiences demonstrate the risks that must be avoided when expanding free public oral healthcare to adults.

Many services have not been able to see all the children that need to be seen each year. Oral health workers expressed distress and frustration at the impact of understaffing and underinvestment in equipment and systems on children who were not being seen and so their teeth were getting worse. It is important to understand the difficulties health workers face due to underfunding when designing a free, public, universal, Te Tiriti-consistent dental system for all.

LACK OF INVESTMENT IN EQUIPMENT AND INFRASTRUCTURE LEADS TO CHILDREN NOT BEING SEEN AND THEIR DENTAL HEALTH GETTING WORSE

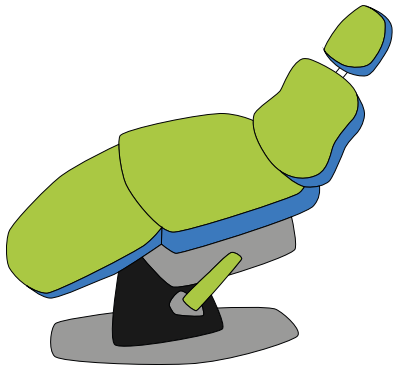
Well we haven't had CapEx here for, what, three years? So we haven't had anything purchased for a long time and things are going to wear out so, you know, we can't do anything about that we just carry on with what we've got.

Community dental services have had very little investment in equipment since the introduction of the hub model fifteen years ago.

Lack of investment in equipment has led to delays in children being seen. A dental worker talked about the lack of equipment at her clinic: 'We have what we call filling trays and drills. Each clinic has about four of them. We probably see 12 to 15 patients a day with four sets of equipment.' The process to sterilise the equipment after use took ninety minutes. She described the workers at the clinic as juggling to make sure the equipment was available: 'Rearrange the day, hope like heck. Lack of equipment slows things down, not only slows things down, it increases the appointments for the child. Sometimes you can't do the next patient because you don't have the equipment'.

Underfunding for equipment meant that appointments were taking longer and fewer children could be seen. Waiting for equipment to be available is not the best use of time for either clinicians or patients. A worker described a clinic that had six chairs and one X-ray machine. In other clinics each chair has its own X-ray machine, or one between two. 'When you have back-to-back exams, there's a queue for the X-ray machine – that sort of thing is ridiculous'.

The lack of investment includes suitable digital systems. In a community dental service, strong digital systems can save time and ensure that clinicians can concentrate on providing care. That is not the situation in the community dental service. Long-term underfunding and fragmentation, combined with recent cuts to Health New Zealand | Te Whatu Ora's Data and Digital function mean that community dental services do not have the equipment they need. Differences in software mean that children's records cannot be transferred from one district to another. If clinicians do not have the information they need, they cannot give children their best care.



Vans are a key part of the model of delivery of dental care and maintenance problems are getting worse each year. As one worker stated: 'Every 10 years they were supposed to be replaced or restored depending on what was needed. And that's not happened here'. That was fifteen years ago. As one worker stated: 'we were definitely told that these things had a life and I know they're well and truly beyond that life now'.

Things keep clapping out. That's all downtime when you're trying to do your job and you've got to ring up. I'm trying to talk to the maintenance guy and he's saying, "can you go and look at this or wriggle that or open this up and turn it this way". Then if we can't sort it out over the phone, they say "okay, well, I'll be there," but these guys are 2 1/2 hours away from us. Often, your parent with the preschooler is sitting there and you're like, "I'm so sorry! my light won't work today or there's no compressor."

Workers in these vans have come to take a lot for granted. One worker described the floor: 'The floor's become spongy in a lot of the vans. We're told that they're still safe to be in. But when the floor's giving way under here a little bit, it can make you quite nervous'. Workers continue to treat children the best they can with spongy floors and failing equipment.

Governments need to make use of the full suite of procurement options available to them to secure the necessary equipment to run these services properly. This also points to a huge benefit to come from building out a universal system based on the community services discussed in this report. A free universal public system would be able to leverage huge efficiencies of scale by procuring equipment across the entire system. This would see huge savings when compared to the current fragmented and privatised system, where smaller independent providers simply do not have the bargaining power to secure a better deal.

VACANCIES IN CLINICAL ROLES REDUCE CHILDREN'S OPPORTUNITY TO BE TREATED

Our early intervention service used to have three people in that service. They're doing the work of three people with two. You can't visit as many early childhood centres. You can't go to as many community events and say, are you enrolled? If they've never been enrolled with us, we don't know to call them. They're lost in the system, or they've come from another area, they're lost in the system. We might not see them until they turn up on a school roll. We try and get them enrolled. Otherwise the first time we see them, they might be 5, and they've already got massive tooth problems. People aren't sleeping at night. This is like some of the worst pain you can have. We don't want that for kids. The early intervention programme is so important and it's not fully funded right now.

Community dental services across New Zealand are not fully staffed. A worker said that there were about 12 full-time equivalent (FTE) Oral Health Therapists/Dental Therapists: 'we're supposed to have about 30. That's what we had a few years ago. So you can see that we're wallowing in dental decay'.

Understaffing makes it harder to provide clinics and means rural children have to travel further to access dental services:

My colleague in the town 40 minutes away used to travel an hour to a small rural area by the coast. And it was a small school, but there was a couple of schools on the way. And so the mobile would service that area. But that service is now gone because the colleague that retired, they didn't replace her. So the whole area has to travel in now.

Many services have far fewer dental assistants than they need. Dental assistants work chairside with the therapist, are responsible for sterilisation of equipment, and complete substantial administrative work. When there are not enough dental assistants, then the juggling of these different roles becomes impossible:



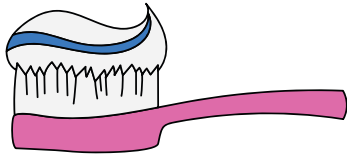
When there are dental assistant vacancies in other places we get sent to cover booked in patients so we can't get to that background work. The running of everything is on the dental assistants really, like running the dental clinic, making sure we're ready to go to schools. I'm the maintenance person, so any reports of maintenance that needs to be done come to me. The days I'm clinical, I can't even get around to reporting the problems because there's not enough time. If we're not fully staffed, there's a real flow on effect.

Longstanding workforce shortages have been exacerbated by the severe restrictions in hiring at Health New Zealand | Te Whatu Ora over the past two years. Whenever a worker has left the community dental service high level approval was needed in order to advertise the new role. This approval was often delayed or denied to save money. One worker stated that it was taking at least a year to fill vacancies when people left.

Since the change in government, there's been a complete hire freeze. Our Service Manager had to jump through a lot of hoops just to try and get Dental Assistants, because we had two Dental Assistants that left to go to uni. Just to get replacement Dental Assistants, she had to do all this work and only one got approved. How it works now is that you have to get approval to replace someone from – is it the middle region board? Some board that's far away. You have to apply to them and say why you need to hire somebody. The whole organisation is competing against each other to get staff from the funding point of view.

Dental services were often denied permission to replace roles when workers went on parental leave, a particular problem in a female-dominated workforce.

A worker who had 33 positions not filled in their service described the impact that had on who could be seen:



When we go into schools, we're not able to see everybody. We focus on seeing those who are due 2022 or 2023 or even further than that. We're not able to see those who are due last year and do preventive work. We're not able to see those kids.

Understaffing means that not all clinics can open. Workers from services across the country mentioned not running some clinics due to understaffing:

Because they haven't got enough staff, I have not been to my small rural town for three years. When there's not enough of us, the children are getting neglected. I'm starting next week and I am scared of what I am going to find. If I had been here every year and the child had a small cavity starting, it would be a small job. I'm expecting to go in and do mass extractions. Because I haven't been able to save my patient's teeth. I find it sad and I get a little angry inside.

Underfunding of community services then leads to increased demand for more expensive hospital services. A dental worker described what happens if they're not able to deliver care in time:

The Hall crown is a wonderful invention. You don't have to pick up a needle and a drill. You can just crown the tooth. But only if you see the children on time. When I see them and it's too late and I think, oh, I could have crowned that six months ago, but now it's down to the nerve.

At that point children need to be referred to hospital services to receive care, but as the worker goes on to say, these services are also underfunded:

Their waiting lists – they try – but the waiting list keeps growing. So I might have to tell a parent that this tooth that's in pain now - here's pain relief. And then they have to sit on the list waiting to get their appointment.

Understaffing in dental services has failed these children twice. First, when they were not seen in community dental services in time for dental problems to be prevented, and second when they sit in pain on long waiting lists.

VACANCIES IN NON-CLINICAL ROLES, SUCH AS DATA AND DIGITAL, LEAD TO EQUIPMENT BREAKDOWN AND CLINICAL WORKERS HAVING LESS TIME TO SEE CHILDREN

Non-clinical roles are vital for an efficient health system. If clinicians do not have adequate support, then they will have less time to spend with patients. The importance of non-clinical roles can be seen very clearly with data and digital.

Health New Zealand | Te Whatu Ora cut 1,000 net data and digital roles in 2025 and since then, the team has faced hiring restrictions.⁸ These changes have made it harder for clinicians facing technology problems to get the support they need. 'We used to be able to ring the main office and either leave a message or someone would answer the phone and deal with it that way. Now you've got to do it online. And I haven't had much luck getting anyone to reply or get back to me'.

The cutting of the service desk has exacerbated existing problems. For example, in one district the X-ray scanner disconnected regularly from the computer and could only be reconnected by the service desk. For an oral health worker, this was the equivalent to if an office worker's mouse disconnected regularly and could only be reconnected by other people. Sometimes patients' X-rays did not connect.

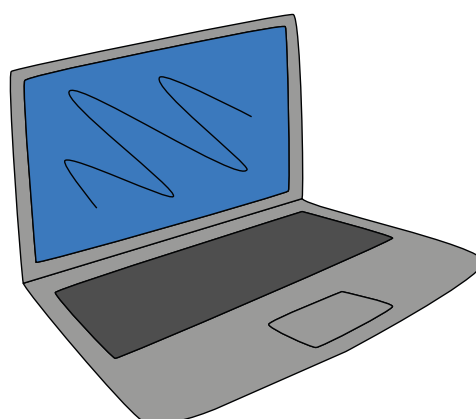
We also interviewed a service-desk worker. Part of the problem was the way the scanner had been set up originally, requiring this connection every day. His team had done a lot to try and address the problem, but it continued:

8. Radio New Zealand, 'Health NZ confirms a third of all IT roles will be cut', 30 April 2025, (<https://www.rnz.co.nz/news/politics/559510/health-nz-confirms-a-third-of-all-it-roles-will-be-cut>)

You might have heard the phrase there's nothing more permanent than a temporary solution. And those temporary solutions all stay in place. Then you end up with a bit of a Jenga tower. And you're doing the best with what you can and they say, we either don't have the budget or don't want to use the budget to go back and fix it because quote-unquote "it works"

The result of these decisions to save money on both service desk people and digital investment was children not being seen, because clinicians were waiting to get through to the service desk to reconnect the scanner, again.

One interviewee described not being allowed to advertise the role of an IT support person for months. In the meantime, a senior dental therapist had to do this work. A clinician was not able to use her clinical skills and see children, because she was doing technical support work that would be better done with someone with the appropriate expertise. Cutting roles that are dismissed as 'back-office' decreases the time clinicians can spend seeing patients.



RELYING ON CLINICIANS TO DO SUBSTANTIAL, MANUAL ADMINISTRATIVE WORK IS INEFFICIENT AND LESSENS THE TIME THEY CAN SPEND WITH CHILDREN.

There is substantial administration work involved in a community dental service and a significant amount of that work is done by clinicians. This is a longstanding problem – even when Health New Zealand | Te Whatu Ora had no hiring restrictions on clinicians, there were restrictions on admin workers:

Before the change in government, oral health had - they called it a green fence. If an oral health therapist turned up and wanted a job, they would get a job. It was like, 'you can hire whoever you want because you need it'. But even then there was an admin hire freeze.

A receptionist described the administrative work she did:

Enrolling new patients. Checking in patients and ensuring their contact details are current and updating if required. Booking appointments from recall list, booking Emergency appointments, cancelling clinics. Doing daily checks to ensure all patients seen that day have a follow up appt booked for treatment if required. Checking the roster. Adding and deleting clinics where necessary. Texting following day's appointments. Scanning all documentation. Covering other clinics remotely when there are staff shortages. Ordering of all supplies including uniform orders. Maintenance requests. I am also the 'go to' person for basic IT assistance.

Many clinics do not have administrators so this work is being done by clinical staff. The lack of admin support is a false economy as clinicians, who end up picking up the work, are paid more and are harder to hire than administration workers.

When a service visits a school, the information about the children has to be updated through a process that requires a lot of manual collation.

Within this clinic we have about 10,000 kids. We have to contact each school and get the school roll. And then

we have to reconcile with our database. We have to go through each and every case and reconcile the school roll in our system, changing their class or if they got a new address.

The complicated and manual nature of this process is a result of not investing in digital systems. An oral health therapist who had spent time in Australia knew that it was possible for the system to be much more efficient, because she had seen it:

The system we had over there was such a great system and a lot more efficient. Here you have to do a lot of stuff individually per patient. We shouldn't have to do that. I should be able to bring up a class list. Take a whole lot of kids. Go tick, tick, tick, tick, tick. You've had your fluoride done today. Bang. No, it's every single kid, one at a time. Can you imagine doing that?

At a time when many children have not been seen, clinicians who could be seeing patients are spending time doing complex manual administration processes. The lack of willingness to spend money on well-run administration systems is costing children dearly.

A lot of the work booking and confirming patients is done by clinicians. In some areas clinicians do a lot of the bookings of non-school-based patients: 'But we do all of our bookings. Administration are not doing many bookings unless someone rings an 0800 number, then they'll book somebody in, but just the day-to-day stuff, that's up to us'. Clinics are also involved in confirming patients once they have been booked. An oral health therapist from a three-chair clinic said they were calling 30 to 40 people each day. Clinicians are responsible for follow-up when a child needs further treatment. This takes considerable time:

If a patient has to come back they go into a follow-up list. When you go back, or when you're on the van at the end of the day, you either call the parent to try and make an appointment or send out a letter. You have three attempts at that. After the third attempt, you issue an incomplete treatment letter and take them off your follow-up list. You have to constantly go back into that follow-up list on a regular basis. We make contact weekly.

The work of booking, confirming and following-up patients takes considerable clinical time that could be spent seeing patients.

Community dental services are also responsible for checking children's eligibility for care based on immigration status. Checking eligibility and processing documents is a time-consuming task that ends up being done by clinical staff. As one oral health therapist said: 'It should be an admin job, but we just don't have an admin. There's no admin person. We are the admin people'.

Dental assistants undertake some administrative work as part of their role, but they are also responsible for sterilising the equipment and assisting chairside. They cannot undertake the substantial administration outlined above and still perform the other parts of their role.

The long-standing problems with administration work for clinical staff has got worse over the last few years because of cuts to administration staff throughout Health New Zealand | Te Whatu Ora. Auckland Regional Dental Service had substantial cuts to administration staff, which meant that clinicians were doing more administrative work:

There's more admin that we are meant to be doing. They used to have a big task force at the ARDS office. When we started, there was close to 30 people working and they're doing all the admin. They were reduced to less than 10, and most of them are part-time, and they put all the workload on us on the floor in here.

In other services, clinical staff had to stop doing their work entirely, to do the work of administrators who had not been replaced:

We had a person leave who answered our 0800 number and they didn't replace them. Someone from here had to go and work in 0800. Frontline staff are covering the staff that they didn't replace, supposedly in the background roles. I'm sorry, it doesn't work.

She explained why it was so important the phones were staffed:

You need the phones manned there, because you'll get a lot of calls of children in pain. If someone rings the 0800 number up at 8 o'clock they'll often be "my child's in pain, can you please see them today?" We'll have that appointment ready to go, and that's really important, because they might need a tooth extraction. Otherwise, their face can swell up and it can endanger their airway.

We'll always see a child in pain. And you need people to answer the phones.

In other cases, the work of administrators just does not get done. This comes at a cost. For example, administrators are responsible for organising maintenance. When administration roles were not filled, maintenance did not happen:

We need the admin team fully recruited, fully up and running to organise all the background stuff. They organise the maintenance for the vans. Now some of the maintenance of the vans doesn't get done. We can't see them at the schools when we want to see them because the van's not running. All that background support is so important, it's a big team effort. For this to run every day it's a big team effort.

When services have administration support it makes a real difference to how many children they can see. One dental therapist had a hub administrator the previous year and described what a difference it had made: 'We used to do all of that stuff ourselves, but this way we can fit in more patients a day. And that's what our skill is. Being supported by hub administrators and assistants makes a real difference'. Such administration support was always fragile. When she was interviewed she did not know if her service would have it again this year, or if she would have to spend more time doing administration and less time seeing patients.

Fully funding administration would make a significant difference to the community dental service. Having clinicians doing administrative work is not the best use of anyone's time.

As a worker, I'd like to do less admin and be more involved with my community. I've always thought that that's the most important thing to do. Because I work with children and they're not a number, it's not a stat for me. It's personal, a real, human being I'm dealing with.

RECOMMENDATIONS

4. Fund sufficient capital investment to ensure equipment and facilities can be properly maintained, repaired and replaced.

5. Fully fund national information technology systems that support efficient and consistent delivery of care.

6. Remove barriers to hiring and retaining clinical staff.

7. Employ sufficient support staff, including administrators and data and digital specialists, so clinicians can focus on patient care.

8. Leverage government procurement power when building a free, universal public oral healthcare system to ensure quality equipment is available across the entire system.





Part Three: Use the expertise of community dental service workers when designing and implementing Dental for All



For a number of our families, the parents come in and there's no way that they can afford to access dental treatment. So they don't.

If you have a mouthful of rotting teeth and periodontal disease, it is a risk to your heart. It's a risk to your whole microbiome. And "it's just fine, oh it's just the mouth". But the mouth leads on to everything else. And Aotearoa has on the whole totally dropped the ball on that.

There is a massive gap. Dentistry is so expensive. If every filling's \$300 what are you supposed to do when that WINZ grant money runs out? Then they're seen that at a hospital, general anaesthetic. If you can avoid that for adults - why wouldn't you? It just makes sense. It could be so much better.

Community dental workers are experts in providing universal public oral healthcare. They have practical ideas about expanding services, improving access, supporting prevention, extending care to adolescents and young adults, and providing care for whole whānau. Their knowledge should help shape the future of public oral healthcare in Aotearoa.

Oral health workers regularly encounter adults who do not have access to oral healthcare. Many parents who bring their children in for appointments can't afford oral healthcare. When community oral health services go to outreach events they are approached by many adults and have to turn them away.

An oral health worker described how they respond to adults who approach them when they're doing outreach in community settings like marae:

We have a list of dentists that take community services card for lower income earners, we inform our whānau about this information, because some people don't even know about that. But that's a hard one too, because there's criteria within that too.

That's not what she wants to say. She wants to be able to offer them care: 'I wish we could just say, come on we can help you. I think that'd be amazing'.

The unaffordability of oral healthcare for adults is not an abstract issue for dental health workers. They see the impact in their own lives, as well as in the services they provide. Some workers in community dental services cannot afford to go to the dentist. An oral health worker said: 'I've got a family and I've got children and I know that if I didn't help my children go to the dentist, I don't believe they could afford to go'.

Unsurprisingly, given everything discussed in the previous section about the impact of underfunding, the possibility of expanding free, public provision of dental care to all was daunting for some workers.

I like the premise or the idea of Dental for All. I really do. I just am scared, I guess, that that's going to be on top of what we're already doing, not just what we're already doing, but also what we're already coping with.

These hesitations (which were expressed by a number of other workers), are exactly why dental workers' views both about the current service and their ideas about how to increase services must be listened to when designing a system in which everyone has access to dental healthcare.

MAKE EXISTING SERVICES THE STARTING POINT FOR DENTAL FOR ALL

Our service is a great model of service – it is. It could expand further for more people into adulthood. I could see that working really well.

The existing community dental health services, with clinics and vans around New Zealand, provide a strong starting point for free, universal, public, Te Tiriti consistent dental health services.

In many areas, there are chairs that are not currently being used:

Why not come and work in some of our clinics? Upstairs there's three chairs and one part-time therapist. Plus, two vans. And there's often nobody upstairs because they're out in the vans.

Not all areas have spare chairs, but in many areas universal public provision could start with publicly owned chairs that are not being fully used.

Many community dental health workers had already thought about how their vans could be used for increased outreach in communities that had difficulties accessing health services.



EXPAND THE WORKFORCE WHILE KEEPING SPECIALIST CHILDREN'S ROLES

The workforce would need to expand to provide dental for all. Widespread use of oral health therapists in adult care will be a central part of this model, as discussed in the Dental for All policy proposal. Oral health therapists can now qualify with an adult scope of practice, but most oral health therapists do not have that scope at the moment. Oral health therapists would have to undertake additional training, so free access to that training would be essential to expand the workforce of oral health workers with adult scope.

Not all oral health therapists wanted to work with adults. The skills and knowledge they had developed about children's oral healthcare were important:

It's a whole different ballgame when you're dealing with kids. I've dealt with adults and I've dealt with children. Children take a lot out of you.

The specialised knowledge of children's oral healthcare that community dental services have built up should be recognised and valued in a new service. Those who want to retrain should be supported to do so, and those that want to remain focused on children should be able to do so.



PROVIDE ACCESSIBLE ORAL HEALTHCARE FOR ADOLESCENTS AND YOUNG ADULTS

Once children complete year 8, they are no longer treated in the public system in most districts. Oral healthcare is still free but provided by private dentists. This is a key moment where children stop receiving oral healthcare:

I always worry about the kids, once they've finished here. They get passed on to the adolescent service. We hope they're going to go see the dentist when they're 13. We hope they're going to use that free service until they're eighteen. They may not. Not the same as we can follow up here. This is a better model than even the adolescents.

Some districts have some public provision for adolescents, either with fixed clinics or vans that go to schools:

We run a small adolescent service in my district. It was good and we had a dedicated therapist that used to love going around their colleges. But because of our lack of numbers of therapists, just the last couple of years it's changed. So that therapist has come back in to treat children. But she clung on to a couple of schools that were really high risk. And so managers said, well, all right, you can have those two, because we knew that they wouldn't transition to the dentists very well.

In areas where there was no public adolescent service, workers thought there should be:

As a service, I'd love to be able to see adolescents. Why can't one service just see them till they're 18? The funding technically is already there. They're paying dentists to see them. You'd just be paying us to continue seeing them. It's just, I guess there's a lot of infrastructure that we need to go in, like we can't just operate out of the same clinics that we have. But I think it's a worthwhile investment. And parents have built relationships with us. They've been coming since they're two. They know where to come. They trust us, most of them. So why would you not keep

going? The age we leave these kids is around 13. 13 to 18 is when all the bad habits start. We know that now kids are buying energy drinks, kids are vaping. And that's when we're losing them. We could set them up so well before 18. We could prevent so many problems when they're adults.

The adolescent service stops providing free dental care the day of a teenager's eighteenth birthday. This means that many school students are not eligible for some or all of their last year of high school. In Whānganui, where there are public dental vans in schools, the barriers this creates were very clear:

We're at the school, so we could continue doing those people. I just don't think it's fair that parents should have to pay while they're still at school. That's my biggest bugbear. And I'll be one of those parents in about three years.

Oral health workers were well aware that access to oral healthcare was a particular concern for young adults, who could not afford to see private dentists.

Often young people aren't getting the dental care they need. They finish college, that might be the last time they see a dentist for quite a long time. If they could access a free checkup every year, you could catch things early and again getting the habits they need when they have children, they're going to pass it on to their children.

Oral health workers knew the long-term costs of young adults' lack of access to dental care: '16- to 25-year-old, that's where we lose so many people, and then they turn up after 25 with, really bad teeth'.

When thinking about oral healthcare for young adults, workers wanted to replicate the ease of access of school-based services. They wanted to make sure that oral health services were available where young people were. One interviewee suggested locating services in tertiary education, or with other youth health services:

There would have to be a hub in a central area because, they're not going to be at school obviously. There's an organisation here that treat up to 25. They have a nurse. They have doctors going in there, and counsellors and stuff for anybody who up to 25, it's all free. Ideally it would be quite nice to sit next to them.

ENSURE PARENTS HAVE ACCESS TO CARE TO IMPROVE CHILDREN'S ORAL HEALTH

Dental workers know that parents' lack of access to dental healthcare has an impact on children:

If parents aren't accessing, then they're less likely to engage with us. They see it as an emergency thing rather than a "let's prevent it before it happens" thing. Also, if you've got parents that have good dental care then their confidence passes on to children, so again the children's more likely to be able to do it as well. I think a fully funded dental for life would be brilliant.

Community oral health workers could see that parents receiving dental healthcare at the same time as their children would make a real difference to children's oral health.

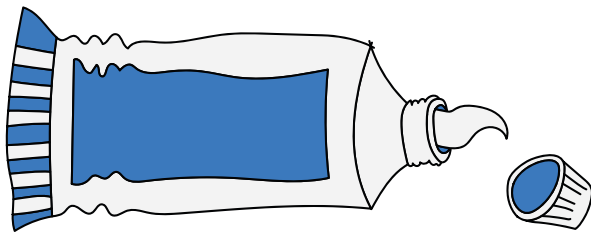
They also saw the opportunity of connecting with parents as early as possible, by providing care for pregnant people:

Seeing pregnant mums for hygiene and that sort of thing. That might be a point of contact with parents before children are born to get them onto that oral health track as well.

I think if parents were able to routinely see a dentist, it would create better long-term habits for their children. I think one is also role modelling for their children, like just the conversations at home, "oh, I've got a sore tooth, but it's so expensive". Like, already children have this narrative built up that going to the dentist is something that's not great.

Oral health workers were enthusiastic about the possibilities that increased oral health access for parents would have on children:

I think if parents were able to kind of see what the dental environment is like now it probably will create a much more positive experience for the whole family. A lot of



parents or older generations will have an idea about what dental is like, which is usually very negative.

Educating families about brushing and looking after their teeth then works down to their tamariki. So, they'll go home and they'll say, "come on. You've got to brush your teeth tonight" type thing. And you know, we've got to do it together, encourage them to do it all together. Show them that you brush your teeth, too.

An oral health therapist described the strength of services where a whole family can be seen at once:

If you look at Ora Toa, they have whole family community dental there. So, the parents can go there, the children could go there, or adolescents could go there as well. You could expand that as much as you like. You could have community dentistry and you could have some that are run on a bi-cultural, fully run version of that you'd get way more community engagement. Please have it where people don't have transport issues. Please have it that when they come in they feel welcome and familiar and safe and done in a way that works for them.

To have the whole family at once would make sense for most families so that they don't have to make multiple rounds of trips of people coming at different times. I think to have both options would be good for families.

If the whole family could receive oral healthcare at once, then that would address the key tension in the current model of care, where services are balancing ease of access against parental involvement.

INCLUDE EDUCATION AND PREVENTION IN DENTAL FOR ALL

But my big problem is we spend all this time and money on developing products and making some company really wealthy, but we don't spend any time or money on making it not happen in the first place. And that irritates me – especially as I've got older. It's one of the most preventable diseases in the world. I had hoped that in my lifetime, I could have been really reduced down the treatment numbers and be doing some kind of a different role in our community to do with teeth. Has never happened. I'm bogged down with work and no one's trying to prevent it.

Interviewees emphasised the importance of community prevention, health promotion and education as part of an expanded public dental service.

Some of the older therapists remembered when they had more time for community education and emphasised the importance of this work:

We have to make it more like the old days where people can bring their whānau in, they can have some fun, they can have a chat. I used to set up mother groups. Come and let the children play on the floor of the dental clinic.

Oral health workers were very aware of the prevention and education work they were not doing and outlined what they would like to do with more funding and resources:

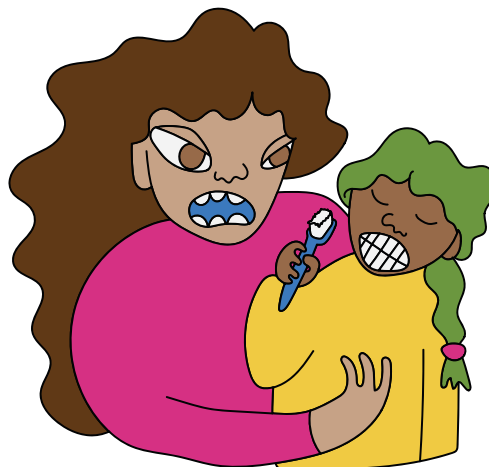
If we had funding to do more oral health public education, it would be great. We could work with our refugee community, our migrant community as they come into the country because at the moment there's nothing. One of my fantasies is winning the big lotto, the \$30 million, and then being able to put half of that back into my area. To be able to go into communities, all communities.

Having free toothbrushes and toothpaste, so you just pick them up as you need them, not just for children, but the whole whānau. Going into preschools and kōhanga and just getting that message across, having brush-ins at lunchtime at schools.

Oral health prevention and education should not be a fantasy like winning lotto – it could be part of our health system.

It was very important to workers that prevention and education was part of an expanded dental service. But the reverse was also true – a free, public, universal, Te Tiriti consistent oral health system was necessary for oral health prevention and education:

There's no point in me telling a mum, “stop doing that”, like stop giving your child juice and fizzy and brush their teeth if that mum has been locked out of dental care since she was 12.



PROVIDE FREE, PUBLIC, UNIVERSAL, TE TIRITI O WAITANGI-CONSISTENT ORAL HEALTHCARE IN AOTEAROA

Community dental service workers are experts on providing public oral healthcare and had thought about how their service could be improved if it was available for all. Their experiences reflected the model put forward by Dental for All.⁹

Workers brought up the strengths of existing iwi provision of health services as an important place to grow further services:

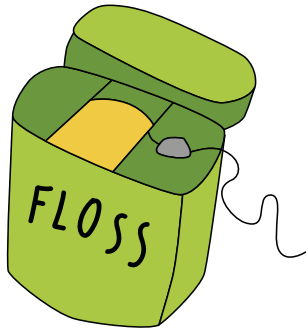
We have Te Taiwhenua, they have a dental thing, but it's nearly impossible to get into. I think more initiatives like that through Māori health providers would be fantastic. I think that's a really good place to start. You'd probably need some clever initiatives, mobiles on a marae, things like that. People who are close to the community that they need to serve.

A worker who provided outreach was enthusiastic about the potential for seeing adults in vans on visits to marae: 'Outreach we'd need vans for our whānau too. I'd definitely increase the fleet. Just get it out there and get vans everywhere'. This worker's experiences reinforced the model proposed by Dental for All.

A dental therapist described why it was important that increased access was in public and community services, rather than private provision:

Otherwise you're going to have to rely on private care. Anything with private care, not just dental, but with anything, there are hidden surcharges everywhere. If a child is hurt in the weekend and they call a dentist and it's covered under ACC, there's a surcharge for that child, for that parent.

9. Dental For All, 'Fixing Oral Healthcare in Aotearoa New Zealand: A Costed Policy Plan for Delivering Dental for All', April 2026, Dental for All Policy Paper April 2026.pdf (<https://drive.google.com/file/d/1vBYUTru-dcAF7aCCzANbBFgWp7Bn6oBA/view>)



Oral health workers know what barriers families face in accessing services for children, and that knowledge can be used when building a free, public, universal, Te Tiriti o Waitangi consistent service and described what they wanted the service to look like:

Make it holistic. Have a hub that has the dentist, the doctors, the physio, the Plunket, they're all in one. There's things out there already that we can access or follow and join in with. And so, you know, I think that gets rid of a few of the barriers as well.

Workers described many elements of the model proposed by Dental for All, showing both the robustness of that model and also the contribution community dental service workers' expertise can make in building a Dental for All service.

Workers could see how much better their services would be if they could provide care for children and their parents at the same time:

We have parents come in and they ask us about their problems. Imagine if I could just say: "oh yeah, give me a moment, like we'll finish this and I'll have a little check for you." I think it'd just be so caring and create such a good environment.

I would really love a facility where a whānau could come as one together into a clinic and have all their dental needs met. That's actually been a dream of mine for a long time. I would love to see that.

Oral health workers' dreams do not have to remain just dreams. We can have free, public, universal, Te Tiriti o Waitangi-consistent oral healthcare in Aotearoa, it just takes political will.

RECOMMENDATIONS

9. Establish a reference group from the existing network of community dental clinics and mobile services to support the build out of an expanded public oral health system with practical knowledge and advice.

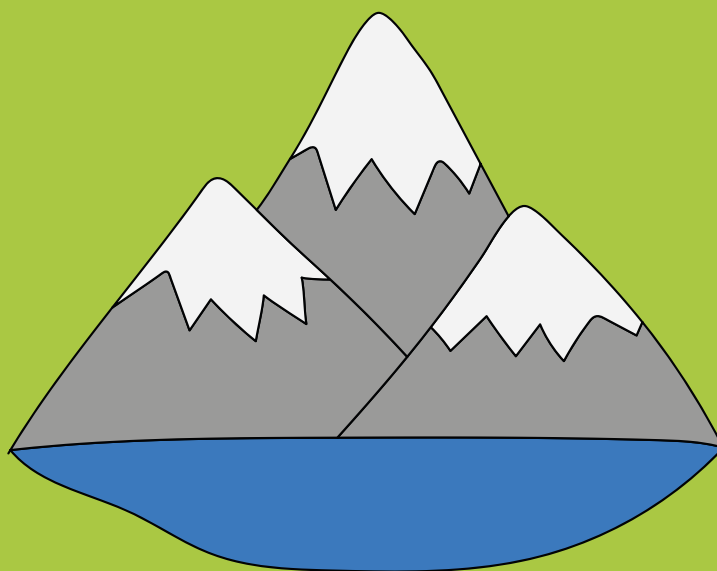
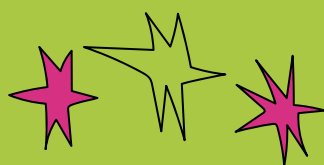
10. Embed community dental service worker expertise in national governance, planning, monitoring and implementation of the Adult Community Oral Health Service.

11. Maintain school-based services and enable whānau to receive care together through integrated community dental services.

12. Support therapists who wish to expand to an adult scope of practice, while maintaining and valuing children's oral health roles.

13. Ensure prevention, education and health promotion are core parts of expanded public oral health services.





ACKNOWLEDGEMENTS

This report is the expression of 19 workers in oral health who gave their time and shared their wisdom as part of their ongoing mahi improving oral healthcare. Thank you to the interviewees and all workers who contribute to providing free, public oral healthcare.

Grace Millar was the interviewer and the lead author. Liam Goulter worked on the transcripts. Sam Huggard, Andrew McCauley, Shannon Walsh and Kirsten Windelov provided editorial support. Angus Lonergan provided campaign support. Kahu Kutia designed the report.

This report has benefited from conversations within and feedback from the wider Dental for All coalition. Thank you to all coalition members. This coalition is real evidence that we are stronger together than we are alone.



APPENDIX 1: METHODOLOGY

This report is based on 19 interviews with PSA members between November 2025 and April 2026. The interviewees include oral health therapists, dental therapists, dental assistants, a health promoter, a receptionist and a service desk analyst. One interview took place over e-mail. All other interviews took place over the phone or in person.

The interview transcripts were auto-generated, then corrected and checked with the interviewees.

All quotes, and any information not otherwise referenced, are from interviews. Quotes have been edited for clarity, brevity and anonymity.



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