Health (Fluoridation of Drinking Water) Amendment Bill

Submission by
Dr Keith T Blayney MBChB; Dip Obs; FRNZCGP
South Taranaki General Practitioner

Background to this submission:

In 2012 South Taranaki Dentists approached the South Taranaki District Council asking them to fluoridate the water of the socially deprived communities of Patea and Waverley because of the very high incidence of dental caries in these communities and the inability of many (but not all) to pay for private dental care.

A representative of this group has his private dental practice in the same building as my general practice and he approached me asking for medical input on the validity of claims by anti-fluoride groups on the medical harm of fluoridation as this appeared to have swayed the New Plymouth District Council to withdraw Community Water Fluoridation (CWF) the previous year (2011), despite input from the Taranaki District Health Board (TDHB).

As a New Zealand trained Vocationally Registered General Practitioner, looking at quality of evidence, literature reviews and differentiating "pseudoscience" from evidence based best practice is second nature and so I took on this task having heard some of the apparent alarming claims of the anti-fluoridation groups. I then researched each and every claim back to source studies (if they existed) and wrote an extensive (indexed) submission to the STDC [see http://www.drblayney.com/Blayney-Fluoride.pdf]. This review was made before the Sir Peter Gluckman / Royal Society of New Zealand 2014 report "Health Effects of Water Fluoridation: a Review of the Scientific Evidence" [http://www.royalsociety.org.nz/media/2014/08/Health-effects-of-water-fluoridation_Aug_2014_corrected_Jan_2015.pdf].

Given the ineffectiveness of the TDHB in providing adequate rebuttal to the very strong lobbying from anti-fluoride groups such as Fluoride Free New Zealand and New Health New Zealand Inc. in New Plymouth in 2011, I decided to keep my submission separate and independent of any TDHB input. As an independent (non-PHO aligned) GP, I also made it clear that there were no political or financial influences on my submission. In my oral submission I further rebutted all unscientific claims made by other written submissions. This proved to be significant as STDC Councillors later informed me that my review of claims had the greatest influence on the decision by the STDC to recommend introduction of CWF to Patea and Waverley. It was also used by the STDC legal team to prove that the STDC had considered all the evidence in subsequent court cases, Judicial Reviews and Appeals.

Submission:

It is my view that both Territorial Authorities (TAs) and District Health Boards (DHBs) are not the proper bodies to decide on the scientific evidence (now or in the future) on safety and

effectiveness of CWF. This must be done at a national level and by appropriate scientists (epidemiologists as well as medical and dental clinicians) reviewing both worldwide and New Zealand evidence. Clinicians are essential as we are trained to consider the effect of any population health measure on individuals and are legally and ethically required to ensure those measures put individual health and safety over convenience or cost.

Local Councils

- [Option 1: Maintaining the status quo: local authority decision-making]
- [Option 2: Status quo plus guidelines]
- [Option 3: Financial incentives for water fluoridation]

It is clear that members of local councils are generally not scientists or lawyers and may be swayed by unscientific claims from anti-fluoride groups and individuals. It is unacceptable that non-scientists make decisions on the validity of scientific research.

In the case of the STDC, despite a decision to add fluoride to the Community Water in Patea and Waverley in 2012, Court Cases, Judicial Reviews and Appeals by New Health New Zealand Inc (all of which have been decided in favour of the STDC), the Council has felt intimidated enough not to progress with CWF for four years.

The High Court ruling (NEW HEALTH NEW ZEALAND INC v SOUTH TARANAKI DISTRICT COUNCIL [2014] NZHC 395 [7 March 2014]) [see http://www.nzlii.org/cgi-bin/download.cgi/cgi-bin/download.cgi/download/nz/cases/NZHC/2014/395.pdf] was that "New Health's application to review the Council's decision fails." but this was appealed. In the NEW HEALTH NEW ZEALAND INCORPORATED v SOUTH TARANAKI DISTRICT COUNCIL [2016] NZCA 462 [27 September 2016], the Court of Appeal also found in favour of the STDC (including costs) [see http://img.scoop.co.nz/media/pdfs/1609/NewHealthvSthTaranaki.pdf]. However it included the provision "Leave is granted to the appellant to adduce further evidence on appeal.". This unfortunately has delayed the introduction of CWF further, so children born in 2012 will be at school in Patea and Waverley with far more dental caries despite all the education on diet, teeth brushing etc (and many face General Anaesthetics for major dental work) all because misguided lobby groups can hold local councils in fear of court action.

Options 2 and 3 may be slightly better but they do not remove the influence of anti-fluoride groups (including standing for Council with an anti-fluoride agenda) or the risk / threat of legal challenges.

District Health Boards

- [Option four: Decision-making by district health boards]

What may not be clear to the Subcommittee, or to Parliament as a whole is that DHBs' decisions are (also) made by mostly non-scientists and are influenced far more by short-term economic, political, and perception factors. Board Members of DHBs may have been motivated to stand (or be selected) on non-scientific grounds (such as an anti-fluoride belief) and are largely advised by managers with accounting, management and sometimes distant clinical backgrounds. Community, Primary, Population and Dental managers are unlikely to

be practising dentists (who are too busy seeing the mass of low socioeconomic patients with dental caries) or epidemiologists. At best we get ex-Dental Therapists who are not trained to analyse scientific evidence. It is clear from the Taranaki situation that the local DHB was ineffective in convincing the New Plymouth District Council that CWF was safe and effective.

The Health (Fluoridation of Drinking Water) Amendment Bill does not make life any easier for DHB members than TA Councillors. Members are expected to "consider... scientific evidence on the effectiveness of adding fluoride to drinking water in reducing the prevalence and severity of dental decay;" [69ZJA (2)a] even if they have no scientific training and are likely to be advised by managers with no understanding of epidemiology, toxicology or assessing scientific evidence. They are also expected to "consider... whether the benefits of adding fluoride to the drinking water outweigh the financial costs" [69ZJA (2)b], which is like re-inventing the wheel as the studies show it is highly cost-effective, but not necessarily in the short-term, so financial pressures may well colour their opinion. They must also consider "the state of the oral health of its resident population" [69ZJA (2)b1], which might be difficult when DHB managers underplay the extent of the dental caries in areas like the most southern part of the TDHB and move community clinics away from schools and into Hawera Hospital making access very difficult, particularly for Maori children.

This option does not remove the threat of legal or protest action or people standing on anti-fluoride agendas (often also holding anti-vaccination beliefs).

Central / national decision making

- [Option five: Decision-making by the Director-General of Health]
- [Option six: A legislative requirement to fluoridate]

New Zealand is just too small to have 20 different policies on important public health measures such as CWF. The more decentralisation with decisions made by non-experts, the patchier and poorer the outcome. Health policies that are nation-wide such as immunization schedules, childhood cancer management, iodising salt, car safety/quality etc work well, but allowing 20 DHBs (or 32 PHOs) to make non-evidence based health decisions has been, I believe, a major drain on the health expenditure with little, if any health gain. We need a nationally consistent, mandatory, evidence based approach.

In Option 5, the Director General of Health is unlikely to make any decisions without referring to top dentists, physicians and epidemiologists so we should get an evidence based approach. Also the Director could easily change instructions eg on ideal levels of fluoridation as and when future evidence indicates. Having nationally consistent standards and requirements could also lead to cost reductions with standardised equipment and bulk buying of sodium fluoride, sodium fluorosilicate or hydrofluorosilicic acid (HFA).

However this option may create considerable work for the Ministry of Health unless a general policy is made, such as "fluoridate all community water supplies except under a certain size or when a valid objection exists (i.e. excluding unscientific claims)". That is essentially Option 6.

In Option 6 we also get a nationally consistent and (hopefully) an evidence based approach. It

has a "built in" exemption option but initially has to convince a majority of MPs to accept something that may appear to be a little draconian.

Summary

I strongly support either Options 5 or 6. Option 4 is certainly better than options 1-3, but plagued by similar issues where non-scientists make scientific decisions with potentially poor advice. Economic, ethical, medical and dental factors strongly favour Community Water Fluoridation so this should become a nationally mandatory and consistent public health measure decided nationally by those who have all the evidence and skills to interpret that evidence and apply it in a consistent and ethical manner.

Having room for exemptions is essential but the expected norm, particularly in low socio-economic areas, should be CWF as this is one of the most important health inequity reducing measures any Government should support.

Dr Keith T Blayney MBChB; Dip Obs; FRNZCGP
South Taranaki General Practitioner