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“Māori are at a greater risk of having diminished access to dental care”

An interview with Bridget Robson, New Zealand

A recent national report on oral health in New Zealand has found that Māori adults are nearly twice as likely as non-Māori adults to be edentulous. They are also significantly more likely to have periodontal disease, as well as untreated coronal and root decay.

Dental Tribune Asia Pacific spoke with Dr Bridget Robson, Director of the Eru Pōmare Māori Health Research Centre at the Wellington School of Medicine and Health Science, University of Otago, about the causes and how better access to dental services could be achieved for the country’s large indigenous population.

Daniel Zimmermann: Ms Robson, has oral health of the Māori always been in such a poor state?

Bridget Robson: Historic records indicate very low rates of caries prior to European contact. Ma¯ ori are at a greater risk of having missing or damaged teeth, bad breath and ill-fitting or damaged dentures. They described problems with communication, mood and being able to chew food. The majority reported experiencing pain, sometimes bad enough that they resort to self-remedies, such as “poking with a needle to try and kill the nerve”, pulling their own teeth with pliers, and using whisky as pain relief. Some discussed the impact on family finances, having to go without other necessities in order to pay for urgent dental care. Sadly, one community had been through the trauma of losing a family member owing to an untreated oral infection.

What impact does poor oral health have on Māori communities today?

The communities that were part of our research talked about the embarrassment and stigma of having missing or damaged teeth, bad breath and ill-fitting or damaged dentures. They described problems with communication, mood and being able to chew food. The majority reported experiencing pain, sometimes bad enough that they resort to self-remedies, such as “poking with a needle to try and kill the nerve”, pulling their own teeth with pliers, and using whisky as pain relief. Some discussed the impact on family finances, having to go without other necessities in order to pay for urgent dental care. Sadly, one community had been through the trauma of losing a family member owing to an untreated oral infection.

The colonial processes that started affecting Māori in the 19th century, owing to loss of land and environmental degradation, Māori diets continued to become “Westernised”, and subsequently caries became more prevalent.

The introduction of a European diet, particularly sugar products, started affecting Māori oral health in the 19th century. As traditional food resources became increasingly inaccessible over the 20th century, owing to loss of land and environmental degradation, Māori diets continued to become “Westernised”, and subsequently caries became more prevalent.

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The minimum hourly wage in New Zealand is currently NZ$18.50 (US$14.00). How many Māori are currently living in low-income conditions?

More than one in four Māori live in economic hardship compared with one in eight of the total New Zealand population. One in four is in the lowest income quintile, and one in four lives in the 10 percent of neighbourhoods that are the most socio-economically deprived. Owning to the disparities in wealth and assets, Māori incomes are more closely tied to employment status than non-Māori and therefore vulnerable to economic shocks, such as the current recession, affecting unemployment.

The unemployment rate of around 14 percent amongst Māori is currently over twice the rate for non-Māori, and much higher for younger Māori. This age group, ranging from 15 to 24, is particularly at risk of not receiving dental care after the age of 18, with increased caries prevalence by the age of 24.

Research has confirmed that only 1 per cent of annual oral health-care spending in New Zealand comes from low-income households. Does the problem extend beyond racial lines?

Unlike other primary health-care services in New Zealand, only a very small proportion of the NZ$1 billion spent on dental care each year is publicly funded (NZ$178 million), of which only 5 per cent is allocated to low-income adults. The lack of systematic provision of care has a differential impact on the Māori population, as the high out-of-pocket expense puts dental care increasingly out of reach.

However, the lack of culturally congruent care and institutionalised discrimination creates extra barriers for low-income Māori compared with low-income non-Māori. Within the disabled population living in households, disabled Māori report higher levels of barriers for the receipt of health care and transport costs than disabled non-Māori. They are also less likely to have seen a dental professional in the past year than their non-Māori counterparts.

A dental system that gets it right for low-income or disabled Māori is also likely to get it right for low-income or disabled non-Māori, but the converse is not guaranteed to achieve equitable outcomes for all.

In 2006, your Ministry of Health published a paper titled “Strategic vision for oral health in New Zealand” in which they committed to increased investment in community oral health care services. What has changed since then?

There has been some investment in a limited number of Māori primary health care providers (not for profit) in recent years to support them in extending or developing their capacity to deliver oral health care to their communities, including prevention, treatment and workforce development. The Ministry of Health and health-care providers have also established a quality improvement group for mutual support and started to extended opportunities for placement of senior dental students and dentistry students in dental care programmes.

Moreover, the scope of practice of dental therapists has been expanded to include oral health care for adults for those who undertake the necessary training. This could allow therapists to work with the whole family a preferred way of working for many Māori health practitioners.