New Zealand Dental Association Position Statement on Child Oral Health
Adopted March 2013

1. Background

1.1 Our unique dental health system for children in New Zealand

Until very recently, dental care for children in New Zealand has been largely provided in school-based dental clinics by dental therapists (the School Dental Service) with support of private and hospital-based general and specialist dentists. Despite a high level of child enrollment (95%) in the service, and a very high restorative index (84% in the primary dentition of 2-11 year olds, MOH 2010) the improvements in child oral health in New Zealand have not been superior to other countries.

Early in the 21st century, the New Zealand government funded the upgrade and re-orientation of the clinical facilities in this primary care service, now known as the Community Oral Health Service. Alongside the facility changes, an opportunity arises for changes in the model of care to follow the principles of the strategic document Good Oral Health for All for Life (Ministry of Health, 2006) and the Ottawa Charter. Emphasis needs to be placed on oral health as an essential and inseparable component of general health, as well as on the promotion of good oral health and prevention of oral disease in a society and environment that supports good oral health. “Good oral health for all, for life, starts with promoting oral health for the youngest and most vulnerable members of our society” (Ministry of Health, 2006).

1.2 Oral health and general health

Oral health is a vital component of general health. Good oral health results from establishing and maintaining a nutritious diet (low in sugar and acid), and good oral hygiene practices during childhood. This is essential for individuals to enjoy good oral health for life.

Specific oral health risks arise from causes including poor food security, poor dietary choices and non-ideal oral hygiene practices. Deleterious dietary behavior includes grazing, snacking and frequent consumption of foods and drinks with high sugar and/or acid content.

Parents and caregivers are responsible for the oral health of the children in their care. Oral health and dietary advice can be given by dental professionals and appropriately trained healthcare workers.
The risk factors for poor oral health are closely aligned to those for systemic conditions such as overweight, obesity and type 2 diabetes, so efforts to improve oral health are also likely to improve the general health of New Zealand children (and adults).

1.3 Use of fluoride

Fluoride is a natural element and it works in three ways to help protect our teeth from decay:

- Fluoride helps to repair the early stages of dental caries.
- Fluoride interferes with the growth of the bacteria that cause dental caries.
- Fluoride makes teeth more resistant to dental caries by strengthening the tooth surface.

Water fluoridation has been proven to be a safe and effective public health measure to reduce dental caries. Not all water supplies in New Zealand are optimally fluoridated. Therefore increasing the proportion of the population who can access optimally-fluoridated water will provide this oral health benefit to more of the New Zealand population.

Fluoride is also available in toothpastes, in professionally applied varnishes and gels, and in mouth rinses.


1.4 Oral Health Services

All children in New Zealand are entitled to high quality oral health care including diagnosis, prevention and treatment services to improve and maintain their oral health. Children are entitled to care by dental professionals with appropriate skills and training. Equivalent services should be available throughout the country. These services should include (but not be limited to)

- Prevention and management of dental caries, erosion and periodontal disease
- Prevention and management of dental trauma
- Timely and appropriate access to specialist services including paediatric dentists and orthodontists as required
e.g. comprehensive treatment under general anaesthetic, specialist care for management dental anomalies (e.g. amelogenesis imperfecta), and management of severe malocclusion or craniofacial deformities (e.g. cleft lip and palate).

Some children may be at particular risk of developing dental disease.

Such groups include, but are not limited to:

- Children from low income families
- Maori and Pacific children
- Those living in rural or isolated communities
- Recent immigrants
- Children with special healthcare needs or developmental conditions
- Children with orofacial anomalies

These children should receive targeted enhanced, culturally appropriate, preventive dental care and appropriate treatment to aid in the reduction of oral health inequalities.

2. **Policy**

2.1 Parents and caregivers have the primary responsibility for the oral health of the children in their care.

2.2 Oral health and dietary advice should be readily accessible to parents, maternity & child health professionals and others involved in the care of children both inside and outside their home (such as early childhood teachers).

2.3 Nutritious foods should be accessible and affordable.

2.4 Marketing and advertising of high sugar and/or acid-containing foods and drinks should not be targeted to children, adolescents, their parents or caregivers.

2.5 Role models in New Zealand society have an obligation to promote behaviours to establish and maintain nutritious diets and optimal oral health.

2.6 High sugar and/or acid-containing processed foods should be taxed and direct advertising banned in a similar way to that of tobacco.

2.7 All children should have access to a fluoridated water supply.

2.8 All New Zealand children are entitled to high quality oral health care including diagnosis, prevention and treatment services to improve and maintain their dental health. There may be a need for targeting of these services to ensure that they can be freely accessed by those most in need,
while allowing other families to access private care.

2.9 There must be a concurrent focus on prevention and treatment of dental caries and erosion in both the deciduous and permanent dentitions.

2.10 Children should receive care provided by dental professionals with appropriate skills and training.

2.11 Equivalent services should be available throughout the country.

2.12 Child oral health services should include (but not be limited to)
   a) Prevention and management of dental caries, erosion and periodontal diseases
   b) Prevention and management of dental trauma
   c) Timely and appropriate access to specialist services as required

2.13 Children at particular risk of dental disease should receive enhanced targeted preventive dental care and appropriate treatment to aid in the reduction of oral health inequalities.

References


Ottawa Charter for Health Promotion 1986, WHO (http://www.who.int/healthpromotion/conferences/previous/ottawa/en)