Proposed changes to the ADC/DCNZ Accreditation standards for dental practitioner programs

13 May 2020

Māori Oral Health Quality Improvement Group

Submission

About the Māori Oral Health Quality Improvement Group

The Māori Oral Health Quality Improvement Group brings together the expertise of Māori oral health experts and practitioners from across the Māori oral health provider sector. Our aim is to progress change to achieve equity of oral health outcomes for Māori. One way we do this is providing high quality advice to the Ministry of health and others by drawing on our clinical and technical expertise as Indigenous sector practitioners in the development of government policy for Indigenous oral health.

The Dental Council is a regulatory authority created by the Health Practitioners Competence Assurance Act 2003. The role of the Dental Council is to ensure oral health practitioners meet and maintain clinical and practice standards in order to protect the health and safety of the New Zealand public and in accordance with the obligations enshrined within the Treaty of Waitangi. Māori are the New Zealand public.

Summary of our submission

The Māori Oral Health Quality Improvement Group (the QIG) has been partnered with the University of Otago in the delivery of culturally competent care since the implementation of the out-placement program for final year students. Improving the cultural competence curricular and quality of cultural competence in training environments is a topic of which the QIG has considerable expertise. It is a fundamental principle for clinical care and we have long advocated for this. It was included in the equity matrix we developed in consultation with the wider health sector think tank in late 2018 and tested at the 2019 Māori Oral Health equity symposium. It is included in the Māori Oral Health Equity Action Plan developed as an output from that symposium. We are pleased to receive the consultation information from Dental Council of New Zealand (DCNZ), and encourage you to continue to focus on this important mahi.

While the intention to include new cultural competence domains is admirable, we have concerns about the framing of the accreditation standards overall and the content of the cultural competence domain for New Zealand. For this reason, we think the standards need to be reworked in partnership with Māori before they are finalised.

This submission provides more detail to our concerns, but in summary our four main points are:

1. **The framing around Māori health, te Tiriti o Waitangi and equity in the consultation document that accompanies the draft accreditation standard is confusing.**

   It requires more clarity about:

   a. the obligations of dental practitioners,
   b. the status of Māori as the Indigenous population of Aotearoa
   c. health equity and the drivers of inequity.

2. **The cultural competence domain for New Zealand is out of step with the most recent literature on cultural safety and health professionals**.

   Our view is that we should be learning from the work of the Medical Council and our nursing colleagues to move away from narrow definitions of cultural competence that tend to perpetuate stereotypes and reinforce the current ways of doing things rather than addressing the real causes of health inequity.

3. **We recommend rewriting the cultural competence domain of the accreditation standards.**

   We propose this be approached in two main ways:
   a. Responsiveness to Māori be woven throughout the standard. In the body of this submission we make some suggestions how this could be done. Our aim

is to make sure the standards as a whole reflect the DCNZ commitments to te Tiriti o Waitangi and Māori and to achieving health equity and public safety.

b. The current domain and standards be updated to better reflect a more developed understanding of cultural competence and its impact on cultural safety, that is more appropriate for Aotearoa.

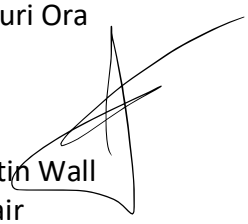
4. **DCNZ must look across its areas of responsibility to address the significant inequities in oral health**.

   This is of course broader than looking just at accreditation standards and includes

   a. ensuring all dental practitioners complete cultural competence and cultural safety training
   b. setting targets to increase the number of Māori in oral health training
   c. reviewing and strengthening existing cultural competence standards for the profession overall. We note that DCNZ have committed to developing a comprehensive cultural competence framework for oral health practitioners in New Zealand at a later stage. We support this work.

Thank you for considering this submission. If you have further questions on the submission or the work of the QIG to achieve equity and improve Māori oral health outcomes please contact us admin@Māorioralhealth.org.nz.

Mauri Ora



Justin Wall
Chair
Māori Oral Health Quality Improvement Group

Introduction

This submission was developed in response to an invitation from the Dental Council of New Zealand (DCNZ) for feedback on its proposal (with the Australian Dental Council (ADC)) on changes to accreditation standards for dental practitioner programmes.

Amongst the most substantive changes proposed by DCNZ is the inclusion of specific proposals for a dedicated domain in the standards for cultural competence for Māori and Pacific Peoples that would apply in New Zealand, and a separate, additional, domain for cultural competence for Aboriginal and Torres Strait Islanders.

The consultation document also seeks feedback on additional criterion requiring programmes ensure students understand their legal, ethical and professional responsibilities and amended criteria to require involvement of dental consumers in programme design, management and quality improvement.

DCNZ and ADC have also sought feedback on whether any additional standards are required or whether proposed standards should be deleted or reworded.

In preparing this submission, we asked ourselves six questions:

- Do the consultation document and accreditation standards appropriately acknowledge and apply te Tiriti o Waitangi?
- Does the bundling of Māori and Pacific Peoples as a single grouping prohibit adherence to the articles of te Tiriti o Waitangi?
- Is the cultural competence domain and general approach in keeping with the ongoing developments around cultural competence and safety that are focused on achieving health equity?
- How will cultural competence be implemented as safety? with particular reference to the role DCNZ has to protect the health and safety of New Zealand citizens, Māori.
- What is the evidence of partnership in the development of this accreditation standard?
- Will this proposal help us achieve health equity for Māori?

After considering the consultation document and draft accreditation standard carefully, our submission focused on four main points.

Framing around Māori health, te Tiriti o Waitangi and equity in the consultation document that accompanies the draft accreditation standard is confusing.

Although not part of the standard itself, the consultation document provides the rationale for including a cultural competence domain for New Zealand. This section is confusing and helps to explain some shortcomings with the standards themselves.

Our specific concerns are driven by the limited analysis or understanding of te Tiriti o Waitangi included in the consultation document and the lack of acknowledgement of the drivers of health inequity in Aotearoa.

In 2019 the Waitangi Tribunal published its *Hauora* report on stage one of its inquiry into health services and outcomes. Although stage one looked mostly at primary health care and general practice, evidence was presented on oral health and there are a number of findings that are relevant to all parts of the health sector.

DCNZ should, in particular, consider how it can truly give effect to the principles of the Treaty as articulated by the 2019 Tribunal report. The following table is adapted from a recent New Zealand Medical Journal article[1] on the Tribunal report and sets out what each of the principles mean.

Treaty principles for the primary health care system
The guarantee of tino rangatiratanga, which provides for self-determination and mana motuhake in the design, delivery and monitoring of primary health care.
The principle of equity, which puts the focus on achieving equitable health outcomes for Māori.
The principle of active protection, which requires us to take action to achieve equitable health outcomes for Māori.
The principle of options, which is about providing for and properly resourcing kaupapa Māori health services. Furthermore, all primary health care services should be provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
The principle of partnership, which is about working with Māori to work in partnership in the governance, design, delivery and monitoring of primary health care services.

The consultation document may well attempt to acknowledge some of these principles, and we support its recognition that a one-size-fits-all approach to Māori oral health is inappropriate and in itself unsafe. In addition the focus the document places on "diversity" and the merging Māori and Pacific people health needs into a singular grouping suggests a lack of regard for Māori Indigenous rights and a misunderstanding of what cultural competence is and what cultural safety should be. We would expect Māori to be referenced on our own. If Pacific peoples health and well being is to be considered it should be in a category of its own and this itself needs to recognise that pacific peoples are not one culture.

Placing Māori with Pacific peoples significantly diminishes the rights of Māori and reinforces ingrained behaviours that deliberately work to disenfranchise Māori.

[1] Baker, G., Baxter, J. and Crampton, P. " The primary healthcare claims to the Waitangi Tribunal" NZMJ 8 November 2019, Vol 132 No 1505

In talking about inequitable outcomes the document fails to recognise the overwhelming evidence, including from Aotearoa, of the complex causes and manifestations of inequities. Included among these are progressive and ongoing impact of colonisation, differential access to the determinants of health, barriers to access including cost, transport, and issues around institutional racism in health care settings.[2]

The cultural competence domain for New Zealand, as set out in the accreditation standards, is out of step with the most recent literature on cultural safety and health professionals.

Our view is that we should be learning from the work of the Medical Council and our nursing colleagues to move away from narrow definitions of cultural competence that tend to perpetuate stereotypes and reinforce the current ways of doing things rather than addressing the real causes of health inequity.

Many of our colleagues are signalling a preference for cultural safety, rather than cultural competence because of its acknowledgement of power relationships in clinical interactions and patient rights. This work has a long history, building off the legacy of Irihapeti Ramsden and others in the context of nursing from at least the 1990s[3].

An important lesson from cultural safety is that we should move away from the idea that, as dental professionals, we should focus on learning cultural customs of different ethnic groups. Instead, as Elana Curtis and colleagues wrote last year[4], we should learn the from the elements of cultural safety that seek "to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice and by allowing the patient to determine whether a clinical encounter is safe".

The cultural competence domain of the (NZ) accreditation standard needs to be re-written.

On balance, we consider that the cultural competence domain for New Zealand as currently written is not fit for purpose. There are two main approaches we would encourage DCNZ to take, in partnership with Māori:

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[2] We recommend considering and applying the thinking of Papaarangi Reid and Bridget Robson from the 2007 *Hauora IV* publication. Although we might have more up to date evidence now, their framing and understanding of inequities would be invaluable in this discussion. The chapter is available online here.

[3] See for example Elaine Papps, Irihapeti Ramsden. Cultural Safety in Nursing: the New Zealand Experience, International Journal for Quality in Health Care, Volume 8, Issue 5, 1996, Pages 491–497, https://doi.org/10.1093/intqhc/8.5.491

[4] Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

a. Responsiveness to Māori be woven throughout the standard. Our aim is to make sure the standards as a whole reflect DCNZ's commitments to te Tiriti o Waitangi and Māori and to achieving health equity.

b. The current domain and standards be updated to better reflect a more developed understanding of cultural competence and cultural safety, that is more appropriate for Aotearoa.

The specific changes we recommend are:

- The standard is to be a specific standard on Māori health, either as a stand-alone domain or as an explicit part of each domain.

- Pacific peoples to be referenced on their own.

- Rewrite the standard statement for the cultural competence domain. At the moment it is written specifically to focus on Māori and Pacific health while stating that cultural competence and culture is broader than these two groups. We agree that Māori health and Pacific health outcomes must be improved through all work undertaken by DCNZ. However, the approach taken here has two consequences. Firstly, it would reinforce stereotypes and be "othering" of Māori and Pacific populations. These are predictable results where cultural competence requirements single out some groups and not others. Secondly it is disappointing that DCNZ has chosen to diminish the status of Māori as the Indigenous population of New Zealand by, unlike ADC, combining an Indigenous and non-Indigenous population in the standard. Grouping Māori and Pacific peoples as a group removes an obligation to uphold and honour te Tiriti o Waitangi. This may be accidental or deliberate, either way it demonstrates why this approach is unsafe. We believe the dental profession must do better for Pacific people, but this must be done in a way that also acknowledges and respects Indigenous rights.

- Amend the current standards by moving them to other domains within the accreditation standards. The following table provides a summary analysis of each of the current standards.

Proposed standard	Recommended action
The program demonstrates its commitment to honouring the Treaty of Waitangi as the foundation document of New Zealand.	Agree that this is fundamental as part of the accreditation standard, but it is not only a cultural competence standard. It is an expectation of all New Zealand health and disability sector. Move to academic governance and quality assurance domain or programme of study domain (noting it applies to NZ only).

The program upholds both the Articles and Principles of the Treaty through its educational philosophy and delivery	As above. And to demonstrate the ongoing harmful impact of colonialisation
The program, staff and students understand the Māori perspective of health and wellbeing, their beliefs and cultural practices as it pertains to oral health in particular.	There is no singular "perspective"[5] and this runs the risk of becoming a one-size-fits-all tick box activity. Of course dental practitioners will need to have a degree of understanding of Māori cultural understandings and models of health but this shouldn't be confused with cultural safety. Reword and include as part of a set of standards on Māori health.
Cultural understanding of Māori and Pacific peoples are integrated throughout the program, clearly articulated in required learning outcomes (including competencies that will enable effective and respectful interaction with Māori).	See earlier comments about 'othering'. Stronger wording would extend beyond acquiring knowledge about other culture and developing appropriate skills and attitudes to instead identifying interventions that acknowledge and address biases and stereotypes[6].
Clinical experiences provide students with experience of providing culturally competent care for Māori and Pacific peoples, and clinical application of cultural competence is appropriately assessed.	As above.
There is a partnership in the design and management of the program from Māori and Pacific peoples.	We strongly agree that partnership with Māori (and Pacific people and other groups) in the design and management of the programme is critical. Recommend moving this to the academic governance and quality assurance domain (noting it applies to New Zealand only). Also recommend that DCNZ role models partnership with Māori in the next and final iteration of this accreditation standard. We acknowledge the reference group used in the development of the

[5] See for example Fiona Cram et. al (2019) ORANGA AND MĀORI HEALTHINEQUITIES, 1769–1992 (Report prepared for the Ministry of Health as part of the Waitangi Tribunal Inquiry into Health Services and Outcomes. Available online here)

[6] See Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

	accreditation standard. While we support the inclusion of Māori oral health experts on this group we note the body of evidence of the difficulty being a lone Māori or Pacific voice on a group[7], and also that this does not represent partnership with Māori. For more information on ways to think about the way partnership could work you will want to consider Te Arawhiti's Guidelines for Engagement with Māori (2018).
The program provider promotes and supports the recruitment, admission, participation, retention and completion of the program by Māori and Pacific peoples.	We agree that this is critical but are not sure that it fits appropriately in this cultural competence standard as well as it demonstrates the programme of study domain.
The program provider ensures students are provided with access to appropriate resources, and to staff and the community with specialist knowledge, expertise and cultural capabilities, to facilitate learning about Māori health.	Consider moving this to a new Māori health domain.
The programme recognises the important role of Māori Te Reo, Ngā Mokai o Ngā Whetu (Māori Dental Student's Association) and Te Aō Marama (The New Zealand Māori Dental Association) in achieving cultural competence to oral health practitioners.	We agree these are critical but suggest: Re-wording so that the important role of the Māori language (Te Reo Māori, not usually referred to as Māori Te Reo) is separated out from the role of Māori groups. This reworded standard should be part of a Māori heath competency. We would also suggest including the Māori Oral Health Quality Improvement Group as a group that supports cultural competence in oral health practitioners. However, the standard needs to be clearer about how the role of these groups can be recognised. The unintended consequence of this kind of statement is that Māori groups are expected to provide additional, unfunded, support just because we are Māori.
Staff and students work and learn in a culturally appropriate environment.	We agree with this standard.

[7] Heather Came, Tim McCreanor, Maria Haenga-Collins & Rhonda Cornes (2019) Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand, Kōtuitui: New Zealand Journal of Social Sciences Online, 14:1, 126-135, DOI: 10.1080/1177083X.2018.1561477

In addition, we consider further standards should be included and recommend DCNZ reflect on whether the standards are sufficiently:

- Focused on achieving equity
- Highlight interventions that acknowledge and address biases and stereotypes
- Promote a framing of cultural safety that requires a focus on power relationships and inequities within health care interactions
- Support monitoring of cultural safety and measurement of (in)equity.

Now is an opportune time for DCNZ to look across its areas of responsibility to address the significant inequities in oral health.

In reviewing the accreditation standard, it is clear that we need to revisit the approach to cultural competence in oral health. This is of course broader than looking just at accreditation standards and includes

- ensuring all dental practitioners' complete cultural competence and cultural safety training to give an understanding of the reasons why inequity exits and how to eliminate it.
- setting targets to increase the number of Māori in dental and oral health training to reflect the proportion of Māori present in the population cohort of that age group.
- reviewing and strengthening existing cultural competence standards for the profession overall. We note that DCNZ has committed to developing a comprehensive cultural competence framework for oral health practitioners in New Zealand at a later stage. We support this work.

We have included many of these considerations in our 2019 equity matrix and subsequent Action Plan, attached, and encourage DCNZ to continue to work to strengthen oral health practice in New Zealand and eliminate inequities.

National Māori Oral Health Equity Action Plan 2020-2023

Acknowledgements

The Māori Oral Health Quality Improvement Group acknowledge all those that have contributed to the development of this plan. The sector Think Tank and wider sector stakeholders that generated the initial foundations of an oral health equity matrix, and the Māori oral health equity symposium participants that helped shape the matrix into this action plan.

A special mihi to the expert advisory group: Kathy Fuge (Hutt Valley District Health Board), Louise Signal (University of Otago Wellington), Bridget Robson (Te Rōpū Rangahau Māori a Eru Pomare), Teresa Wall (Māori health expert), Cheryl Britton (Te Hiku Hauora), and Moira Smith (University of Otago Wellington).

Nā koutou te hohonutanga o ngā korero hei hāpai te hauora kia whai te mana taurite mō te iwi Māori.

Ka pū te ruha, ka hao te rangatahi.

Justin Wall
Chair, Māori Oral Health Quality Improvement Group

Contents

Introduction

Equitable health care is necessary to the success of any quality health system. Achieving equity in health recognises that different people with different levels of advantage require different approaches and resources to achieve the same outcome (Ministry of Health, 2018). Māori experience unacceptable inequities in health outcomes, and oral health is no exception. Māori are disproportionately represented in measures of oral health disease and outcomes and this is having a huge impact on the health and well-being of whānau Māori across the age spectrum. Child oral health data shows a far greater proportion of tamariki Māori have dental disease and their experience of this disease is more severe. As a result of this severe experience, a greater proportion of tamariki Māori are admitted to hospital for treatment of this dental disease. Rangatahi Māori (13-18 years old) have poorer oral health service utilisation rates compared to non-Māori youth, and from the age of 18 years have higher rates of unmet oral health disease and are more likely to delay treatment due to cost (Ministry of Health, 2010; Public Health Advisory Committee, 2003; Ministry of Health, 2019).

'Good oral health, for all, for life' (Ministry of Health, 2006) provided the platform for designing and delivering an equitable fit-for-purpose oral health system. The reorientation of school dental service to community-focused dental hubs was a main action of the strategy to enable equitable oral health outcomes. But equity has not been achieved. Research, reports, and innumerable whānau voices have identified ongoing barriers to access to care. Unresponsive and inappropriate models of care, and cultural incompetence have been identified as main contributors of continued inequities in oral health for Māori.

The current plan aims to address oral health inequities. Throughout its development, there has been a clear and resounding willingness from the oral health sector to deliver an oral health system that leaves no-one behind. Implementing this plan, and making sustainable improvements, will take substantial effort, and a continued commitment from everyone to ensure all Māori enjoy good oral health, for life.

Being accountable to Māori

The place and role of Te Tiriti o Waitangi in health and health care provision is well established. Māori have unique rights as Treaty partners, and as citizens of Aotearoa New Zealand, to enjoy good oral health. But we know this has not been the case. The WAI2575 Health Services and Outcomes Kaupapa Inquiry identified consistent failures of the Crown in its commitment to achieve equity of health outcomes for Māori. Provisions to ensure Māori have adequate decision making, influence, investment, and appropriate accountability mechanisms to ensure the delivery of quality health care to Māori communities have not been met (Waitangi Tribunal, 2019).

The Health and Disability System Review has also investigated how the system could be better designed and delivered with a specific goal of achieving equity of outcomes for Māori. The review revealed that Māori, as Tiriti/Treaty partners, have not been well served by the health system, and looking forward, mātauranga Māori and rights under Te Tiriti o Waitangi must be fully implemented (NZ Health & Disability System Review, 2019).

Oral health is an integral part of the health system, and is necessary for achieving the overarching goal of He Korowai Oranga, Pae Ora – healthy futures (Ministry of Health, 2014). This action plan presents an opportunity to better implement the partnership established in Te Tiriti o Waitangi, to bring about the fundamental disruptive change needed to move to a model that is whānau centric, kaupapa Māori driven, and where prevention, promotion, and integration are embedded as best practice. But the success of this model will rely on a mix of providers and practitioners, who are clinically competent, culturally safe, and willing to work as a team, with a common purpose to eliminate inequity in oral health outcomes for Māori.

As a united oral health system, we can collectively make ourselves accountable for equity improvements for Māori. This action plan is the first step toward achieving long term, sustainable change.

Māori oral health equity action plan

The development of this plan has been informed by a number of sector activities and wide consultation. In December 2018, the Māori Oral Health Quality Improvement Group, in partnership with Te Ao Marama the Māori Dental Association, held an invited sector Think Tank.

Comprising key experts from across the oral and broader health sectors, the Think Tank identified key issues impacting on whānau Māori, the barriers within current structures and practices that disadvantage Māori, and potential solutions. The Think Tank bought a strategic focus to these issues, and discussed urgent and long-term changes needed to achieve oral health equity.

A Māori Oral Health Equity Matrix ('the matrix') was developed from the Think Tank, and subsequently circulated to wider stakeholders for feedback. A national Māori Oral Health Equity Symposium held in October 2019 provided a further opportunity to gather sector-wide input on the matrix priorities and activities, through workshops built into the programme. The Symposium had a cross representation of oral health, health, and Māori health, and non-health sector stakeholders.

Finally, an analysis of the discussion generated by the symposium workshops – and supported by an expert advisory group, identified four main priorities to focus efforts over the next three years. The four priority areas are:

Priority 1: Achieving an equitable oral health system
Priority 2: Responsive oral health services
Priority 3: Greater whānau participation
Priority 4: Building a fit for purpose oral health workforce

Priority 1: Achieving an equitable oral health system

	Action	Lead	Year	Investment	Measuring Success	Impact
Disruptive fundamental change						
1.1	Commission a model of care that provides quality oral health services across the lifecourse. Key elements: responsive to Māori, best practice for Māori, integrated with primary care, flexible workforce, flexible hours, whānau centric, community centric, focus on oral health prevention and promotion (Ministry of Health, 2006).	QIG Partners: NZDA, Te Ao Marama, NZCGP, Te Ora, MOH	1-3	New and existing	New oral health model for Māori developed with key elements are included, and adopted	Future gain
An equitable national approach						
1.2	Review the National Service Framework for the community oral health service and make explicit equity actions, expectations, and accountabilties.	MOH Partners: QIG, DHB COHS, Te Ao Marama	1	None	NSF reviewed and equity actions, expectations and accountabilites are explicit in revised version	Quick win
1.3	Reinstate, and make mandatory oral health promotion roles as an integral function of oral health services.	MOH	2	Required	Promotion roles established; oral health services model is responsive to whānau needs; Whānau engagement improves	Future gain
1.4	Integrate Kaupapa Māori oral health promotion, prevention, and education into National Service framework service specifications.	MOH	1-3	Required	An upstream and culturally safe approach to prevent dental disease and support good oral health in the home is established and implemented Whānau engagement improves	Future gain
1.5	Introduce a funding formula for universal proportionalism to take into account greater oral health needs of tamariki Māori, and secure total funding envelope.	MOH, DHB P&F, QIG, TAS	1-3	Shift	Implementation of a universal proportionalism funding formula Ring-fenced oral health funding that cannot be used by DHBs for other purposes	Quick win

1.6	Establish national contracts for Māori oral health providers, with set minimum levels of funding, fair reporting, review and auditing practises/processes.	MOH Partners: QIG, DHB	2	Existing	National contract developed and adopted	Quick win
Supporting the oral health environment						
1.7	Urgently advance second and third reading of the Health (Fluoridation of Drinking water) Amendment Bill.	QIG, Te Ao Marama	1	None	Amendment Bill is passed. DHBs mandate to optimise fluoride to all community reticulated water supplies	Quick win
1.8	Work with Māori communities and marae to ensure access to fluoridated water supplies.	DHB Public Health Units	1-3	Required	Proportion of marae with access to a fluoridated water supply Proportion of rural Māori communities with access to a fluoridated water supply	Future gain
1.9	Ministry of Health to develop a national water only policy for all government entities.	MOH	1-2	None	Water only policies are developed and adopted	Quick win
1.10	Introduce a sugary drinks tax to reduce consumption of sugary drinks and promote oral health (Teng et al, 2019).	SSB to lead	1-3		A reduction in the consumption of sugary drinks Improvements in caries experience for tamariki and rangatahi Māori	Quick win
1.11	Review, recommend and establish evidence-based fiscal measures to enable better oral health e.g. subsidies on healthy food to increase consumption of healthy kai, and taxes on unhealthy food.	MOH	1.3	None	Review completed, remedial actions, and recommendations to achieve equity gain for Māori	Quick win
1.12	Make oral health and oral health equity a whole of Government approach especially MOH, MSD, TPK, Oranga Tamariki, research funders, and treasury.	MOH	1-3	None	Get oral health on the agenda of existing cross-agency groups	Quick win
1.13	Investigate and identify actions to address the impact of poverty and social determinants on oral health equity for Māori.	Research Groups	1-3	Required	Social impacts on inequity for Māori are understood and structural solutions identified	Future gain
Leading Māori oral health improvement						
1.14	Establish an executive leadership oral health position within the Ministry, that is equivalent to the chief nursing,	MOH	1	None	Role is established and elevated	Quick win

	medical, and allied health roles, with responsibilities for acheiving equity for Māori					
1.15	Establish a Māori oral health equity role within the Ministry of Health Oral health team and a Māori oral health portfolio within the Māori health unit.	MOH	1	Required	Roles are established	Quick win
1.16	Require Oral Health sector leaders to work with DHB Māori Relationship Board Chairs to establish oral health as a health and Māori development priority.	QIG, Te Ao Marama NZDA NZSSCOHS, OHCAN	1	Existing	# MRB with oral health as a priority	Quick win
1.17	Include Māori participation on the Combined Dental agreement group – The Oral Health Group.	MOH Partners: DHB, QIG, NZDA, ACC	1	None	Māori participation on the Group	Quick win
Being accountable for Māori oral health						
1.18	Elevate the right of Māori to good oral health under Te Tiriti o Waitangi; the right of indigenous peoples to health that is Accessible, Available, Acceptable, and Quality under the United Nations Declaration, and the right of a child to the highest standard of health and care attainable under the United Nations Convention on rights of the Child, and in particular the provision of primary and preventive healthcare (Committee on the Rights of the Child, 2013a).	QIG, Te Ao Marama	1	None	Government is holding itself accountable to Te Tiriti o Waitangi, UN expectations to indigenous peoples, and the UN Convention on the rights of the Child	Quick win
1.19	Measure DHB oral health spending against oral health outcomes in target population to enable greater funding accountability.	TPK	1	None	DHB oral health spending is explicitly accounted for in annual reporting	Quick win
1.20	Investigate the quality, and reporting of, oral health ethnicity data.	MOH	1-2	None	Audit complete Actions identified and implemented	Future gain
1.21	Establish an independent role to monitor equity trends, performance, workforce, model of care, and investment analysis.	MOH	1.3	Required	Role established, trends identified and improvement actions in place	Future gain

Priority 2: Responsive oral health services

	Action	Lead	Year	Investment	Measuring success	Impact
Models of care						
2.1	Improve the community oral health service responsiveness to whānau Māori by making the following changes: - Move away from enrolment to engagement - Review the hub and spoke model and its impact on whānau Māori - Expand operating hours and contracts to allow wider availability and flexibility for whānau - Introduce outreach services that are community based and oriented to whānau in the home - Review pathways and implement actions to improve access to dental care for rural Māori - Review pathways and implement actions to increase attendance rates of Māori - Integration with primary care - Provide targeted oral health services based on need.	MOH, DHB COHS	1	Existing	# and % tamariki Māori seen at age one Report and actions to improve COHS responsiveness to Māori is implemented	Quick win
2.2	Review pathways and implement actions (with Māori) to improve Ambulatory Sensitive Hospital (ASH) Admission rates for GA dental. Tamariki Māori are currently disproportionately represented in this group.	DHB P&F, DHB COHS	1-2	Required	# and % decrease in ASH dental rates for Māori	Quick win

2.3	Move to a model of essential rather than emergency dental for low income adults and make preventive care a core component.	MOH, MSD, DHB	1-3	Required	Decrease in emergency care Decrease in dental decay	Quick win
2.4	Introduce a free oral health care programme for Māori mothers (prioritising 18-30 years olds), low income adults, and for those with chronic conditions.	MOH, DHB, PHO, MOHP	1-3	Required	Increase in engagement of priority groups Improvement in diabetes management	Quick win
2.5	Integrate primary and oral health practices as per Ngā Ara Tika and investigate other models which delineates the activites that primary care teams can take to protect and promote oral health.	MOH, DHB, NZCGP, PHO	1-3	Required	Ngā Ara Tika and/or other models integrated	Future gain
Oral health service monitoring and accountablity						
2.6	Report current targets and actions for remediation by ethnicity, and include in MoH reporting cycle.	DHB, MOH	1-2	None	New targets in place, and embedded in DHB reporting	Quick win
2.7	Hold all DHB Oral Health Clinical Directors accountable and responsible for oral health equity for Māori.	DHB	1	None	# of DHBs with oral health equity champions	Quick win
2.8	Require all DHB funder arms to carryout a tender process for oral health services, with clear expectations, actions, and accountability for improving equity for Māori.	DHB P&F	1-3	Existing	Providers meet expectations for equity, service responsiveness, and value for money	Future gain

Priority 3: Greater whānau participation

	Action	Lead/s	Year	Investment	Measuring Success	Impact
3.1	Develop a Māori oral health research agenda, based on whānau Māori preferences and priorities, and establish a Māori oral health research group.	Te Ao Marama, QIG, Māori health research group, MOH, Ngā Pae o te Maramatanga	2-3	Required	Agenda produced Research Group established	Future gain
3.2	Co-design approaches with whānau Māori to ensure their preferences and priorities are embedded in service design and delivery.	DHB COHS, DHB Maori Health, Māori community, Te Ao Marama, QIG, Māori health research group	1 – 3	Required	Whānau preferences are reflected in services	Future gain
3.3	Undertake a whānau experience survey to gauge service responsive to whānau.	QIG	1-3	Required	Survey findings reported and a plan to implement improvements in progress	Future gain
3.4	Provide a forum for community and stakeholders to advocate for equitable oral health outcomes, be informed, lead research, and provide evidence based policy advice.	MOH, QIG	1	Required	KPI's to be put in place. Research data based information	Quick win
3.5	Establish a Māori Oral Health Equity Reference Group, with Māori community representation, to oversee the implementation of the Māori Oral Health Equity Action Plan.	MOH, QIG Partners: Te Ao Marama, DHB, QIG, Māori community, Primary Care, Tertiary provider, Professional bodies	1	Required	Group established Successful implementation by end of Year 3	Quick win

Priority 4: Build a fit for purpose oral health workforce

	Action	Lead/s	Year	Investment	Measuring Success	Impact
Strengthening the oral health workforce						
4.1	Develop a workforce plan for the non-clinical oral health workforce roles i.e. for those working in oral health education, promotion and integrated settings that includes: training, resources, and competencies.	HWNZ	1-3	Required	Training, resources, and competencies are developed	Future gain
4.2	Develop a comprehensive workforce plan that transitions new graduates into a new entry training programme, establishes an upskilling regime for practitioners. The workforce plan includes clinical competence, cultural safety, social responsibility, and equity.	Tertiary providers, HWNZ, DCNZ Partners: QIG, Te Ao Marama, Associations	1-3	Required	Workforce plan developed # new graduates entering and completing new entry training programmes Workforce plan contains explicit actions for cultural, safety, social responsibility and equity Implementation of workforce plan leads to practice changes reflecting cultural safety, social responsibility, and equity	Future gain
4.3	Expand the HWNZ Voluntary Bonding Scheme to include oral health therapy; provide greater incentive for placements at Māori Oral Health Providers, and report progress to QIG & Te Ao Marama.	HWNZ	1	None	HWNZ expanded to include DT MOHP VBS placements incentivised Reporting to QIG/TAM annually to monitor participation	Quick win
Building a culturally safe oral health workforce						
4.4	Strengthen DCNZ cultural safety standards.	DCNC Partners: QIG, Te Ao Marama	1	None	Approved cultural safety standards	Quick win

4.5	Investigate and improve the cultural safety curricula and teaching within tertiary oral health education.	Tertiary providers, DCNZ Partners: Te Ao Marama, QIG	1-2	None	Curricula meets cultural standards and expectations	Future gain
4.6	Enable all oral health practitioners to complete cultural safety training and competencies.	NZDC Partners: NZDA, NZDOHTA, Te Ao Marama, QIG	1-2	Required	Training available # completed training Competencies confirmed Audits undertaken	Future gain
Building a representative Māori oral health workforce						
4.7	Invest in increasing the number of Māori dentists with post graduate qualifications.	Tertiary providers, HWNZ, DCNZ	1-3	Required	Increase # Māori dentists with post graduate qualifications	Future gain
4.8	Fund dental assistant training within Providers with pipelines to dental therapy or BDS targeting Māori.	HWNZ, MOH, DHB, Te Ao Marama	1–3	Existing	Programme implemented	Future gain
4.9	Increase the number of tauira Māori from low decile schools and high deprivation areas linked to DHB workforce projections based on population forecasts at a minimum of 30%[1].	DHBs, Tertiary providers	2-3	Required	80% of tauira Māori in training or employment leading to tertiary training and higher learning and skills by 2028	Future gain
4.10	Establish annual targets for all universities for Māori entering dental or dental therapy programmes to address the equity need.	Tertiary providers Partners: QIG, Te Ao Marama	1	None	Targets established # and % of Māori enrolled reported annually Increasing # of qualified Māori dentists	Quick win
4.11	Utilise other workforce areas- i.e. Well Child Tamariki Ora, maternity, family start, whānau ora, and primary care sectors - to provide oral health education, prevention, and screen for obvious dental disease.	MOH, WCTO, MSD, DHB, NZCGP, Te Ao Marama, QIG, NZCOM	2- 3	Required	Health stakeholders are involved	Future gain

[1] 30% based in the projected age cohort available for traning are Māori

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