Delivering Specialist Oral Health Services to Regional and Rural Communities in Aotearoa New Zealand

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A report on findings from a study trip to Scotland & England in 2025,

supported by the Winston Churchill Memorial Trust.

Submitted: November 2026

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Acknowledgements

I am grateful to the Winston Churchill Memorial Trust for supporting my research trip to the United Kingdom in late 2025. This allowed me the time to reflect in 2026, while writing up findings and presenting and sharing ideas in New Zealand. I am particularly thankful to Professor David Felix (OBE) for his introduction to a vast network of specialists and healthcare providers within Scotland. My sincere thanks go to the many people who generously shared their time, insights, and expertise; whose names can be found in the Appendix. I am also indebted to those who offered accommodation, R.W and G.W of Edinburgh and C.B. of London, which helped extend the Trust's funding.

From New Zealand, I thank my family for making this work possible. I am especially grateful to my in-laws K.H. and G.H. for their daily intellectual thoughts beyond the world of specialist dentistry and to D. and T. who are always there to guide me.

This report is dedicated to all people who are advocating for their communities.

Executive Summary

This report examines how specialist oral health care can be delivered to regional and remote communities and its application to Aotearoa New Zealand. Through visits to rural health services, specialist training centres and national agencies across Scotland and England, it identifies practical models for extending specialist expertise beyond major urban centres.

The study was undertaken in response to persistent inequities in access to specialist oral health care in Aotearoa New Zealand. Rural, regional, and remote communities face significant barriers due to workforce shortages, limited specialist services, geographic isolation, and the cost of care.

Despite differences in geography, culture, and health system structure, many of the lessons from the United Kingdom are relevant to Aotearoa New Zealand. Across all sites visited, a consistent message emerged: geographic isolation need not limit access to high-quality specialist care when supported by strong local leadership, culturally responsive services, professional networks, and integrated systems that bring care closer to home.

Successful services combined specialist oversight with shared-care models, enabling patients to receive care locally while maintaining access to specialist expertise. Outreach clinics, hub-and-spoke networks, digital health, and structured supervision frameworks were commonly used to improve access and strengthen local capability.

The Fellowship also highlighted the importance of workforce development. Effective training pathways were integrated into routine clinical practice and tailored to regional service needs, with national organisations providing oversight while supporting local flexibility.

Strong community partnerships were essential for building trust, improving service uptake, and ensuring care remained culturally responsive and locally relevant. Participants emphasised that sustainable services require not only local innovation, but also supportive national leadership, clear policy direction, and ongoing investment developed in partnership with regional and remote communities.

The findings demonstrate that improving access to specialist oral health care requires more than increasing workforce numbers. Success depends on coordinated clinical networks, clear care pathways, strong community partnerships, empowered local leadership, and supportive national systems.

These observations align closely with current New Zealand based advocacy for rural communities and acknowledges the mahi of Health and Kaupapa Māori providers across Aotearoa New Zealand. It aims to illustrate efforts to improve access, health outcomes, and long-term service sustainability.

Introduction

Rural, regional, and remote communities in Aotearoa New Zealand face significant barriers to oral healthcare due to workforce shortages, limited access to specialist services, geographic isolation, and the cost of care.[1,2] These challenges contribute to delayed diagnosis, preventable disease progression, and poorer health outcomes, particularly for Māori, Pacific peoples, young families, and those living in areas of high deprivation.[1,2]

One in five people live in rural communities.[2,3] Over time, many of these resilient communities have experienced a gradual erosion of local health services.[2,4] As highlighted in national reporting and the media, Te Tai Tokerau (Northland), Te Tairāwhiti, West Coast, South Canterbury and Southland consistently rank among the regions with the lowest dentist-to-population ratios, with fewer than 45 full-time equivalent dentists per 100,000 adults,[4] a threshold associated with workforce shortages and clinic closures in rural communities.[5] Limited face-to-face access to care can deepen isolation and place additional pressure on already stretched rural health providers, including general practitioners, rural doctors, nurses, community health workers, charitable organisations, and informal support networks.[6] These providers are often required to manage complex oral health conditions that would be more appropriately treated within the dental system.[2,7,8]

Compounding these challenges is the limited availability of dental specialist services and the number of dentists being trained.[1,15] People living with intellectual disabilities, head and neck cancer, and complex medical conditions often require specialist-led oral healthcare. Restricted access to specialist care contributes to delayed treatment, preventable disease progression and poorer health outcomes compared with those achieved in well-resourced urban centres.[1,2,8] Specialist oral health services, including oral and maxillofacial surgery, orthodontics, periodontics, endodontics, oral medicine and special needs dentistry, provide care for complex

conditions that cannot be managed within general dental or medical practice. However, these services remain concentrated in major urban centres, underfunded to train future specialists, leaving many rural and remote communities underserved.[4, 7, 8]

In rural and regional settings, care may be delivered by non-specialist clinicians, general practitioners, community health workers, or intermittent visiting services operating in resource-constrained environments. This can result in delay in treatment, disease progression, increased clinical risk, and the expectation that local health professionals work beyond their usual scope of expertise, adding to fatigue and burnout.[9,10] For those who can access specialist services in urban centres, care often involves significant travel, time away from whānau and community, additional transport and accommodation costs, and reduced social support during vulnerable periods of treatment.[2,9]

Rural and remote communities have long advocated for improved access to healthcare services nearer to home.[2,9] The Buller Declaration identified several priorities relating to the healthcare needs of rural communities.[11] Similarly, the New Zealand Dental Association (NZDA) has highlighted rural workforce shortages and continues to advocate for greater oral health equity across Aotearoa New Zealand.[1]

Acknowledging the significant mahi undertaken by rural and remote communities,[2,3] their advocates, healthcare providers, and organisations throughout Aotearoa New Zealand,[10,12] there is value in examining international experiences that may offer complementary insights. The United Kingdom has experience of coordinating specialist dental services across geographically dispersed populations since the development of the National Health Service (NHS) in 1948 and has developed approaches that emphasise accessibility, equity, integration, and sustainable service delivery.[13] This is particularly true for Scotland, placing social justice as a priority via funding and the importance placed on public healthcare.

While many solutions, particularly those developed by and for Māori[14] and Pasifika communities, already exist within Aotearoa New Zealand, international models may provide additional perspectives. Lessons from the United Kingdom may help inform future approaches to strengthening specialist oral health services in rural and underserved communities, while recognising that solutions must ultimately be adapted to the unique cultural, geographic, and health system context of Aotearoa New Zealand.

Key Questions and Themes

There is much New Zealand can learn from international examples of specialist dental care provision to regional and rural areas. This project explored services across Scotland and England to understand how remote communities continue to provide high-quality specialist care despite geographic challenges, workforce shortages, and limited resources.

The site visits focused on five key areas:

- Developing and supporting the specialist workforce
- Integrating or building specialist services within the wider health system
- Outreach and/or visiting specialist models to remote and rural regions
- National level clinical governance and patient safety and its relevance to regional health
- Sustainable approaches to service delivery

The above themes guided discussions, and conversations were intentionally open, allowing participants to share their experiences, challenges, and lessons learned.

Methodology

Specialist oral health care depends on many parts of the health system working together. To understand this, I met with a wide range of people and providers involved in planning, training, leading, and delivering specialist dental services both in England and Scotland.

Site visits included rural and regional NHS health providers, universities, specialist educators, health leaders, and clinical specialists. This provided perspectives from both frontline services

in rural or regional communities through to specialist centres in larger cities who undertake supervision, training, policy development, and workforce planning (Appendix).

With guidance from Professor David Felix (OBE), a national leader in postgraduate specialist dental education, I identified key sites in Scotland where innovative models of care were thriving or responsive to the needs of their community. These connections also led to opportunities to meet with the following experts in their field:

- Dr Tom Ferris
- Dr Steven Johnston
- Dr Alison Milne
- Dr Lee Savarrio
- Dr Alexander Crighton

I interviewed the Chief Dental Officer of Scotland, along with past and present Postgraduate Dental Deans and the Director of Dentistry at NHS Education for Scotland. Their national leadership perspectives helped place local innovations within the broader context of workforce development, service planning, policy, and health system priorities.

To complement the Scottish models, I visited two leading dental specialists in London, at King's College London Dental Institute and the UCL Eastman Dental Institute. These visits explored how specialist training, and sustainable service models are developed to support the delivery of specialist care across England.

Key Learnings

1: Remote centres can deliver high-quality specialist care when supported by strong local leadership and community ownership

Visits to the Balfour Hospital, Orkney, and Dumfries Dental Centre demonstrated the importance of committed local leadership, well-defined clinical pathways, and strong community partnerships in sustaining specialist oral health services in remote regions. Despite ongoing workforce and access challenges, both services have developed innovative models of care that reflect the unique needs of their communities.

Under the leadership of Dr Steven Johnston, Director of Dentistry for NHS Orkney; and Dr Alison Milne, Director of Dentistry for NHS Dumfries and Galloway, these regions have each developed modern, fit-for-purpose facilities that provide safe, effective, and locally responsive care. Located at opposite ends of Scotland, both regions face challenges associated with distance from major urban specialist centres and have responded by investing in infrastructure, workforce development, and community-focused service design.

Orkney: Integrated rural healthcare

The dental service in Orkney is based within the Balfour Hospital, a modern rural general hospital serving approximately 22,000 people across the islands. Designed with extensive community input and opened in 2021, the hospital reflects a true "cradle-to-grave" model of care, providing services ranging from maternity, emergency care, inpatient, and day stay care, rehabilitation, palliative care, and services for older adults. Purpose-built community spaces, including sensory gardens, playgrounds, and quiet areas, contribute to a welcoming environment for patients and families.

Importantly, the dental unit is fully integrated within the wider hospital, providing direct access to medical specialties, operating theatres, and multidisciplinary support. This enables a coordinated approach to patient care while strengthening the sustainability of oral health services.

Orkney's island geography has fostered a culture of self-reliance. The nearest major specialist centre is Aberdeen, approximately 50 minutes by air and can be inaccessible during adverse weather conditions. Consequently, a broader range of oral surgery procedures is undertaken locally. NHS Orkney also works closely with visiting specialists in Oral and Maxillofacial Surgery, Orthodontics, and Restorative Dentistry, ensuring local access to specialist expertise while reducing the need for patients to travel.

Community feedback on the new hospital has been overwhelmingly positive, reflecting the success of combining contemporary healthcare infrastructure with a strong sense of local ownership and identity.

Dumfries: Combining service delivery and workforce development

Dumfries is geographically closer to Glasgow and Edinburgh than many remote Scottish regions, however it continues to experience significant oral health challenges. The NHS region of Dumfries and Galloway has some of the lowest rates of dental registration in Scotland, driven by socioeconomic deprivation and longstanding difficulties attracting and retaining dental professionals who can provide NHS dental services.

In response, Dr Alison Milne has led the development of the Dumfries Dental Centre, a modern public dental facility that integrates patient care with workforce training. The centre provides supervised clinical placements for dental students from the Glasgow Dental Hospital and

School, and dental hygiene trainees, creating a learning environment that benefits both patients and future clinicians. It is the biggest dental outreach training program in Scotland.

Students work alongside experienced clinicians and educators. Patients benefit from improved access to care that is closer to home, reduced waiting times and cost, and high levels of clinical attention, while students gain valuable experience managing a broad range of oral health conditions in a regional setting. Students report increased training exposure to more diverse clinical presentations than they might routinely encounter in urban training centres while being supervised at a high standard. Educators have appreciated the option of living and working outside a major urban centre while still being connected to an academic network or a top academic institution such as The University of Glasgow.

The centre demonstrates how service delivery and education can operate in partnership, improving access to care while strengthening the future workforce. Importantly, it creates a sustainable pipeline of clinicians who gain first-hand experience of regional practice and may be more likely to remain or return to rural communities.

Lessons for New Zealand

Both Orkney and Dumfries and Galloway demonstrate that improving specialist access in remote communities involves more than increasing specialist workforce numbers alone. Success depends on investment in modern facilities, strong local leadership, meaningful community engagement, and service models tailored to local needs which sets up a foundation to attract specialists to the region.

A notable feature of both centres was the presence of respected local leaders with strong ties to their communities. These leaders had built trusted relationships, understood local challenges, and were committed to incremental, long-term improvements in access and workforce

sustainability. Their experience suggests that community-connected leadership can be a critical factor in developing resilient rural or regional healthcare services.

Key Finding 2: National specialist and leadership networks are essential for safety, sustainability, and clinician confidence while maintaining consistent standards for all regions

A consistent theme across interviews with specialist clinicians, educators, NHS leaders, and policymakers was the importance of strong national leadership and professional networks in supporting high-quality oral health care across Scotland. These networks provide mentorship, peer support, case discussion, and access to specialist advice, helping to reduce professional isolation and improve clinical confidence, particularly for practitioners working in regional and rural communities. National initiatives such as the Scottish Dental Clinical Effectiveness Programme (SDCEP) play a key role in translating research evidence into practical clinical guidance [16], ensuring clinicians across the country have access to practical evidence-based resources that support safe and effective care.

Scotland's oral health system combines clear national direction with local flexibility. The legislated role of Chief Dental Officer in Scotland provides independent professional leadership and strategic advice to government, while national programmes such as *Childsmile* demonstrate how coordinated leadership, sustained investment, and a prevention-focused approach can significantly improve oral health outcomes and reduce inequalities [17]. Similar coordination exists within postgraduate education, where national oversight of specialist training is balanced with regional responsibility for service delivery. Scotland has a Dean of Postgraduate Dental Education who is responsible for the planning, delivery, and quality management of postgraduate dental education and training throughout Scotland. Regular collaboration between NHS dental leaders enables shared problem-solving, and the spread of

successful innovations between regions. Split roles between a central hub and regional time may make training positions viable. The need for mapping future specialist needs by demographics and how clinicians work i.e. part time or mixed roles was discussed as being important to inform service delivery.

Although workforce shortages remain a challenge, particularly in remote areas, Scotland has responded through coordinated workforce initiatives, targeted rural recruitment schemes such as the Scottish Dental Access Initiative [18], and strong professional support structures through technology-enabled training which can help with remote supervision or assessment and drastically reduce travel burden. A recurring message from interviewees was that national leadership should establish standards, provide resources and workforce reports that accurately map future specialist needs by regions and demographics, and create enabling policy frameworks, while allowing regions the flexibility to tailor services to local population needs. This balance and aspiration between national consistency and local innovation has helped create a more connected, sustainable, and equitable oral health system.

Scotland's dental system is built on universal access and targeted subsidies, with free dental care for pregnant women, new mothers, and all children. Subsidised, capped-cost treatment for adults, with government contributions aims for affordability. The following policies will be of interest to New Zealand:

- **Risk-based and personalised preventive care for adults** at greater risk of poor oral health via *Caring for Smiles,*
- **Targeted programmes for priority populations**, including older adults, people with additional care needs, people with experience of the justice system, and individuals experiencing homelessness via *Caring for Smiles*
- **A prevention-first approach** with proven success such as *Childsmile*.

Recommendation

For New Zealand, the Scottish model demonstrates the value of a legislated role in government (Chief Dental Officer). A Postgraduate Dean may help New Zealand navigate and advocate for sufficient training positions that accurately reflect all regions of New Zealand with the ability to map future need and design training schemes that will prevent specialist shortages in the future.

Key Finding 3: Shared-care models allow specialist expertise to be delivered through non-specialist clinicians

Remote and rural communities cannot always sustain resident specialist services. Scotland has responded by developing shared-care models that allow specialist expertise to be delivered through local clinicians who are supported by specialists.

Regional NHS health boards work closely with specialist centres to ensure patients can move efficiently between primary, secondary, and tertiary services. Remote communities frequently rely on specialist support from larger centres such as Glasgow, Edinburgh, and Aberdeen, while retaining much of the patient's ongoing care locally.

Technology has strengthened these relationships. The NHS funded 'Near Me' videoconferencing platform has enabled remote consultations, specialist advice, and multidisciplinary case discussions while reducing the need for patient travel. However, clinicians consistently emphasised that telehealth complements rather than replaces face-to-face care, particularly during initial assessment and diagnosis.

Discussions with Dr Alexander Crighton, a highly respected Oral Medicine specialist, highlighted the importance of building long-term relationships between specialists and regional

clinicians. Throughout his career, he has helped develop models of care in which local dental practitioners receive ongoing support, advice, and education while retaining responsibility for aspects of patient management.

When supported by clear protocols, appropriate training, and access to specialist supervision, non-specialist clinicians can safely manage many chronic and high-risk oral conditions following diagnosis. This approach improves access to care, reduces unnecessary referrals and travel, and allows specialist resources to be directed toward patients with the most complex needs.

Existing dental specialist led examples can already be seen in orthodontics, where orthodontic auxiliaries work under specialist supervision to increase treatment capacity and improve access. Similar dentist-led models may offer opportunities within other specialist disciplines in the future.

Recommendation

For New Zealand, structured shared-care arrangements offer an opportunity to improve specialist access without requiring a resident specialist workforce in every rural region.

Key Finding 4: Specialist training must be practical, accessible, and embedded in everyday clinical practice

Educators in Scotland and London highlighted the importance of training that is relevant to real-world clinical practice. Their academic work informs the profession on best standards of care with the aim to disseminate knowledge widely [13]. The multi-disciplinary Facial Pain Clinic at the UCL Eastman Dental Hospital and Professor Tara Renton's work on facial pain are examples of specialist centres of excellence who are approachable and willing to upskill non-

specialists globally with the hope that clinicians may take these skills and adapt them to their own communities to improve patient outcomes.

Participants emphasised that clinicians working in remote locations require education that is practical, flexible, and directly applicable to the challenges they encounter. Academic knowledge alone is insufficient; evidence must be translated into usable tools, accessible guidance, and ongoing educational support.

Several leaders suggested that exposure to rural and regional healthcare settings should form a routine part of undergraduate and specialist training programmes. Such experiences help clinicians develop confidence in managing complexity, understand the realities of rural healthcare, and encourage future careers in underserved communities.

The Dumfries Dental Centre provides an excellent example of this approach. Students gain experience within a regional service while contributing meaningfully to patient care. This model benefits both learners and the local community and creates opportunities for future workforce recruitment.

Scotland has also implemented policies that encourage graduates to remain in the country and consider regional practice. Scotland also has a bonding payment ‘The Dental Student Support Grant’ for NHS retention. Several interviewees emphasised the effectiveness of developing ‘home-grown’ clinicians and leaders. Many of Scotland's most effective rural healthcare leaders have strong personal connections to the communities they serve, contributing to both workforce stability and community trust.

The experience of NHS Orkney illustrates this principle particularly well. Leaders with longstanding connections to their region often possess a deep understanding of local needs and are strong advocates for both their communities and their services.

Recommendation

For New Zealand, there is value in expanding rural training pathways, strengthening regional placements with major universities, and supporting clinicians with local connections to develop leadership roles within their communities.

Key Finding 5: Community partnership strengthens trust and improves uptake of care

Community partnership emerged as a consistent theme across every site visited during the Churchill Fellowship. Services that understand local priorities and adapt to community needs were more likely to achieve sustained engagement, earlier presentation, and improved health outcomes.

Participants noted that communities possess significant local knowledge about what works in their region. Successful services recognise this expertise and work alongside communities rather than imposing externally designed solutions.

The NHS region of Dumfries and Galloway provides a compelling example. The region experiences significant challenges with dental access and registration with substantially lower rates of dental registration than the Scottish average, creating significant unmet need. Dr Alison Milne has observed and understands the determinants of unmet need whether it is clinics linked to bus timetables through to finding safe practicing numbers to staff smaller rural clinics to prevent communities travelling over 80km to their nearest health provider.

In addition, service innovations acknowledge that workforce retention depends on more than salary and financial incentives. Community integration, employment opportunities for partners, quality schooling, and social connections, all contribute to a sense of belonging and influence whether clinicians remain in regional areas over the long term. Dr Milne and her family have

found job opportunities for partners through to creating regular social events where people can meet each other.

The locations of the *Childsmile* programme offers a further example of community-centred care. Through partnerships with families, schools, nurseries, and community organisations, *Childsmile* delivers universal and targeted preventive oral health interventions as a collective approach. Now in its 20th year, this policy has shown to improve outcomes across entire communities and reduce oral health inequalities.

Recommendation

For New Zealand, strengthening relationships between oral health services and communities via clinics or community settings that are closer to home, while offering additional support and intervention for high-risk groups as a whanau or family may improve patient engagement, particularly in rural and underserved regions.

Stakeholders and those doing the mahi

A key benefit of this report is the opportunity to enhance understanding of how specialist oral health services can be delivered effectively in rural and remote communities, while maintaining equitable access to care. For policymakers, funders, and healthcare providers, including Health New Zealand, the findings offer practical insights into strengthening specialist services, improving integration of care, and reducing geographic inequities in access to oral health care.

For funders, I would like to highlight the significant contribution of organisations, community leaders, clinicians, and advocates who are working in this space to improve oral health outcomes and influence health policy within Aotearoa New Zealand. These include the *New Zealand Dental Association*, *Te Ao Mārama Aotearoa Māori Dental Association*, the

Association of Salaried Medical Specialists (ASMS) and *Hauora Taiwhenua*, national organisations that advocate for the health and wellbeing of rural New Zealanders.

It also acknowledges the many clinicians who provide patient-centred care within their local communities such as *Kaitiaki Niho*, an iwi-led oral health initiative operating in Murihiku (Southland), led by Dr Manu-Aroha Walker; through to the work of Dr Wiremu Reihana and Erana Reihana, who co-founded *Oniho 35,* a kaupapa Māori mobile dental and oral health service in Tairāwhiti. Health funders could benefit from understanding their mahi and ideas. As highlighted and written by Dr Walker, while Indigenous communities are increasingly invited into consultation and co-design processes, meaningful decision-making authority and resource control often remain within state structures [14].

Notable examples of leadership and innovation in rural regions include the *Mene Mai Anō* Wairoa Locum Dental Service, as presented to the Waikato Bay of Plenty branch meeting by Dr Ben Sorenson; the *Buller Declaration*, led by Dr Malcolm Mulholland, which advocates for equitable access to services in rural communities and who has undertaken a nation-wide roadshow to hear the health needs and aspirations of communities.

There are many examples of clinicians, advocates and organisations who are sharing their messages of aspiration for their community and this report has highlighted just a few.

Importantly, this research demonstrated that communities striving to improve access to oral health care are not working in isolation. Many of the challenges faced in rural Aotearoa New Zealand are shared internationally, and there is considerable value in connecting clinicians, communities, advocates, and policymakers who are pursuing similar goals. The relationships developed through the Churchill Fellowship create new links between New Zealand, England, and Scotland, providing opportunities for ongoing collaboration, shared learning, and the

development of innovative solutions to improve access to dental specialist care in underserved, regional, and rural communities.

Conclusion

Improving access to specialist oral health care in rural and remote communities is not simply a matter of geography. Rather, it depends on building connected systems, supporting local leadership, investing in people and relationships, and ensuring communities remain at the centre of service design.

The United Kingdom's experience with coordinated specialist services offers examples of how accessibility, equity, and integration can be used sustainably to strengthen specialist oral health capability in remote and underserved populations. Together, these findings suggest that Aotearoa New Zealand has an ongoing opportunity to create a more equitable and sustainable oral health system by combining specialist expertise with strong local partnerships and community-centred models of care.

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Further Reading

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Appendix

The following is a list of people whom I met and interviewed during my research trip. I am grateful for their contribution.

Date	Name	Organisation	Location	Relevance
28/8/25	Dr Emma Hayes	Kings College Hospital NHS Foundation Trust	London	Consultant in Oral Medicine & Facial Pain; expert on service and training provision
3/9/25	Dr Roddy McMillan	University College London Hospitals NHS Foundation Trust	London	Consultant in Oral Medicine & Facial Pain: Eastman Multidisciplinary Facial Pain Meeting; expert on service and training provision
5/9/25	Dr Steven Johnston,	Director of Dentistry, NHS Orkney	Kirkwall, Orkney	Regional service provision and tour of The Balfour Hospital, Orkney
8/9/25	Dr Alexander Crighton	Consultant in Oral Medicine (Scotland and England)	Edinburgh	Expert on NHS specialist care and professional networks in Scotland
8/9/25	Dr Tom Ferris	Chief Dental Officer in Scotland, Scottish Government	Edinburgh	Role of Chief Dental Officer & national policy
11/9/25	Dr Alison Milne	Director of Dentistry, NHS Dumfries and Galloway	Dumfries	Regional service provision and tour of The Dumfries Dental Centre
12/9/25	Professor David Felix (OBE)	Former Dean of Postgraduate Dental Education and Director of Dentistry at NHS Education for Scotland	Glasgow	Extensive experience of the structure of postgraduate education within the UK, overseas and key strategic UK-wide roles.
12/9/25	Dr Lee Savarrio,	Dean of Postgraduate Dental Education and Director of Dentistry at NHS Education for Scotland	Glasgow	Planning, delivery and quality care outcomes for a capable and resilient postgraduate workforce in Scotland
New Zealand				
7/8/25	Dr Robin Whyman	New Zealand Dental Association – Director Dental Policy	Rotorua via zoom	Clinical leadership, health policy, governance and workforce
24 & 25/7/26	Multiple speakers	NZ Society of Hospital and Community Dentistry Conference	Rotorua	First hand case studies on regional care in New Zealand
7/8/26	Multiple speakers	ANZAOMS	Christchurch	Case studies on regional care from OMS and Orthodontic Specialists
27/8/26	Multiple speakers	NZDA Conference	Auckland	Dental Profession
13/10/26	Professor Tara Renton OBE	Emeritus Chair Oral Surgery Kings College London	London via zoom	Global expert on facial pain, nerve injuries and education.