Pre-school children enrolled in publicly funded child oral health service

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Outcome

All children and their families and whānau achieve their health and wellbeing potential.

Measure

Pre-school children enrolled in publicly funded child oral health services

Type

Contributory measure

Relationship(s) to other frameworks

This measure is drawn from the:

- Well Child Tamariki Ora (WCTO) Quality Improvement Framework (Quality Indicator 5): Ministry of Health. 2015. Indicators for the Well Child/Tamariki Ora Quality Improvement Framework – March 2015. Wellington: Ministry of Health Framework available at: www.health.govt.nz
- District Health Board (DHB) Non-financial monitoring framework and performance measures (measure PP13): Ministry of Health. 2015. DHB Non-financial monitoring framework and performance measures – Sept 2015. Wellington: Ministry of Health Framework available at: www.health.govt.nz

Rationale

Poor oral health is a marker for a range of poor health outcomes in childhood and later life, and there is high variance among priority populations. Achieveing improvements in oral health requires a cross-sector response and a multi-faceted approach, and improvements may not be seen in the short term.

Delivery of this measure most strongly supports the following sector outcomes and government priorities: By increasing the number of pre-school children less than five years of age (0 – 4 year olds, inclusive), who have enrolled for DHB-funded oral health services and reducing the number who are overdue for their scheduled examination, the DHB will show that it has made an impact on the outcome of protecting and promoting good health and independence. The measures indicates the accessibility and availability of publicly-funded oral health programmes, which will in turn reduce the prevalence and severity of early childhood caries, and improve oral health of primary school children.

The measures provide information that allows DHBs and the Ministry of Health to evaluate how health promotion programmes, and services such as Well Child and the Community Oral Health Service (COHS), are influencing the oral health status of children and whether oral health service programmes are delivering timely oral health services to children. Through the intermediate outcome, the measure contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives.

The WCTO programme has an important role in the assessment and support of oral health at core and additional contacts, and through referral to oral health services, to minimise the inequitable burden of poor oral health among all, and in particular Māori and Pacific children.

Eligible population

All children who are within the five year old cohort during the reporting period who are enrolled with the DHB at the beginning of the qualifying year

Measure status

Active

Numerator

In the year to which the reporting relates, the total number of children under five years of age, (i.e. aged 0 to 4 years of age inclusive), who are enrolled with DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).

Denominator

DHBs do not need to report a denominator. The Ministry will source denominator data, and advise denominator prior to DHBs' targets being set. In the year to which the reporting relates, the total number of children under five years of age, i.e. ages 0 to 4.

National target

95%

Local target

Milestones to be decided by Alliance

Data Sources

- DHBs via their Community Oral Health Services and other oral health providers
- New Zealand Census sourced estimates of DHB population by age

Data extracted from data sources

Available through DHB

Data availability

Available through DHB

Measure calculation process

Available through DHB

Relationship(s) to other measures

Not applicable

Measure development notes

1. The data reported in the Numerator and Denominator can also be broken down by:

(i) Ethnicity, using “prioritised ethnicity” approach. (ii) into the following (in order of assignment):

- Māori;
- Pacific (only for the seven ‘official’ Pacific DHBs); and
- Other (includes Pacific children in the other DHBs that are not ‘official’ Pacific DHBs); and

(iii) water fluoridation status of the school area the child attends, defined as:

- fluoridated; and
- non-fluoridated.

2. The data for this indicator will be generated by DHBs. There is a number of technical interpretation issues associated with oral health, which are centred largely around variances in:

- processes for data collection amongst DHBs
- technologies for management of data amongst DHBs.

3. DHBs are encouraged to record data at the unit (individual child) level, using the National Health Index, but data are reported in an aggregated format and should be provided using the Ministry of Health Excel template, available on the quarterly reporting database or from the Ministry of Health’s oral health team.

- DHBs are required to separately report the number of decayed, missing (due to caries), or filled teeth (dmft).

It is acknowledged that the use of the 'priortised ethnicity' approach is consistent with New Zealand's Statistical Standard for Ethnicity, but it is considered that this approach is acceptable given that:

- the historical use of this approach in the long-term data series since 1990 and
- the standard “total response” approach will not provide an accurate picture of the number of children examined by DHBs’ Community Oral Health Service and other contracted third party providers.