



**AUSTRALIAN DENTAL
ASSOCIATION INC.**

**Submission to the
Australian Communications and Media Authority
on the
Children's Television Standards Review**

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**Authorised by
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Submission in response to the
Children's Television Standards Review**

The Australian Dental Association Inc (ADA) thanks you for the opportunity to comment on this review. We note that the Coalition on Food Advertising to Children (CFAC), of which ADA is a member, has made a submission to this review which is endorsed by ADA Inc.

The Australian Dental Association (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The primary objectives of the ADA are to promote the practice of evidence-based dentistry and encourage access for all Australians to affordable preventive oral care. Each State and Territory has its own Branch, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

The Australian Dental Association (ADA) has a commitment to the delivery of oral health care for children (see ADA Policy Statement 1.3.1 attached). In view of its commitment to dental health promotion the focus of this submission will be on the impact to children of television advertising in so far as it will concern children's dental health.

The ADA provides the following comments:

Television Food Advertising to Children

It is noted that the Children's Television Standards (CTS) has attracted significant public interest in the past few years in relation to the debate about the link between food advertising and obesity.

The ADA acknowledges that childhood obesity in Australia is a significant problem that needs to be addressed. We also note the evidence that associates food marketing and behaviours to childhood obesity.

However, the ADA believes that childhood dental decay is also a matter of great concern which needs to be addressed. Dental decay has been estimated to be Australia's most expensive diet-related disease.¹

ADA Inc supports restrictions on television food advertising during children's viewing times as evidence suggests there are strong links between television advertising, poor diet, nutrition and obesity. The impact of poor diet and its relationship to dental health is of primary concern to the ADA.

Australian studies show that children view an average 23 hours of television per week with four hours of this time spent watching advertisements. It is estimated that food advertisements account for 30% of all advertisements during children's hours. Television advertisements largely feature food products that are high in fat, salt and sugar, and low in fibre.² Over consumption of these foods can lead to both general and oral health problems.

Developmentally, young children are unable to discern the persuasive messages of advertising and tend to accept statements made in advertising as being true. The amount of time children spend watching television correlates with their request, parental purchase and consumption of those foods advertised on television.³

Childhood dental decay

At the same time that obesity levels are rising, there are signs that the incidence of childhood dental decay is increasing. The ADA considers there is a clear link between the increased consumption of the type of foods advertised during children's viewing hours and the increase in childhood decay.

Changes in children's oral health were reported in the latest national survey, *The Child Dental Health Survey, Australia 1999: Trends across the 1990s*.⁴ Decay rates of primary teeth (baby teeth) across children of all age groups increased during the period from 1996-1999, reversing the trend which saw a decline in rates of decay during 1991-1996. The trend since 1996 was most significant for five-year old children who experienced a 21.7% increase in decay during this period.⁵ The number of children hospitalised for dental treatment has also risen. These statistics are disturbing given that untreated decayed teeth can cause infection and other dental problems later in life.

¹ Crowley, S., Antioch, K., Carter, R., Waters, A-M., Conway, L. and Mathers C (1992) cited in NHMRC (2003) *Dietary Conditions for Children and Adolescents in Australia Incorporating the Infant Feeding Guidelines for Health Workers*, National Health and Medical Research Council, Endorsed 10 April.

² Zuppa, J., Morton, H. and Mehta, K. (2003) 'Television food advertising: Counterproductive to children's health? A content analysis using the Australian Guide to Health Eating', *Nutrition and Dietetics*, Vol. 60, No. 2: 78-84.

³ Ibid.

⁴ Armfield, JM., Roberts-Thompson, KF. and Spencer, AJ. (2003) *The Child Dental Health Survey, Australia 1999: Trends Across the 1990s*, AIHW Cat. No. DEN 95, The University of Adelaide, AIHW, Dental Statistics and Research Series No. 27, p. 27.

⁵ Ibid, p. 27.

Australia's National Health and Medical Research Council's dietary guidelines for children and adolescents argue that "historically the prevalence of dental decay has increased when the diet has changed to include more sugars and other sweetened products".⁶

Soft Drinks and Sports Drinks

According to the National Health and Medical Research Council carbonated drinks and sports drinks are likely to exacerbate dental erosion (Dietary Guidelines for Children and Adolescents in Australia).

A 600ml bottle of soft drink can contain the equivalent of up to 13 teaspoons of sugar, as well as high acid levels – both of which can potentially damage teeth. Some also have caffeine which can dry the mouth by reducing the flow of saliva and do damage to teeth. The frequent consumption of soft drinks is particularly bad for children's oral health and can lead to tooth erosion and contribute to other health problems such as Type 2 diabetes and obesity.

Additionally, so-called sports drinks have a high sugar content and are quite acidic, which is a recipe for dental erosion. This is particularly the case if used in conjunction with heavy exertion. Studies into regular consumption of sports drinks show that they may lead to dental decay and/or dental erosion because their acid levels have been linked to harming the tooth enamel. According to the University of Sydney's NSW Centre for Overweight and Obesity, the consumption of sports drinks was also contributing to the growing childhood obesity problem.⁷

A study published in a 1997 issue of the British Journal of Sports Medicine found eight brands of sports drinks showed pH levels ranging from 4.46 to 2.38. A low pH level means a beverage is acidic and the lower the pH the more acidic the product. Damage can start to occur when the pH drops below 5.5. Acids can gradually erode enamel from teeth leading to loss of the tooth's natural shape, or premature exposure of the dentine, which can make a tooth sensitive – especially when exposed to heat and cold.

In early May this year, the ADA expressed great concern over Gatorade's Australian launch of its 'world first' sports drink specifically targeting children under 13 – 'the tween market'. The pressure maintained by the ADA and other health authorities on the negative consequences of Gatorade on children's health resulted in the organisation removing their smaller 200 ml packs off the supermarket shelves.

⁶ NHMRC (2003) *Dietary Conditions for Children and Adolescents in Australia Incorporating the Infant Feeding Guidelines for Health Workers*, National Health and Medical Research Council, Endorsed 10 April, p. 205.

⁷ Burke, K., (2007) *Experts pour cold water on Gatorade*, 3 May at www.smh.com.au

Community support for better regulation

As well as the support from public health groups, there is strong community support, particularly from parents, for more effective regulations that limit food and beverage advertising directed at children.^{8 9}

The Australian Dental Association notes the results of the recent CFAC commissioned survey of 400 parents which found the following:¹⁰

- 86.2% support a ban on advertising of unhealthy foods at times when children watch TV.
- 88.7% agree the government should introduce stronger restrictions on food advertising at times when children are watching.
- 74.6% of 366 parents are concerned about advertising using toys and giveaways to promote unhealthy food to children.

The Australian Dental Association was also an active supporter of the CFAC's Pull the Plug campaign.

We believe that the strong level of community support for more effective regulations compels ACMA to act and develop new Children's Television Standards, which effectively ban unhealthy food and beverage advertising at the times when children are watching television.

Key questions on food and beverage advertising to children raised in the ACMA Issues Paper

ADA Inc supports the conclusions and recommendations made by CFAC specifically in relation to questions 15 to 20.

The ADA acknowledges that much of CFAC's focus is on food advertising and its impact on childhood obesity. The ADA would like to stress that the impact of food and beverage advertising to children is equally applicable and detrimental to dental health.

General

90 % of all dental disease is preventable. Clearly the advertisements of products are designed to improve sales. Restrictions on food and beverage advertising to children will reduce consumption of products high in fat, salt and sugar; and will therefore reduce the propensity for dental disease to occur.

Childhood dental decay must be a major concern for ACMA - it is a serious issue that the government must address. We acknowledge that food marketing reform is not the only action necessary, but must be

⁸ CHOICE. Food Marketing: Child's Play? Australian Consumers Association . 2006. 18-9-2006.

⁹ Morley B. National community survey of TV food advertising to children. Centre for Behavioural Research in Cancer, The Cancer Council Victoria. 2007. Coalition on Food Advertising to Children.

¹⁰ Ibid.

part of a range of strategies to improve the dental health of Australian children.

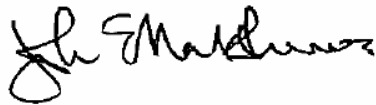
Key recommendations

As there is a clear link between the increased consumption of the type of foods advertised during children's viewing hours and the increase in childhood decay, restrictions should be placed on television food advertising to children.

ACMA should act and develop new Children's Television Standards, which effectively ban unhealthy food and beverage advertising at the times when children are watching television.

Food marketing reform must be part of a range of strategies to improve the dental health of Australian children.

Thank you for the opportunity to comment.

A handwritten signature in black ink, appearing to read "John E Matthews". The signature is fluid and cursive, with the first name "John" being more prominent.

Dr John E Matthews
Federal President
ADA Inc.

DELIVERY OF ORAL HEALTH CARE SPECIAL GROUPS: CHILDREN

1 Introduction

- 1.1 Most children enjoy good oral health, largely as the result of exposure to fluoride in various forms.
- 1.2 Particular groups of children, especially indigenous Australians and low socio-economic groups, have been identified as being of relatively high risk for oral diseases.
- 1.3 Specific oral health risks for this age group arise from such causes as poor parental supervision, lack of exposure to fluoride, and inappropriate diet.
- 1.4 At the time the School Dental Services were formed, caries rates in children were very high. Although fluorides in various forms, and other interventions, have reduced the prevalence of dental caries, School Dental Services still exist.

2 Principles

- 2.1 Establishing good oral hygiene and other preventive habits and maintaining good oral health during childhood is essential if people are to enjoy good oral health throughout life.
- 2.2 Eligibility for treatment in the School Dental Service should be restricted to disadvantaged children.
- 2.3 Systematic preventive procedures should be provided to achieve and maintain dental health in primary school children.
- 2.4 All preventive maintenance programmes should be monitored and evaluated.
- 2.5 Health promotion activities should be conducted in co-operation with the appropriate education and community authorities to prepare all school children to make knowledgeable decisions about their own dental health.
- 2.6 A system of personal dental care services should be organised whereby accumulated needs are met on entry, and systematic and timely detection and correction of disease are thereafter undertaken.
- 2.7 Effective referral of all treatment outside the scope of the School Dental Services should be provided.
- 2.8 Positive referral of all children to dentists in private practice or in community dental facilities should be provided whenever eligibility for care ceases.

3 Policy

- 3.1 All children should start having regular dental examinations from the age of one.
- 3.2 All children with malocclusions should be referred to an orthodontist for assessment at seven years of age.
- 3.3 The aim of Governments in the provision of dental services to children should be to improve their dental health through preventive interventions and, for eligible children, also through treatment.
- 3.4 Treatment of school children should be provided by dentists [or allied dental personnel under the supervision and direction of dentists] with support from dental assistants.
- 3.5 **School Dental Services**
 - 3.5.1 There should be an appropriate mix and number of personnel, and supervision and direction should be consistent with the welfare of the children receiving the service, the relevant dental legislation, and the needs of the system.
 - 3.5.2 The overall lower levels of caries in the school population should shift the emphasis from an operative to a preventive role. As the need for operative treatment is reduced and dental services are directed towards prevention, education and evaluation, the training of allied dental personnel should be adjusted accordingly.

Policy Statement 1.3.1

Adopted by ADA Federal Council, November 21/22, 2002.
Amended by ADA Federal Council, November 10/11, 2005.
Amended by ADA Federal Council, April 20/21, 2006.