

**Submission
No 21**

**INQUIRY INTO INQUIRY INTO CHILDHOOD
OVERWEIGHT AND OBESITY**

Organisation: Australian Dental Association NSW Branch

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Sarah Dunn
Senior Council Officer | Upper House Committees
Parliament of New South Wales

By email: Committee.SocialIssues@parliament.nsw.gov.au

Dear Ms Dunn,

Attached is the Australian Dental Association (NSW) submission into the Upper House Inquiry into Childhood Overweight and Obesity. Thank you for this opportunity.

ADA NSW would be happy to discuss any information provided in this submission, should further information be required.

Regards,

Ian Burgess
Chief Executive Officer
Australian Dental Association (NSW Branch) Limited

AUSTRALIAN DENTAL ASSOCIATION NSW SUBMISSION INTO CHILDHOOD OVERWEIGHT AND OBESITY

INTRODUCTION

The Australian Dental Association NSW (ADA NSW) is the peak professional body representing dentistry in NSW and the ACT. ADA NSW welcomes this Upper House Inquiry into Childhood Overweight and Obesity.

The inquiry calls for the potential for collaboration with the non-government and private sectors on strategies to reduce childhood overweight and obesity (Terms of Reference F). As dentists work at the coalface of dental care delivery and are well placed to provide advice and work with government on the prevention and management of chronic disease, ADA NSW would like to partner with other organisations to collaborate on these strategies. This requires collaboration and commitment of oral health professionals with other professions and service providers across health, community and education sectors.

The ADA NSW submission regarding this inquiry is based on the evidence that oral health and obesity share some common risk factors, and both obesity and poor oral health tend to cluster in population groups with a lower socioeconomic status. ADA NSW, therefore, recommends an integrated risk factor approach by directing action to the social determinants of obesity and oral health and the common risks affecting both. For these reasons, this submission addresses the Inquiry's Terms of Reference F and G (other related matters).

INQUIRY TERMS OF REFERENCE F AND G

OBESITY AND ORAL HEALTH

Consumption of free sugars is a risk factor both for dental caries and obesity. The World Health Organisation (WHO) ¹ defines free sugars as

- monosaccharides (such as glucose and fructose) and disaccharides (such as sucrose or table sugar) added to foods and drinks by the manufacturer, cook or consumer, and
- sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates.

In May 2015, WHO issued recommendations on the consumption of free sugars to reduce the risk of non-communicable diseases (NCDs) in adults and children, with a particular focus on the prevention and control of weight gain and tooth decay. This was in recognition of the rapidly growing epidemic of overweight and obesity around the globe and its role as a risk factor for several NCDs. In addition, dental caries is the most common NCD, and the cost of treatment places a heavy burden on healthcare budgets in many countries.

Based on analysis of the latest scientific evidence, WHO¹ issued a guideline recommending that daily sugar intake be reduced to 10% of total energy intake (with a further reduction of 5% recommended). The research also confirmed that children with the highest intake of sugar-sweetened drinks were more likely to be overweight or obese than children with a low intake of sugar-sweetened drinks.

Historically, numerous independent expert and consensus reports have concluded that sugars are the most important dietary factor in the development of dental caries. However, recommendations have not yet been developed through systematic review of the evidence.

Recently an in-depth systematic literature review conducted by WHO ² concluded that free sugars are the primary necessary factor in the development of dental caries. The review also demonstrated a dose–response relationship between free sugar intake and the progressive lifelong development of caries. This situation results in a substantial dental health burden throughout life.

There is a strong relationship between deprivation and both obesity and dental caries in children. Dental caries and obesity are largely diseases of social deprivation and their control is as much about improving the social environment as about intervening to improve the oral environment.

There is now evidence that obesity is associated with periodontitis and dental decay. Overweight children have also been shown to be more likely to have dental decay than non-overweight children^{3, 4}. A recent study has shown that childhood obesity is associated with reduced flow rate of saliva and dental decay⁵.

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The World Oral Health Report⁶ stated clearly that the relationship between oral health and general health is proven by evidence. Evidence clearly demonstrates that oral diseases are not just limited to the mouth, but importantly are linked to general health overall. This is an important connection in terms of preventing chronic disease and disability, and reducing healthcare costs.

WHO recommends public health solutions for oral diseases are most effective when they are integrated with those for other chronic diseases and with national and state public health programs. An integrated common risk factor approach, where health is promoted by controlling a small number of risk factors, potentially at a lower cost than a disease-specific approach, has been widely promoted and accepted⁷.

CASE FOR ACTION

Dental decay, although preventable, is the second most costly diet-related disease in Australia, with an economic impact comparable to heart disease and diabetes⁸. In Australia, young children have the highest rates of preventable hospitalisations due to dental conditions, and efforts to reduce such rates reduce cost and resource burden on the hospital system⁹.

Children have been identified as a priority population in state and national oral policy documents in Australia. Improvements to children's oral health and prevention of dental caries will reduce the overall burden of disease and improve long-term oral health across the population. Good oral habits should be established early, when children are learning about health priorities, developing taste preferences for foods, and developing respect for their bodies.

Poor oral health detracts from children's quality of life: they experience pain, discomfort, disfigurement, acute and chronic infections, and eating and sleep disruption as well as higher risks of hospitalisation, high treatment costs and loss of school days with the consequently diminished ability to learn. Caries affect nutrition, growth and weight gain. Toothache and infection alter eating and sleeping habits, dietary intake and metabolic processes. Disturbed sleep affects glucocorticoid production. In addition, there is suppression of haemoglobin from depressed erythrocyte production.

A focus on preventive and early intervention strategies will help reduce more serious decay and infection, reducing admissions to hospitals for removal of teeth under anaesthetic.

In NSW, dental decay is one of the most prevalent chronic diseases in childhood with 40% of children aged 5–6 years having untreated — or having experienced — dental disease. This is significantly higher for certain populations, including Aboriginal children (2.5 times higher), children from a lower socioeconomic background, children living in remote/very remote areas (up to 6 times higher), and children of mothers born in non-English speaking countries¹⁰.

While we hear a lot about the impact of sugar on major health issues – such as diabetes, obesity and cardiovascular disease – surprisingly, we hear less about the impact on oral health. Every day, in dental hospitals across New South Wales, children as young as 3 or 4 are being wheeled into theatre to have serious dental surgery under general anaesthetic to repair the damage done by soft drinks.

Children aged less than 5 years who require the removal or restoration of teeth due to dental caries are likely to be hospitalised in order to access general anaesthesia. Trends of hospitalisation rates for the removal or restoration of decayed teeth among NSW children under 5 years for the years 2001-2 to 2012-13¹¹ can be seen in figure 1. In 2012-2013 the hospitalisation rate for removal and restoration of teeth for dental caries was 312.2 per 100,000 population.

WHO recommends that country-level programs to combat obesity should include economic tools, such as taxes and subsidies, to improve the affordability of healthy food products and discourage the consumption of unhealthy options. Sugar-sweetened beverages are the most commonly recommended target for food taxes, primarily due to the strong association with poor health, oral health and obesity¹². Many countries have enacted food taxes to improve population health, most notably Mexico, France, Hungary, United Kingdom, Switzerland and a number of countries in the Western Pacific.

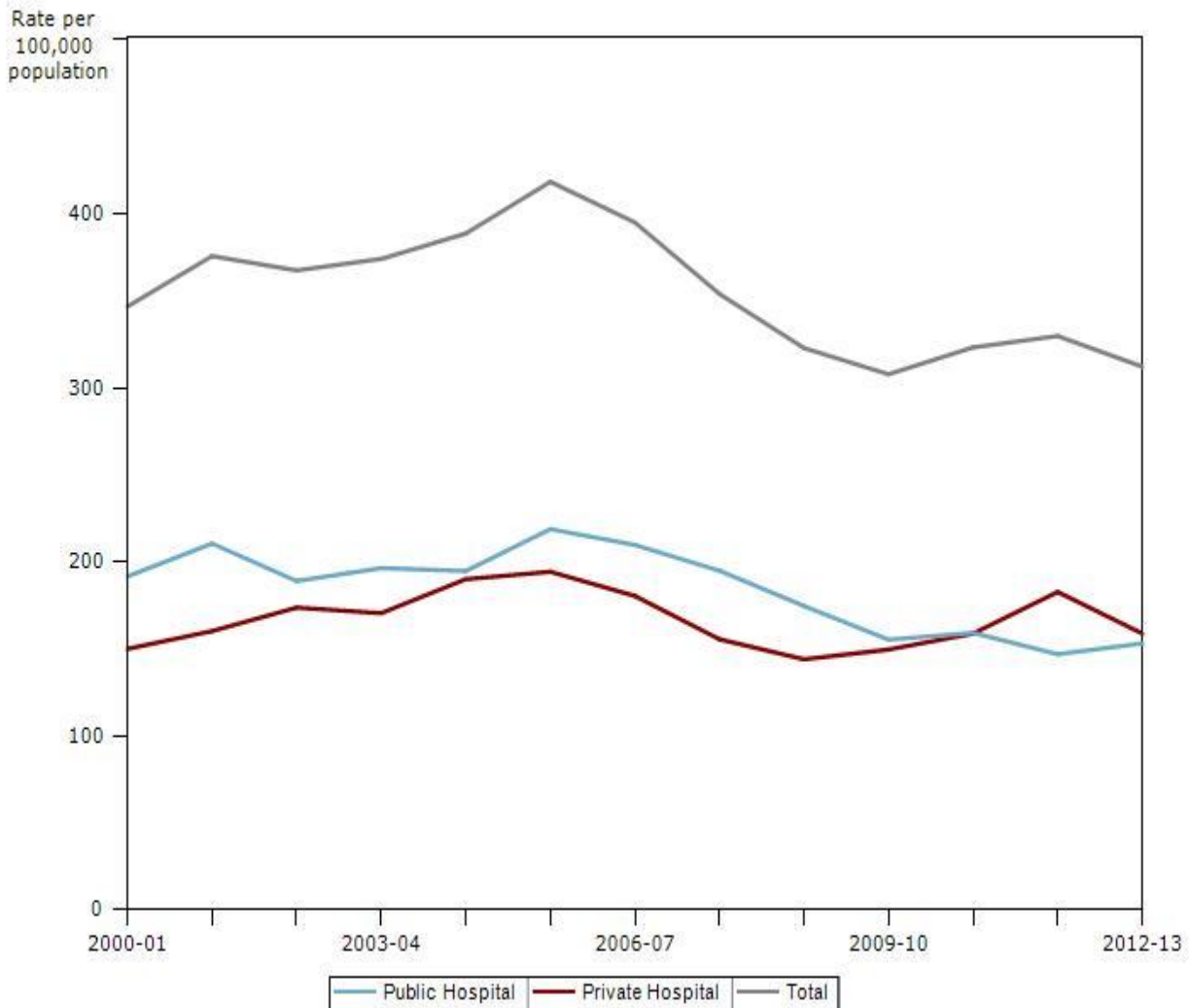
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Recent Australian research¹³, modelling the impact of a tax on sugar-sweetened beverages on health and health care costs, estimated the tax would generate an estimated AUD400 million in revenue each year. The study demonstrated the tax has the potential to reduce the burden of disease attributable to consumption of sugary drinks and the associated health care costs. The authors recommend, drawing on their evidence and international experience, a tax on sugar sweetened beverages should be considered in Australia.

ADANSW believes upstream measures, such as a tax on sugar sweetened beverages will be most effective in halting the epidemic of diet-related diseases – tooth decay, obesity and diabetes – that are overwhelming our children. Other leading professional organisations in NSW and Australia have also called for the tax on sugary drinks.

Figure 1

Removal and restoration of teeth for dental caries: hospitalisations by hospital type, children aged 0-4 years, NSW 2000-01 to 2012-13



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RECOMMENDATIONS

Profound inequalities in oral health provision have been well documented in NSW and Australia. In the New South Wales Council of Social Services' recent poll of people on low incomes, respondents nominated timely, affordable dental care as the number one policy that would make a difference in their lives and the lives of their families. Despite the overwhelming evidence of the burden of oral health and the fact that physical, mental, social and financial costs of poor oral health can further cement existing social inequities, oral health has not been identified as a health priority.

Prevention of childhood overweight and obesity is a priority for the NSW Government and has recently been identified as a priority by the State Premier. These are compelling reasons for an integrated risk factor approach by directing action to the social determinants of obesity and oral health and the common risks affecting both. Upstream interventions that impact on the social determinants of health and foster supportive food environments are recommended as part of the common risk factor approach which could have the potential to impact on both obesity and oral health of the NSW population.

ADA NSW RECOMMENDS THAT THE NSW GOVERNMENT

1. Implement a truly comprehensive, multi-sectoral, adequately funded, across-government, long-term program to address obesity and dental decay in vulnerable children and adolescents, and reduce growing inequalities in health and oral health.
2. Advocate and work with Commonwealth Government to impose a tax on sugar-sweetened beverages.
3. Support fiscal, policy and legislative changes to support WHO guidelines to limit intake of free sugars to less than 10 % of total energy intake. This equates to approximately 50 gm (around 12 teaspoons) per day.
4. Ensure the WHO guidelines to limit intake of free sugars to less than 10 % of total energy intake, along with existing NSW dietary guidelines, are incorporated into public health interventions which seek to reduce sugar intake.
5. Support Initiatives to improve the accessibility and affordability of healthy food for children and young people in low-income families and other at risk groups.
6. Support the urgent need for tighter and enforceable controls on the advertising, promotion and labelling of food and drinks containing free sugars, especially those targeting children and young adults.
7. Consider strategies to reduce the marketing of sugary food and drinks, and working with manufacturers to reduce hidden sugar content in processed foods.
8. Work with pharmaceutical companies to reduce the production of sugar-sweetened medicines.

ADA NSW is committed to reducing inequalities in oral health and obesity, and looks forward to partnering with NSW government and other organisations to collaborate on these recommendations and other initiatives that may be identified by the Inquiry.

We would welcome the opportunity to answer any questions in relation to this submission, including appearing at a hearing.

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