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Submission on the Health (Fluoridation of Drinking Water) Amendment Bill

Thank you for the opportunity to provide a response to the Health (Fluoridation of Drinking Water) Amendment Bill.

The following submission has been prepared by the Auckland Regional Public Health Service and the three Auckland district health boards (DHBs), Auckland, Waitemata and Counties Manukau Health.

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Yours sincerely

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KEY RECOMMENDATIONS

The Auckland Regional Public Health Service (ARPHS), and the three Auckland district health boards (DHBs), strongly support community water fluoridation (CWF) as the most cost-effective population-based strategy for improving oral health.

In April 2016 the government announced its intention to transfer decision-making for CWF from territorial local authorities (TLAs) to DHBs. The introduction of the Health (Fluoridation of Drinking Water) Amendment Bill (the Bill) formalises this decision and outlines the process DHBs must follow when making CWF decisions.

ARPHS and the three Auckland DHBs support the Bill's intent and recommend that the Health Committee:

- Rewords section 69ZJA (3) to ensure its interpretation is unambiguous.
- Ensures DHB assessments to determine whether to fluoridate a drinking water supply are based on the assessment of health benefits and there is not an expectation of other non-health assessments, outside the reasonable scope of expertise of DHBs.
- Considers the financial implications of the Bill for DHBs, and that financial assistance may be required.

Benefits of fluoridation

1. The scientific and dental consensus is that CWF is the most cost-effective population-based strategy for dental caries prevention for all ages across the socio-economic spectrum. It is especially beneficial for those without access to regular dental care.
2. The New Zealand Prime Minister's Chief Science Advisor, Sir Peter Gluckman and the president of the Royal Society of New Zealand, Sir David Skegg, agree with the verdict of public health authorities worldwide; that CWF is the most effective public health measure to reduce the prevalence and severity of dental caries.[1]
3. The New Zealand Oral Health Survey[2], a cross-sectional survey involving face-to-face interviews and dental examinations, demonstrated that although New Zealanders' oral health has improved over time, the country has a relatively high-caries population.
4. Analysis of the New Zealand Oral Health Survey showed that children, adolescents and adults living in fluoridated areas had significantly less lifetime decay than those in non-fluoridated areas. It found no significant differences in the prevalence of fluorosis, a possible side-effect of too much fluoride during tooth development.
5. Significant differences in decay rates persist between populations supplied with fluoridated and non-fluoridated drinking water, even when the majority of people use fluoride

[1] Health Effects of Water Fluoridation: a Review of the Scientific Evidence. (2014). A report on behalf of the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor.
http://royalsociety.org.nz/media/2014/08/Health-effects-of-water-fluoridation_Aug_2014_corrected_Jan_2015.pdf

[2] Ministry of Health, Our oral health: Key findings of the 2009 New Zealand Oral Health Survey, 2010, Ministry of Health: Wellington.

toothpaste. At present, 85 percent of Auckland's population receives fluoridated water and, as such, has better oral health than unfluoridated parts of New Zealand[3].

6. Dental decay is the most prevalent chronic and irreversible disease in New Zealand[4]. We experience significant disparities in both oral health and access to preventive and treatment-focussed dental care. CWF, which works irrespectively of an individual's behaviour, ethnic or socio-economic status, offers an important opportunity for addressing inequity. We consider that it is an effective component in helping to address health inequity in the Auckland region.

Rewording of section 69ZJA (3)

7. ARPHS and the three Auckland DHBs support the inclusion of section 69ZJA(3) as it recognises the need for DHBs to agree before a decision is made on whether to fluoridate drinking water supply systems that cross DHB boundaries. However, we consider section 69ZJA(3) should be amended to ensure it is not invoked when a water supply does not cross DHB boundaries, even though other networks in those DHBs' areas might do so.
8. The current wording of this section does not consider drinking water networks or infrastructure that do not interconnect and that operate as stand-alone entities.
9. For instance, the Auckland region is governed by a unitary authority, Auckland Council. One of its council-controlled organisations, Watercare, provides reticulated drinking water services to the majority of Aucklanders, who reside within the Waitemata, Counties Manukau and Auckland DHB geographical areas. That network is interconnected. However, Watercare also owns and operates drinking water schemes in areas that are not connected to its metropolitan network, and these schemes supply populations entirely contained within single DHBs' geographical areas. There is no need in these cases for the relevant DHB to reach an agreement with the other DHBs in Auckland.
10. As currently worded, section 69ZJA(3) could be interpreted to mean that a DHB cannot make a direction for such standalone networks unless other DHBs agree because the supplier, Watercare, also services their populations through another network.
11. We consider the nature of the drinking water infrastructure should be the central focus in the provision and not the supplier. To ensure the provision reads as intended, we suggest the following ought to be amended from:

> (3) If a local government drinking-water supplier supplies drinking water within more than 1 geographical area and any of the affected district health boards wish to make a direction,—
>
> (a) all affected district health boards must consider the matters in subsection (2) together, as if the resident population of each district health board were 1 resident population; and
>
> (b) an affected district health board must not make a direction unless all affected district health boards agree.

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[3] NZ Health Statistics. Age 5 and Year 8 oral health data from the Community Oral Health Service. http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/oral-health-data-and-stats/age-5-and-year-8-oral-health-data-community-oral-health-service

[4] Ministry of Health, Our oral health: Key findings of the 2009 New Zealand Oral Health Survey, 2010, Ministry of Health: Wellington

to:

(3) If *a drinking-water distribution system* supplies drinking water within more than 1 geographical area and any of the affected district health boards wish to make a direction,—

> (a) all affected district health boards must consider the matters in **subsection (2)** together, as if the resident population of each district health board were one resident population; and
>
> (b) an affected district health board must not make a direction unless all affected district health boards agree.
>
> (b) a district health board can make a direction for a stand-alone network without seeking the agreement of other unaffected district health boards.

This clause is not applicable if a drinking-water system does not cross district health board boundaries.

DHBs assessment requirements for making a direction

12. We strongly believe the extent of analysis DHBs should be required to undertake before making a direction on whether to fluoridate a drinking water supply should be restricted to assessing the health benefits.
13. The Cabinet paper states that DHBs will need to assess the circumstances related to any particular water supply as part of its decision to fluoridate a nominated water supply. In particular, section 69ZJA(2)(iii) refers to DHBs needing to consider the financial cost of adding fluoride to a drinking water supply, including any ongoing management or monitoring costs of adding fluoride, when undertaking its assessment. This implies that the DHBs will need to have an understanding of the capabilities of drinking water systems, and the financial costs of maintaining and monitoring the addition of fluoride to a drinking water supply.
14. We consider local authorities are best placed to determine the cost of fluoridating a drinking water supply. These costs, primarily capital and ongoing maintenance, materials and monitoring costs, will be relatively easy for local authorities to determine and this work would be integral to any implementation.
15. However, undertaking a cost-benefit analysis is less straight forward. For example, assessing the economic benefit of individuals having more of their own teeth intact over their lifetimes – even if that were possible – is likely to require the application of economic assessment techniques that are outside the expertise of DHBs. New Zealand currently collects childhood oral health data but this is limited to primary school aged children.
16. While we understand standard tools are to be developed to help with assessment, it is our view that DHBs should not have to undertake economic cost-benefit analyses when determining whether fluoridating drinking water supplies would improve dental health, in each and every instance.

Cost considerations of undertaking assessments

17. ARPHS and the three Auckland DHBs accept that the potential financial impact on DHBs for undertaking assessments will be dependent on how extensive the assessment requirements would be under the standardised national tools, which are yet to be determined. Nonetheless, we consider the financial implications of all DHBs undertaking assessments needs to be considered. The Cabinet paper suggests that the Ministry of Health may need to provide additional financial support to DHBs. We endorse the need for the provision of such assistance if such assessments were required.

Conclusion

18. ARPHS and the three Auckland DHBs thank you for the opportunity to submit on this Bill. Although oral health in New Zealand as a whole is improving, this country still has a relatively high caries population; and it has significant ethnic and socio-economic disparities in both oral health and access to preventive and dental treatment. CWF is universally endorsed by the scientific community as a safe and effective, population-based oral health strategy, and it is especially beneficial in addressing inequalities in dental health. We wish to see the improvement in all New Zealanders' oral health continue, and CWF will play a significant role in achieving this goal.

Appendix 1 - Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Counties Manukau Health and Auckland and Waitemata District Health Boards).

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, infrastructure requirements, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.