

The development of Oranga niho services

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Abstract

In order to address the disparities in dental health and to provide an affordable and appropriate dental health service that is accessible to Maori a new approach to dental health services for Maori must be established in New Zealand. The generally poor oral health status of Maori indicates that there are barriers to dental care and other determinants of oral health that include good diet, access to fluoride, knowledge of dental entitlements and compliance with dental follow-up. This paper outlines some of the innovative developments in oranga niho services promoted by the School of Dentistry in Dunedin that include Te Whare Kaitiaki, a whanau dental clinic in the School of Dentistry at the University of Otago in Dunedin, the establishment of working partnerships between a dental provider and Maori communities (eg Ratana Pa/Good Health Wanganui, Tipu Ora/School Dental Service and Te Hauora o Turanganui a Kiwa Ltd/1 Mobile Dental Unit, Royal New Zealand Dental Corps) and an Iwi based oranga niho service at Te Atiawa Medical Centre in New Plymouth. These initiatives demonstrate an increasingly independent Maori partner with the Iwi-based service highlighting the assertion of tino rangatiratanga by Iwi in the development and implementation of their own services.

Introduction

Dental health is just one part of overall health and well-being.^(1,2) It has long been apparent that the dental health of the Maori people is far below that of the non-Maori people. Although the dental health status of Maori people ranges

from good to very poor, the emphasis is skewed towards abysmal. In the past, dentistry has had a very low priority with Maori people. Indeed, for many Maori people, dentistry did not rate at all. Although, there is now an increase in the awareness of oranga niho within the Maori population, current dental data indicates significant disparities with little hope of changing in the near future.

In order to address the disparities in dental health and to provide an affordable and appropriate dental health service that is accessible to Maori, then a new approach to dental health services for Maori must be established in New Zealand. This will lead to a much improved oral health status for Maori across all age groups, which will then impact enormously on the general health and well being of Maori.

There are two streams of dental services in New Zealand, publicly funded dental services and privately funded dental services. Publicly funded dental care provides for all children, both pre-school and primary school children through the School Dental Service. High school students are catered for under the Dental Benefit Scheme in which school pupils are expected to enrol with the dental practitioner of their

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choice for basic restorative dental care. This service is free for all young people up to their 16th birthday or until their 18th birthday if they are still dependent. Public funding is also available for pain

and infection control for low-income adults. Fee for service or privately funded care, is the basis for orthodontic care and dental care for adults.

An appreciation of the dental health status of Maori people can be gained from the available literature and from the records of the School Dental Service. For example:

For Mokopuna and tamariki, an evaluation⁽³⁾ of the ethnicity and child dental health status in the Manawatu-Wanganui Area Health Board in 1993 revealed that for 5-year-old children:

- a) Non-Maori children were three times more likely than Maori children to be caries free upon completion of their first dental treatment after leaving school.

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- b) Maori children were three times more likely than non-Maori children to have high caries experience of dental caries, (five or more missing or filled teeth).
- c) Maori children were three times more likely to have experienced general anaesthesia for dental treatment.
- d) Maori children were over three times more likely not to have been enrolled in the School Dental Service prior to starting school.

Results from the same study showed that for Form II children:

- a) Non-Maori children were twice as likely to be caries-free at the end of their time in the School Dental Service than Maori children.
- b) Maori children were more than twice as likely to have had high dental caries experience than non-Maori children.

For Rangatahi, Midland Health reported in 1996 ⁽⁴⁾ that approximately 50% of Maori adolescents in their region drop out, or do not utilise the dental benefit scheme compared to 25% of non-Maori adolescents.

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The only current data on the oral health status of adult Maori is the 1976 New Zealand Survey of Adult Oral Health ⁽⁵⁾ that substantiated the poor dental health status of adult Maori people compared to non-Maori. The results of this study showed that adult Maori had:

- a) Many more carious lesions than the non-Maori.
- b) Early and rapid permanent tooth loss.
- c) Become edentulous much younger than non-Maori.
- d) A higher extraction need at all ages.
- e) A higher periodontal disease prevalence and severity than non-Maori.
- f) That many edentulous Maori people did not have dentures.

The dental health status of Maori is summed up in the comment by Dr Tony Ruakere of Te Atiawa Medical Centre, New Plymouth, a marae-based GP service. He reported that poor oral hygiene was a major health problem among the 5,000 clients, second only to respiratory disease. ⁽⁶⁾

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The generally poor oral health status of Maori people indicates that there are barriers to dental care. Identified barriers are the affordability, acceptability, appropriateness and accessibility of existing services. Other determinants of oral health include diet, fluoride, knowledge of entitlements,

and compliance. This paper now outlines some important strategies in the establishment of oranga niho services for Maori. This is a dental health care service for whanau that operates under kaupapa Maori and will meet their needs as Maori.

Oranga niho services

The last decade has seen the evolution of some innovative services which, although they have not occurred without some difficulty, they have been driven by the commitment of Maori. Some examples include:

- i) Within mainstream, Te Whare Kaitiaki¹, is a whanau dental clinic in the School of Dentistry at the University of Otago in Dunedin. This clinic opened in 1990 and provides a full range of services for all age groups.

Although the clinic only operates for one morning a week, whanau throughout the rohe know that this is their clinic. And support it they do.

ii) The establishment of working partnerships between a dental provider and Maori has been a very effective

means of developing oranga niho services. Examples of this model include:

- Ratana Pa and Good Health Wanganui, 1992.
- Tipu Ora, Rotorua and the School Dental Service, 1998.
- Te Hauora o Turanganui a Kiwa Ltd, Gisborne, and 1 Mobile Dental Unit, Royal New Zealand Dental Corps, 1999.
- i) An iwi based oranga niho service is the dental clinic at Te Atiawa Medical Centre, New Plymouth, which opened in 1999, operating for two days a week.

The significance of both mainstream services and services in partnership is the acknowledgement and recognition of both the Articles and the Principles of Te Tiriti of Waitangi by the respective parties. The iwi-based service highlights the assertion of tino rangatiratanga by iwi in the development and implementation of their own service.

The dental programme at Ratana Pa ⁽⁷⁾ initiated in 1992 is a good example of an effective dental programme because it overcame all the barriers to dental care for Maori. The community identified oral health as a major issue and were successful in gaining funding for a small project through establishing a partnership with the Dental Unit of Good Health Wanganui. The plan involved taking the School Dental Service caravan to Ratana Pa in the school holiday period when it would otherwise be idle. A locum Maori dentist was employed for the period. The factors for the success of the project at Ratana Pa were:

- i) The Maori Community Health Worker at Ratana Pa who initiated the project on behalf of the community. She consulted her community, made the appointments and was present the whole time to awahi and tautoko the patients.
- ii) The co-operation with the Dental Centre of Wanganui Base Hospital who made the facilities, equipment and materials available was also a major factor in the success of the programme. Access to health services is a barrier for many Maori people. In this case the dental health service was taken to the people and set up within their own community.
- iii) Ownership and control of the project. This was a community based project which ensured that community input was part of the programme right from the outset. The running of the project at Ratana Pa was the responsibility of their own Maori Health Community Worker.
- iv) The two dentists who undertook the work were Maori. The presence of a brown face, was a factor in the initial acceptance by the people to attend for treatment.
- v) The whanau concept being made a natural part of the dental service was another important factor. Other whanau members were welcome at all times in the surgery whilst treatment was being undertaken. The patient did not feel isolated from their whanau who were there to provide support in what may otherwise appear to the patient to be an intimidating and alien environment.
- vi) The appreciation by Central Regional Health Authority for the need to address the dental health status of Maori people must be acknowledged. They provided the funding for this pilot project

In order to meet the oral health goals and targets for Maori, new approaches to dental care delivery systems are necessary.

Both the Ratana Pa and the Tairāwhiti projects were conducted within finite time frames and were not continued long term. However, they were important for raising the profile of *oranga niho* within their respective communities. From these beginnings, more tangible dental health services must be developed.

Further developments in Oranga niho services

There is now an increasing awareness of *oranga niho* within the Maori population.⁽⁸⁾ Current dental health data indicates that the disparities in oral health between Maori and non-Maori require significant improvement in Maori oral health. This can occur through the development of *oranga niho* services. The outcome of this development will contribute to the Government's objective for Maori health which states that:⁽⁹⁾ The Crown will seek to improve Maori health status so that in the future Maori will have the same opportunity to enjoy at least the same level of health as non-Maori.

This policy is reflected in the Health Funding Authority's Treaty of Waitangi policy⁽¹⁰⁾ which includes the clause that all HFA contracts "shall demonstrate how the policies and practices of their provider organization and service delivery shall benefit Maori clientele". In October 1998, the Board of the Health Funding Authority⁽¹¹⁾ identified eight priority areas for Maori health gain, one of which was oral health. The Budget⁽¹²⁾ announcement on 19 May 1999 noted that "this year's Budget takes real steps to improve the daily lives and opportunities for Maori". The Budget included an integrated dental care programme called *Oranga Niho* which would be introduced as a pilot programme. This was a major step and came about through the combined efforts of a number of groups. The first was the Maori Health Commission who

developed the proposal through its formative stages.⁽¹³⁾ This work was assisted by Te Ao Marama, The New Zealand Maori Dental Association whose influence and support was crucial. The third stream of

support came from the New Zealand Dental Association who had developed and published the New Zealand Oral Health Goals for the New Millennium.⁽¹⁴⁾ The aim of this document was to provide goals and targets to improve the oral health of all New Zealanders. Within this strategy were Maori specific goals and targets which were developed in close consultation with Maori.

In order to meet the oral health goals and targets for Maori, new approaches to dental care delivery systems are necessary. The basis of the *Oranga Niho* pilot is the establishment of a Maori oral health team: a dentist and a school dental therapist, working together as part of an existing Maori provider. The existing Maori provider has:

- an administrative infra-structure already in place;
- an established client base;
- community networks and communication strategies;
- Maori health community workers who become an important part of the team;
- primary medical care back-up and support;
- integration with other health service components.

On the operational side, a main dental clinic would be established which could be supplemented by a mobile clinic to access outlying or more remote areas. The dental health professionals would provide a seamless service that caters for all age groups from *mokopuna* to *kaumatua*. The links with whanau can be maintained by the Maori health community worker who could also undertake *oranga niho* promotion and education. The outcomes of an *Oranga Niho* Service is improved oral health for whanau which can be illustrated within the framework of *Te Whare Tapa Wha*:

The basis of te taha Tinana is a sound functional natural dentition for life. The impact upon overall physical health can also be significant if the individual has a chronic illness such as rheumatic fever. The impact of health on whanau well being cannot be overlooked. Poor oral health can be a barrier to employment. A restored dentition can mean a job, income and economic independence. The impact of a restored dentition upon self worth and self esteem can be enormous and is summed up in the whakatauki, "oranga niho, oranga kata". The slogan "smile like our tupuna" means just that. In pre-European times there was no dental decay in Aotearoa/ Te Waipounamu; dental caries is an introduced disease.

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HE KUPU HOU

he maiuiui	<i>exhausted/feeling really unwell</i>
he kirikaa	<i>feverish</i>
he werawera	<i>sweaty</i>