RURAL AND REMOTE ORAL HEALTH ADVISORY PANEL (RROHAP) OF THE AUSTRALIAN DENTAL ASSOCIATION 2013-2014 REPORT

The role of RROHAP is, as its name suggests, to advise the Federal body of the Australian Dental Association (ADA) of the vastly different dental landscape in rural and remote Australia to that being faced in metropolitan areas and to a large extent major regional centres. RROHAP supports the policies of the ADA and has the opportunity to give opinion on their relevance and their chances of having beneficial impact on rural and remote oral health.

The RROHAP panel consists of a rural dentist from each state and from the NT. The panel meets twice a year in Sydney. The meeting outcomes to the Federal Council of the Australian Dental Association (ADA). RROHAP appoints a member, usually the convenor of the panel, as their representative on the NRHA. Please see core aims of the ADA as attached.

The last year has seen dramatic changes in the oral health landscape the most significant being the oversupply of graduates from all areas of oral health care. This growth in numbers, where for many there is no prospect of employment, will continue until some action is taken. Amazingly there is no entity among all the respected institutions providing this training or access by overseas trained dentists willing to take leadership on this issue. The exception being the Victorian State Government who removed the occupation of dentist from the State based skilled migration list in 2013. Despite years of lobbying dentists continue to remain on the Federal Skilled Occupation List 2014-2015.

The relevance of this oversupply of oral health professionals to RROHAP is that though these numbers exist, the composition of these graduate years means the majority will need well developed ongoing program of mentoring, social and professional support to prepared for a transition to practice in rural and remote positions. As a person working in outer regional Australia I must point out conditions for professionals in country towns are not improving due to a multitude of factors. RROHAP once again calls for the strict application of compulsory quotas of rural students into health courses and maximization of support to achieve success in the face of the many inequities they are challenged with. It will require a redrawing of the geographical classification map to make the selection process effective.

The current geographical classification results in programs in all areas of health being cherry picked to result in the least beneficial outcome to rural and remote health. I am sure all my colleagues in the
NRHA are aware of this and it has been a topic of concern for the Rural Doctors and in the application of the Dental Relocation and Infrastructure Support Scheme (DRISS).

Please see the attached National Dental Update from the ADA specific to the **The Child Dental Benefits Scheme (CDBS)**. RROHAP feels the NRHA could help oral health in rural and remote areas by speaking to issues raised in the update. Of high importance, as a rural practitioner using operating theatre facilities to achieve the best outcomes for young children with multiple dental problems/disabilities, I urge the addition of provision of CDBS services under general anaesthesia become available.

The CDBS is better than nothing but many more inclusions to the eligible range of treatments need to be made to make it more than an incomplete basic service.

The meeting of the RROHAP in April discussed at length the issue of the benefits of fluoride being available in rural and remote areas. All the panel members were in favour of the NRHA position on fluoride and in fact I have not encountered any disagreement but I also have not been able to find anybody or organization with the capability to progress this. This disempowerment in the face of big issues has similarity to the workforce issues mentioned earlier. Some of the problem lies in the fact that often action is taken on fluoride at a state, local or even health service level but there is no nationwide agreement or implementation for rural and remote areas.

In light of my reference to difficulties faced in rural areas I would draw attention to the “**Sentencing Amendment (Emergency Workers) Bill 2014** introduced by the Victorian Government. Feedback from the NRHA to the Victorian Department of Health would be appreciated.

The link between oral and systemic disease is an issue of increasing concern and this coupled with the power of the food lobby creates a “perfect storm” for increasing chronic disease statistics throughout Australia. I know this topic will be raised by other member bodies of the NRHA and I wish to state this is of great concern to the ADA and RROHAP and that we support any actions to improve the outcomes. The manifestations of the “perfect storm” are seen in higher proportions in rural and remote areas.

Simon Sheed

Convenor of RROHAP