

<b>Title of Matter:</b>	Four yearly review of modern awards
<b>Section:</b>	s.156 -4 yearly review of modern awards
<b>Subject:</b>	Health Professionals and Support Services Award 2010
<b>Matter Number:</b>	AM2016/31

**SUBMISSIONS BY THE AUSTRALIAN DENTAL ASSOCIATION  
AND THE AUSTRALIAN DENTAL PROSTHETISTS ASSOCIATION**

**A. Background**

**The Australian Dental Association**

1. The Australian Dental Association Inc. is the peak professional membership organisation representing Dentists. Its members include the great majority of practicing dentists, around 73%, with 53% of members being self employed, 22% as employees and 25% identifying as contractors. Its members also include dentistry students and retired dentists.

**The Australian Dental Prosthetists Association**

2. The Australian Dental Prosthetists Association is the single and national peak body representing dental prosthetists who are both employers and employees in Australia. The Australian Dental Prosthetists Association currently has 700 members nationally, representing approximately 56% of practising dental prosthetists in Australia.

## Profile of dentists and dental prosthetists

3. Health professionals are highly regulated and both dentists and dental prosthetists are required to be registered with the Dental Board of Australia.

	<b>Dentists</b>	<b>Dental prosthetists</b>
Registered practicing 2019	17,208 <sup>1</sup>	1,234 <sup>1</sup>
Registered practicing 2017	16,244 <sup>2</sup>	1,236 <sup>2</sup>
Average age	42.8 <sup>3</sup>	49.9 <sup>4</sup>
Average weekly hours	36.1 <sup>3</sup>	38.9 <sup>4</sup>
% female	41.8% <sup>3</sup>	15.2% <sup>4</sup>
Principal role only in the public sector	11.2% <sup>3</sup>	10.8% <sup>4</sup>

4. Generally, dental prosthetists work as independent practitioners in the assessment, treatment, management and provision of removable dentures and flexible removable mouthguards used for sporting activities. Dental prosthetists work in a professional relationship with other dental practitioners as part of the overall dental team.
5. Dentists and dental prosthetists are registered nationally with the Dental Board of Australia, the same board that registers other dental professionals such as dental hygienists, dental therapists and oral health therapists. These dental professionals are subject to registration requirements and are also subject to the guidelines and codes of practice in relation the conduct of their profession.

<sup>1</sup> Table 3.1, general and specialists Dental Board of Australia [Registrant data: 1 April 2019 to 30 June 2019](#). Does not include those with multiple registrations.

<sup>2</sup> Table 3.1, general and specialists Dental Board of Australia [Registrant data: 1 April 2017 to 30 June 2017](#). Does not include those with multiple registrations.

<sup>3</sup> Department of Health [Dentists 2017 Factsheet](#).

<sup>4</sup> Department of Health [Dental prosthetists 2017 Factsheet](#).

## **B. THE CLAIMS**

6. There are two substantive matters remaining before the Commission in relation to the *Health Professionals and Support Services Award 2010*:
  - a. whether the occupations of Dental Hygienist and Oral Health Therapist should be covered by the Award; and
  - b. whether the List of Common Health Professionals contained in Schedule C of the Award should be indicative or exhaustive.
7. In relation to the second question, the Full Bench expressed a preliminary view that *"it is undesirable to constrain the coverage by reference to an inflexible list of occupations, the names of which and/or work performed may change over time as advances in the health profession occur."*<sup>5</sup>
8. There is no application to vary the coverage of the Award. The nature of the question assumes that the two extremes are alternatives when that is not necessarily the correct conclusion. It follows that in answering the question, the Commission should consider two subsidiary matters, being :
  - i. **Who, in the Commission's view, is the Award intended to cover or not cover; and**
  - ii. Do the terms of the Award make that sufficiently clear, or do the current terms require clarification in this respect?
9. The position of the Australian Dental Association and the Australian Dental Prosthetists Association is that the list of Common Health Professionals contained in Schedule C of the Award is and should remain exhaustive in that :
  - a. the Award has never been intended to cover professions that are not listed, such as dentists and dental prosthetists, whose work is of a different nature to those listed;
  - b. there is no application to extend the coverage of the Award, nor any evidence to support such an extension;

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<sup>5</sup> *Re Health Professionals and Support Services Award 2010* [2018] FWCFB 7350 at 113.

- c. most, but not all of the titles in Schedule C of the Award are static, reflecting the titles and duties that are protected under the Health Practitioner Regulation National Law, being restricted to registered practitioners; and
- d. while the HSU attempt to cast their approach to Schedule C of the Award as being indicative, in reality their approach is that the list in the schedule is irrelevant.

## **C. PRINCIPLES**

- 10. The principles to be adopted in relation to the conduct of a 4 yearly review are now well established, having been set out in the following decisions of a full bench of the Commission:
  - a. Preliminary Jurisdictional Issues Decision;<sup>6</sup>
  - b. Annual Leave Decision;<sup>7</sup> and
  - c. Penalty Rates Decision.<sup>8</sup>
- 11. These principles may be summarised as follows:
  - a. The Commission must take into account the objects of the Act set out in s.3 and the object of Part 2-3 as expressed in s.134,<sup>9</sup> and relevant provisions of the Act;<sup>10</sup>
  - b. **The Review is conducted on the Commission's own motion, it is not constrained by the terms of a particular application and may vary a modern award in whatever terms it considers appropriate, subject to its obligation to accord interested parties procedural fairness and the application of relevant statutory provisions;**<sup>11</sup>
  - c. Where a significant change is proposed it must be supported by a submission which addresses the relevant legislative provisions and be

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<sup>6</sup> Preliminary Jurisdictional Issues Decision [\[2014\] FWCFB 1788](#) at [19]-[27].

<sup>7</sup> Annual Leave Decision [\[2015\] FWCFB 3406](#) at [11]-[38].

<sup>8</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [95]-[141], [162]-[165], [230]-[270].

<sup>9</sup> Annual Leave Decision [\[2015\] FWCFB 3406](#) at [24].

<sup>10</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [105].

<sup>11</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [110].



accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation;<sup>12</sup>

- d. Each of the matters set out in paragraphs 134(1)(a) to (h) must be treated as a matter of significance in the decision-making process;<sup>13</sup>
- e. There is a degree of tension between some s.134 considerations. The **Commission's task is to balance the various considerations and** ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net of terms and conditions;<sup>14</sup>
- f. In the context of s.134, **the expression 'a fair and relevant minimum safety net of terms and conditions'** includes that :
  - i. fairness is to be assessed from the perspective of the employees and employers covered by the modern award in question;<sup>15</sup>
  - ii. **'relevant' is intended to convey that a modern award should be** suited to contemporary circumstances;<sup>16</sup>
  - iii. the award safety net is of a protective nature.<sup>17</sup>
- g. The party seeking a variation must demonstrate that the modern award, if varied as proposed, would only include terms to the extent necessary to achieve the modern awards objective. **What is "necessary" in a particular case is a value judgment based on an assessment of the s.134 considerations having regard to the submissions and evidence directed to those considerations;**<sup>18</sup>
- h. In the review the Commission will proceed on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time that it was made.<sup>19</sup>

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<sup>12</sup> Preliminary Jurisdictional Issues Decision [\[2014\] FWCFB 1788](#) at [23].

<sup>13</sup> Annual Leave Decision [\[2015\] FWCFB 3406](#) at [18].

<sup>14</sup> Annual Leave Decision [\[2015\] FWCFB 3406](#) at [20].

<sup>15</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [117].

<sup>16</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [120].

<sup>17</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [121]-[128].

<sup>18</sup> Annual Leave Decision [\[2015\] FWCFB 3406](#) at [23].

Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [136].

<sup>19</sup> Preliminary Jurisdictional Issues Decision [\[2014\] FWCFB 1788](#) at [24].

- i. Previous Full Bench decisions should generally be followed,<sup>20</sup> but there may be cogent reasons for not doing so, including changes in the legislative context, the extent of evidence and submissions and the absence of detailed reasons in a previous decision;<sup>21</sup>
- j. It is not necessary to demonstrate a “**material change in circumstances**” since the making of the modern award. Although it is not a condition precedent, a material change may warrant the variation of a modern award;<sup>22</sup>
- k. The Review must be conducted by reference to the particular terms and the particular operation of each particular award rather than by a global assessment based upon generally applicable considerations;
- l. If a variation to minimum wages is sought, the effect of ss.135, 156(3) & (4) is that such a variation can only be made if the Commission is satisfied that the variation is justified by work value reasons.<sup>23</sup>

#### **D. Background and evidence**

- 12. Health practitioners are regulated by the Health Practitioner Regulation National Law, which is the Schedule to the *Health Practitioner Regulation National Law Act* 2009 of Queensland<sup>24</sup> and is given effect to by each of the states and territories.
- 13. The *Health Practitioner Regulation National Law* defines the health profession at clause 5. This is followed by a broader definition of health service which would include various services included in the Schedule C list.
- 14. Various titles and duties are protected under the Health Practitioner Regulation National Law, being restricted to registered practitioners.
- 15. The Award was made as part of the award modernisation process. The award modernisation request made by the Minister for Employment and Workplace

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<sup>20</sup> Preliminary Jurisdictional Issues Decision [\[2014\] FWCFB 1788](#) at [27].

<sup>21</sup> Preliminary Jurisdictional Issues Decision [\[2014\] FWCFB 1788](#) at [27].

<sup>22</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [230]-[264].

<sup>23</sup> Penalty Rates Decision [\[2017\] FWCFB 1001](#) at [244].

<sup>24</sup> [Health Practitioner Regulation National Law Act 2009 \(Qld\)](#).

Relations pursuant to s.576C(1) of the then *Workplace Relations Act* 1996 relevantly set out the objects of that process being :

1. *The aim of the award modernisation process is to create a comprehensive set of modern awards. As set out in section 576A of the Act, modern awards:*
  - (a) *must be simple to understand and easy to apply, and must reduce the regulatory burden on business; and*
  - (b) *together with any legislated employment standards, must provide a fair minimum safety net of enforceable terms and conditions of employment for employees; and*
  - (c) *must be economically sustainable and promote flexible modern work practices and the efficient and productive performance of work; and*
  - (d) *must be in a form that is appropriate for a fair and productive workplace relations system that promotes collective enterprise bargaining but does not provide for statutory individual employment agreements; and*
  - (e) *must result in a certain, stable and sustainable modern award system for Australia.*
2. *The creation of modern awards is not intended to:*
  - (a) *extend award coverage to those classes of employees, such as managerial employees, who, because of the nature or seniority of their role, have traditionally been award free. This does not preclude the extension of modern award coverage to new industries or new occupations where the work performed by employees in those industries or occupations is of a similar nature to work that has historically been regulated by awards (including State awards) in Australia;*
  - (b) *result in high-income employees being covered by modern awards;*
  - (c) *disadvantage employees;*
  - (d) *increase costs for employers;*
  - (e) *result in the modification of enterprise awards. This does not preclude the creation of a modern award for an industry or occupation in which enterprise awards operate. However section 576V of the Act provides that a modern award is to be expressed not*

*to bind an employer who is bound by an enterprise award in respect of an employee to whom the enterprise award applies.*<sup>25</sup>

16. The Australian Dental Association and the Australian Dental Prosthetists Association rely upon the evidence previously given by Ms Eithne Irving and have filed with these submissions statements of :
- a. Ms Eithne Irving updating various matters given the passage of time since her previous statement was filed; and
  - b. Ms Jenine Bradburn addressing matters specific to dental prosthetists.

**E. Is Schedule C of the Award indicative or exhaustive**

17. The issue concerns the coverage of the Award. In this respect the Award relevantly provides:

**4.1** *This industry and occupational award covers:*

**(a)** *employers throughout Australia in the health industry and their employees in the classifications listed in clauses 14—Minimum weekly wages for Support Services employees and 15—Minimum weekly wages for Health Professional employees to the exclusion of any other modern award;*

**(b)** *employers engaging a health professional employee falling within the classification listed in clause 15.*

...

**4.8** *Where an employer is covered by more than one award, an employee of that employer is covered by the award classification which is most appropriate to the work performed by the employee and to the environment in which the employee normally performs the work.*

18. The classifications in clause 15 are defined in Schedule B Classification definitions which provides:

**B.2 Health Professional employees—definitions**

*A list of common health professionals which are covered by the definitions is contained in Schedule C—List of Common Health Professionals.*

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<sup>25</sup> Award modernisation Amended request ([consolidated version](#)).

19. The Full Bench has previously referred to some of the pertinent background to the publishing of the exposure draft and the making of the Award,<sup>26</sup> with reference to:
- a. comments by the Full Bench of the IRC in publishing the draft;<sup>27</sup>
  - b. submissions from APESMA;
  - c. submissions from the ACTU;<sup>28</sup>
  - d. supporting submissions from the Ai Group in respect to scientists;<sup>29</sup> and
  - e. the apparent absence of any decision or statement issued by the AIRC in publishing the final Award, including whether the schedule was intended to be indicative or exhaustive.
20. The Full Bench expressed a preliminary view that it was undesirable for it to constrain the coverage of the Award by reference to an inflexible list of occupations, the names of which and/or work performed may change over time as advances in the health profession occur.
21. Schedule C lists some 52 health professionals. there are a handful of other common health professionals, in addition to Dental Hygienists and Oral Health Therapists referred to earlier, who are regulated by the *Health Practitioner Regulation National Law* that are not listed in Schedule C, being:
- a. Aboriginal and Torres Strait Islander Health Practitioner or Allied Health Practitioner
  - b. Dentist;
  - c. Dental prosthetist;
  - d. Medical practitioner;
  - e. Midwife;
  - f. Nurse;
  - g. Optometrist;

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<sup>26</sup> Health Professionals and Support Services Award 2010 [\[2018\] FWCFB 7350](#) at [109]-[114].

<sup>27</sup> Award Modernisation Statement [\[2009\] AIRCFB 50](#) at [78] and [81].

<sup>28</sup> [ACTU Submission - 13 February 2009](#) at 228-233.

<sup>29</sup> [Ai Group Submission - 13 February 2009](#) at 262-266.

- h. Optician; and
  - i. Paramedic.
22. Whilst the HSU claims that health professionals are changing, these professions cannot be said to have emerged since 2010, to have changed titles, or to have been so uncommon as to not warrant mentioning.
23. Instead, the proper inference is that these health professionals were not overlooked, but rather have been deliberately omitted as they are not covered by the Award.
24. Some of the occupations regulated by the *Health Practitioner Regulation National Law*, but not included in the Schedule C list are, to the extent that they are award covered, would appear to be covered by other awards, including :
- a. Aboriginal Community Controlled Health Services Award 2010 [[MA000115](#)] discussed at paragraph 33 below
  - b. Medical Practitioners Award 2010 [[MA000031](#)] discussed at paragraph 36 below;
  - c. Nurses Award 2010 [[MA000034](#)] discussed at paragraph 35 below; and
  - d. Ambulance and Patient Transport Industry Award 2010 [[MA000098](#)].

### **The proper construction of the Award**

25. When interpreting a specific clause contained in an industrial instrument, regard must be had to the ordinary and natural meaning of that clause and the terms of the industrial instrument must be read in the context of the clause and in the context of the entire instrument. The well settled principles in relation to the construction of an award were summarised by the Full Court of the Federal Court in *Short v FW Hercus Pty Ltd* where Burchett J stated:

*The context of an expression may this be much more than the words that are its immediate neighbours. Context may be extended to the entire document of which it is a part, or to other documents with which there is an association. Context may also include, in some cases, ideas that gave rise to an expression in a document from which it has been taken. When the expression was transplanted, it may have brought with it some of the*

*soil in which it once grew, retaining a special strength and colour in its new environment. There is no inherent necessity to read it as uprooted and stripped of every trace of its former significance, standing bare in alien ground. True, sometimes it does stand as if alone. But that should not be just assumed, in the case of an expression with a known source, without looking at its creation, understanding its original meaning, and then seeing how it is now used.*<sup>30</sup>

26. The other well known enunciation of the principles of award interpretation is in *Kucks v CSR Limited*,<sup>31</sup> where Madjwick J stated:

*It is trite that narrow or pedantic approaches to the interpretation of an award are misplaced. The search is for the meaning intended by the framer(s) of the document, bearing in mind that such framer(s) were likely of a practical bent of mind: they may well have been more concerned with expressing an intention in ways likely to have been understood in the context of the relevant industry and industrial relations environment than with legal niceties or jargon. Thus, for example, it is justifiable to read the award to give effect to its evident purposes, having regard to such context, despite mere inconsistencies or infelicities of expression which might tend to some other reading. And meanings which avoid inconvenience or injustice may reasonably be strained for. For reasons such as these, expressions which have been held in the case of other instruments to have been used to mean particular things may sensibly and properly be held to mean something else in the document at hand.*

*But the task remains one of interpreting a document produced by another or others. A court is not free to give effect to some anteriorly derived notion of what would be fair or just, regardless of what has been written into the award. Deciding what an existing award means is a process quite different from deciding, as an arbitral body does, what might fairly be put into an award. So, for example, ordinary or well-understood words are in general to be accorded their ordinary or usual meaning.*<sup>31</sup>

### **Different language indicates a different approach.**

27. Fundamental to the question of coverage arising from clause 4.1 of the Award are the classifications referred to, but not defined in clauses 14 and 15.

Instead the classifications are defined in Schedule B to the Award which is divided into 2 parts. Those provide for classification definitions for:

- a. Support Services employees (set out in paragraph B.1 of the Award); and
- b. Health Professional employees (set out in paragraph B.2 of the Award).

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<sup>30</sup> *Short v FW Hercus Pty Ltd* [1993] FCA 51; (1993) 40 FCR 511 at 518.

<sup>31</sup> *Kucks v CSR Limited* [1996] IRCA 166; (1996) 66 IR 182 at 184.

28. As noted at paragraph 18 above, in relation to health professionals, Schedule B at B.2 identifies the list as being “*A list of common health professionals **which are covered by the definitions***” (emphasis added). At no time is the word ‘indicative’ used in the Award in relation to Health Professionals.
29. This is in contrast to the language of Schedule B at B.1, in relation to Support Services employees, where each of the levels identifies the requisite experience, responsibility and supervision at the level, followed by a list of indicative roles at that level. It should be noted there is no list of common support services employees.

### **History to the making of the Award.**

30. The Australian Dental Association has previously made detailed submissions on the making of the Award and relies upon those submissions.<sup>32</sup> The history set out therein reinforces the proposition that dentists and dental prosthetists were not overlooked in the process of making the Award and their omission is not accidental, but rather a the result of a deliberate policy choice.

### **Approach of the Commission on previous occasions**

31. The HSU acknowledges that the Award was explicitly intended not to cover doctors and nurses,<sup>33</sup> by reference to the AIRC award modernisation decision publishing an exposure draft of the award.<sup>34</sup>
32. The HSU are properly acknowledging the intention of the decision, however they omit any reference to how that intention was put into effect. Neither the exposure draft nor the Award make any reference to doctors or nurses or their exclusion from the Award.
33. The Award was made by a full bench on 3 April 2009 as part of stage 2 of the award modernisation process.<sup>35</sup> On 25 September 2009 the same full bench published exposure drafts of stage 4 awards, including the draft Aboriginal

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<sup>32</sup> Submissions of the Australian Dental Association [filed on 9 June 2017](#) at paragraphs 39 to 65.

<sup>33</sup> Email from the Health Services Union to the Commission [dated 3 September 2019](#).

<sup>34</sup> Award Modernisation Statement [\[2009\] AIRCFB 50](#) at [78].

<sup>35</sup> Award Modernisation [\[2009\] AIRCFB 345](#) at [78].



Community Controlled Health Services Award 2010. In relation to occupational coverage, the full bench stated:

*[126] In making the exposure draft we have largely adopted the draft provided by the National Aboriginal Community Controlled Health Organisation (NACCHO). One significant departure from NACCHO's draft is that we have not included coverage of doctors, nurses or dentists. We have previously made a Medical Practitioners Award 2010 and a Nurses Award 2010 to comprehensively cover doctors and nurses. For reasons previously given, we consider that those occupations are best covered by the separate occupational awards already made. **We have not to date made any award for dentists and the lack of any significant award coverage for the profession leads us to the conclusion that dentists should not be included in the draft award.**<sup>36</sup> (emphasis added)*

34. This contemporaneous statement by the same Full Bench, supports the inference that the omission of dentists from the List of Common Health Professionals contained in Schedule C of the Award was not an oversight but rather the result of a deliberate decision by the Commission that they were not covered by the Award.
35. Clause 4 of the Award deals with coverage in a way that is consistent with other modern awards that excludes employees covered by an award whose classification is more appropriate. The Nurses Award, an occupational award, is clearly the more appropriate classification for a nurse or midwife.
36. The HSU has previously asserted that there is an occupational award for doctors.<sup>37</sup> This assertion however is ill founded. At first blush, the coverage clause of the Medical Practitioners Award appears to be an occupational award. Turning however to the definition of medical practitioner indicates that it is limited:

***medical practitioner*** means a person who is employed as a medical practitioner in hospitals, hospices, benevolent homes, day procedure centres, aboriginal health services, community health centres, the Red Cross Blood Service, the South Australian Institute of Medical and Veterinary Science, the Victorian Cytology Service or the Victorian Institute of Forensic Medicine.<sup>38</sup>

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<sup>36</sup> Award Modernisation: Stage 4 [\[2009\] AIRCFB 865](#) at [126].

<sup>37</sup> Email from the HSU to the Australian Dental Association 12 August 2019.

<sup>38</sup> Medical Practitioners Award 2010 [\[MA000031\]](#) at clause 3.1.

37. This approach to the application of the Medical Practitioners Award has been confirmed in a full bench decision of this Commission in *Gourabi v Westgate Medical Centre*. There was no question that Dr Gourabi was a medical practitioner in the ordinary sense of the expression, however he was not covered by the Medical Practitioners Award because of the special and narrower definition which evinces “a clear intention that the Award is not to apply to medical practitioners generally”.<sup>39</sup>
38. It follows that doctors were not excluded from coverage of the Award due to coverage by an occupational award. Instead the only way that the Full Bench gave effect to their decision to exclude doctors from coverage of the Award was by not including them in the schedule.
39. Whilst the earlier full bench decision refers to various submissions prior to the making of the Award, it does not specifically address the HSU submissions. The HSU draft award was wide ranging seeking to cover all health professionals, including not only nurses, medical practitioners, dentists, dental prosthetists and optometrists, but also included both oral health therapists and dental hygienists.<sup>40</sup>
40. The Full Bench of the AIRC in publishing the exposure draft, by and large did not accept the approach that the HSU had advocated, not only making separate awards for nurses and medical practitioners, but omitting from the exposure draft the well known common health professionals of dentists, dental prosthetists and optometrists. They Full Bench included dental hygienists but omitted oral health therapists.
41. The response of the HSU was to submit that Occupational Therapist and Diversional Therapist were accidentally omitted from the exposure draft.<sup>41</sup> Tellingly, there was no submission that the omission of dentists, dental prosthetists, optometrists and oral health therapists was an oversight.

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<sup>39</sup> *Gourabi v Westgate Medical Centre* [2019] FWCFB 3874 at [28].

<sup>40</sup> Paragraph 66 Supplementary submissions of the HSU, page 100 of [Annexures A-J to the Submissions of the Australian Dental Association](#).

<sup>41</sup> Exposure Drafts – further submissions of the HSU, page 253 of [Annexures A-J to the Submissions of the Australian Dental Association](#).

42. The clear and unavoidable inference is that the Full Bench of the AIRC in making the Award did not intend for it to cover those common health professionals that had been omitted.
43. The correctness of this approach is highlighted by the approach of the Full Bench in removing dental hygienists from the coverage of the award. There can be no doubt that the Commission had decided that Dental Hygienists should be excluded from the coverage of the Award. This was not achieved by a variation to the coverage clause, nor by adding a clause excluding Dental Hygienists. Instead the Commission simply deleted them from the Schedule, thereby removing Dental Hygienists from the Award coverage.<sup>42</sup>
44. The HSU do not address this issue in any way. It is not apparent how the HSU say that their interpretation of the Award is consistent with the orders of the Commission.
45. The Full Bench has previously agreed with the inherent logic of the Ai Group submission that if the Schedule were not exhaustive, the decision made by the **AIRC would be "superfluous"**.<sup>43</sup>
46. While the Commission has decided to reconsider the position in relation to Dental Hygienists and Oral Health Therapists in light of developments in the health profession, such reconsideration does not take away from the force of the submission that the Schedule was intended to be exhaustive, not merely in relation to the omission of dental hygienists.

### **Common titles**

47. The HSU assert that the Award could be avoided and undermined merely by **changing the title of an employee, such as from "remedial masseur" to "massage therapist"**.
48. To use the well known phrase, ***"The parties cannot create something which has every feature of a rooster, but call it a duck and insist that everyone else recognise it as a duck."***<sup>44</sup>

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<sup>42</sup> Health Professionals and Support Services Award [PR991493](#) 24 December 2009.

<sup>43</sup> Health Professionals and Support Services Award 2010 [\[2018\] FWCFB 7350](#) at [114].

49. The HSU's argument seeks to suggest that the only alternative to the HSU's entirely unconstrained interpretation is to take a narrow or pedantic approach to the interpretation of the Award, an approach that has been consistently been rejected.<sup>45</sup>
50. The proper approach to the application of award classifications was conveniently summarised by a Full Bench of the Australian Industrial Relations Commission in *Brand v APIR Systems Limited*,<sup>46</sup>

*[12] Much of the argument advanced on Mr Brand's behalf in the appeal was directed at whether his employment was within the incidence of the award. As we have indicated above, even if his employment was within the incidence of the award, his application was not within jurisdiction unless he was employed in one of the award classifications.*

*[13] We note that the Commissioner adopted and applied a test based on the principal purpose for which the applicant was employed. She relied upon the Full Bench decision in *Carpenter v Corona Manufacturing Pty Ltd* in that respect.<sup>47</sup> An analysis of the authorities referred to in that case shows that industrial courts and tribunals have at different times adopted different formulations of the test to be applied in determining whether the work of an employee or group of employees is within a particular occupation or classification. One formulation requires that the question should be decided by reference to the major and substantial employment of the employee.<sup>48</sup> Another formulation requires that the principal purpose or purposes of the employment be identified.<sup>49</sup> In some cases the formulations have both been referred to.<sup>50</sup> In one case a Full Bench of the Commission held that the principal purpose formulation was a refinement of the major and substantial employment formulation.<sup>51</sup> A Full Court of the Federal Court of Australia, without reference to other authorities, adopted a test based on whether the employees were "engaged substantially" in the duties of the relevant occupation.<sup>52</sup>*

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<sup>44</sup> *Re Porter* [1989] FCA 226; (1989) 34 IR 179 at [13] p. 184 per Gray J; *On Call Interpreters & Translators Agency Pty Ltd (ACN 006 272 760) v Commission of Taxation (No 3)* [2011] FCA 366; (2011) 279 ALR 341 at [192] per Bromberg J.

<sup>45</sup> *Kucks v CSR Limited* [1996] IRCA 166; (1996) 66 IR 182 at 184.

<sup>46</sup> *Brand v APIR Systems Limited* PR938031 (unreported 16 September 2003).

<sup>47</sup> PR925731 at para [9] [(2002) 122 IR 387].

<sup>48</sup> *Ware and O'Donnell Griffin (Television Services) Pty Ltd* [1971] AR (NSW) 18.

<sup>49</sup> *Merchant Service Guild of Australia v J Fenwick & Co Pty Ltd* (1973) 150 CAR 99 at 101-2.

<sup>50</sup> *Comdox (No. 272) Pty Ltd t/as Ronald Stead Golf v Dawson* (1993) 49 IR 458 at 462; *Logan v Otis Elevator Co Pty Ltd*, Unreported, Industrial Relations Court of Australia (Moore J) 20 June 1997.

<sup>51</sup> *Re The Australian Workers' Union Construction, Maintenance and Services (WA Government) Award 1987* 1991/12 CAR 68 at 72.

<sup>52</sup> *Federated Tobacco Workers Union of Australia v Amalgamated Metal Workers Union and another* (1988) 29 IR 263 at 275.

*[14] In this appeal both parties accepted that the "principal purpose" formulation as stated in *Carpenter v Corona Manufacturing Pty Ltd* should be applied. We are content to decide this application on that basis. We should add, however, that we are satisfied that whichever of the formulations referred to might be applied, in this case the result would be the same.*

51. After referring to this passage in *Brand*, the Full Bench majority (Acton SDP and Simpson C) in *Australasian Meat Industry Employees Union v Teys Australia Beenleigh Pty Ltd*<sup>53</sup> said:

*[85] In *Brand* and each of the cases cited in this extract from *Brand*, whether it is a "principal purpose", "major and substantial" or "engaged substantially" formulation that is adopted, **it is the work of the employee that is considered relevant in that regard.**<sup>53</sup> (emphasis added)*

52. The Australian Dental Association and the Australian Dental Prosthetists Association submit that, on the well settled authorities, the adoption of an uncommon title would not take away from the fact that the duties and qualifications remained the same.

53. Using the example previously cited, the question of award coverage for a person with the title of child life therapist is properly answered by considering whether the duties and qualifications of the position are substantially the same as those of a play therapist.

### **Schedule is not indicative of dentists, dental prosthetists or others**

54. While the HSU attempt to cast their approach to Schedule C as being indicative, there is nothing of substance in their submissions as to how the Schedule "indicates" dentists, dental prosthetists or optometrists. There is relevantly nothing new about the industry, nothing new about the occupations, nor can it be said that the work is of a similar nature to work performed by those health professionals listed in Schedule C.

55. In reality the approach of the HSU is that the Schedule C List of Common Health Professionals is superfluous and irrelevant.

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<sup>53</sup> *Australasian Meat Industry Employees Union v Teys Australia Beenleigh Pty Ltd* [2014] FWCFB 5643; 245 IR 170.

## **The modern awards objective**

56. In conducting the review the Commission is required to take into account the modern awards objective, which is to ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions.
57. Turning to the specific matters in s134(1):
- (a) in relation to the health professions that have been omitted from Schedule C, there is no evidence that dentists or dental prosthetists have low relative living standards or can in any way be described as low paid. It is of particular note that the median starting salary of a graduate dentists was \$78,300 was significantly greater than that applying to a Health Professional Level 1 at that time.<sup>54</sup> Put simply there is no evidence of dentists or dental prosthetists being paid less than they would receive if they were covered by the Award;
  - (b) the biggest impediment to collective bargaining is that most dentists are engaged in small dental practices. There is no evidence that would suggest that having these professions covered by an award would increase the extent of collective bargaining;
  - (c) there is no evidence that would suggest that having these professions covered by an award would have any positive impact on the extent of workforce participation and social inclusion; (d) one of the concerns of the Australian Dental Association and the Australian Dental Prosthetists Association is that if their employee members were covered by an award, the imposition of time based remuneration would discourage the flexible modern work practices and the efficient and productive performance of work that currently exist in these professions;
  - (da) the data published by the Department of Health for dentists<sup>55</sup> and dental prosthetists<sup>56</sup> shows that the professions are not generally working excessive hours. While irregular or unpredictable hours are a genuine

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<sup>54</sup> Annual Wage Review 2015–16: Health Professionals and Support Services Award 2010 [PR579789](#).

<sup>55</sup> Department of Health [Dentists 2017 Factsheet](#).

<sup>56</sup> Department of Health [Dental prosthetists 2017 Factsheet](#).

issue for some employees in the health industry, there is no evidence of any significant level of casual employees in these professions. Similarly the evidence in this matter in relation to the span of hours indicates that these professions are not generally working unsocial hours or shiftwork;

- (e) given the significant differential between the Award rates and the earnings of dentists and dental prosthetists, having these professions covered by an award would not appear to assist in furthering the principle of equal remuneration for work of equal or comparable value
- (f) The likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and
- (g) **once the Commission has determined who, in its' view, the Award is intended to cover**, it must consider the need to ensure a simple, easy to understand, stable and sustainable modern award system. This is a consideration that is addressed by considering whether the terms of the Award make the coverage sufficiently clear, or whether the current terms require clarification in this respect;
- (h) while the oral health of Australians is an important issue, the question of award coverage appears unlikely to give rise to any likely impact on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

### **The award modernisation request**

58. A related consideration arises from the terms of the award modernisation request, in particular that the professions of dentists and dental prosthetists have traditionally been award free because of the nature of their role.

59. As the Full Bench said in 2009, there was no significant award coverage for the profession of dentists.<sup>57</sup> The same is true of the profession of dental prosthetists. Whilst there were exceptions, principally involving employees in

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<sup>57</sup> Award Modernisation: Stage 4 [\[2009\] AIRCFB 865](#) at [126].

the public sector, representing a small percentage of the profession, and in Tasmania in relation to dental mechanics.<sup>58</sup>

60. This is not a new industry nor can dentists and dental prosthetists be said to be new occupations.
61. Their work is not of a similar nature to any of the health professionals listed in Schedule C.
62. The other concern of the Australian Dental Association is that if the profession was covered by the Award, it would be to the disadvantage of their employee members. This concern is that, far from acting as a safety net, the stipulation of an Award rate of pay for dentists may in fact reduce the remuneration of the profession by suggesting that a fair and reasonable wage is significantly less than those employees are currently receiving.
63. The Australian Dental Prosthetists Association has always been of the understanding that in the private sector, dental prosthetists are award free and its position, put on behalf of its employee members is that dental prosthetists should remain award free in the future.
64. The position the HSU is adopting in these proceedings directly affects many employee members of Australian Dental Prosthetists Association and is of great concern for the association and its members.
65. The Commission should place significant weight on the views of those employees, as expressed through their professional associations.

**The proper approach is that the schedule is exhaustive**

66. For the reasons set out above, the Commission should properly conclude that the Award was not intended to cover dentists, dental prosthetists nor the other common health professionals omitted from Schedule C.

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<sup>58</sup> Statement of Ms Jenine Bradburn on 14 October 2019 at [19].



## **Are the terms of the Award sufficiently clear?**

67. As noted above, having satisfied itself as to who the Award was intended to cover, it must consider the need to ensure the Award is simple and easy to understand.
68. In terms of the example of the role of a Play Therapist, the evidence was to the effect that the title of Child Life Therapist. It would be proper and appropriate for the Commission to amend Schedule C to include Child Life Therapist.
69. Given the time, energy and resources spent on addressing this issue, it is apparent that clarity in relation to Schedule C can only assist in ensuring that the Award is simple and easy to understand.
70. The Australian Dental Association and the Australian Dental Prosthetists Association submit that this could be achieved by an opening paragraph to the schedule along the lines that:

*This Award applies to those health professionals whose duties and qualifications are the same or substantially the same as the common titles for those professionals in the following list.*

## **F. Dental hygienist and Oral Health Therapist**

71. Neither the Australian Dental Association nor the Australian Dental Prosthetists Association have members who are registered exclusively as dental hygienists or oral health therapists.
72. Members of the Australian Dental Association work in a professional relationship with dental hygienists or oral health therapists such that the Australian Dental Association is able to assist the Commission by reference to relevant information.
73. The submission of ADOHTA that the recognition of the occupation of Oral Health Therapist by the Dental Board of Australia occurred after the award was made in 2010<sup>59</sup> is factually unsound. As is discussed at paragraph 77 below, the occupation existed prior to the making of the Award in 2009 and as noted

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<sup>59</sup> *Re Health Professionals and Support Services Award 2010* [2018] FWCFCB 7350 at 117.

at paragraph 38 above the HSU explicitly sought that the Award include Oral Health Therapists.<sup>60</sup>

### **NSW State award coverage**

74. The Full Bench noted that in 2018 the NSW Industrial Relations Commission made an award covering the occupations Dental Therapist, Dental Hygienist and Oral Health Therapist.<sup>61</sup> Despite the suggestion in the year, the Australian Dental Association and the Australian Dental Prosthetists Association agree with the submission of the HSU,<sup>62</sup> that there is little that is new in the award, in that it falls within a long history of award coverage within the NSW public service, commencing with the 2008 award,<sup>63</sup> which was replaced in 2012,<sup>64</sup> and again in 2017.<sup>65</sup>
75. The 2008 award itself replaced the Public Hospital Dental Therapists (State) Award 2005.<sup>66</sup> The principle difference being the addition of Oral Health Therapist, defined in the way already noted by the Full Bench.<sup>67</sup>
76. The public sector has traditionally had much more extensive award coverage. In NSW, for example all employees up to and including the executive officers of the public service were covered by industrial awards until 1989.<sup>68</sup>
77. Dental hygienists and dental therapists are distinct occupations, having existed for more than 90 year. Dental hygienists were predominantly engaged in the School Dental Service.<sup>69</sup>

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<sup>60</sup> Paragraph 66 Supplementary submissions of the HSU, page 100 of [Annexures A-J to the Submissions of the Australian Dental Association](#).

<sup>61</sup> *Health Employees Oral Health Therapists (State) Award 2018* [\(2019\) 384 NSW Industrial Gazette 624](#).

<sup>62</sup> Submissions of the HSU [filed on 8 August 2019](#) at paragraphs 6 to 10.

<sup>63</sup> *Health Employees Oral Health Therapists (State) Award 2008* [\(2009\) 368 NSW Industrial Gazette 414](#).

<sup>64</sup> *Health Employees Oral Health Therapists (State) Award 2012* [\(2012\) 373 NSW Industrial Gazette 168](#).

<sup>65</sup> *Health Employees Oral Health Therapists (State) Award 2017* [\(2018\) 382 NSW Industrial Gazette 277](#).

<sup>66</sup> *Public Hospital Dental Therapists (State) Award 2005* [\(2006\) 357 NSW Industrial Gazette 977](#).

<sup>67</sup> *Re Health Professionals and Support Services Award 2010* [\[2018\] FWCFB 7350](#) at 122.

<sup>68</sup> [Public Sector Management \(Executives\) Amendment Act 1989](#), Schedule 1 at 42J.

<sup>69</sup> Oral Health Therapy Programs in Australia and New Zealand (2010), Annexure 11 to the statement of Ms Eithne Irving on 14 October 2019.

78. The NSW Commission did not create the role of Oral Health Therapist. Instead it arose in practices in Western Australia since 1971, South Australia in 1980 and with impetus from a 1993 inquiry in the United Kingdom. This was formalised initially through a diploma in Oral Health Therapy in Victoria in 1996 and then a Bachelor of Oral Health in 1998 in Queensland.<sup>69</sup>
79. Given the highly regulated nature of the Health Profession, it could not arise from industry practice. At the time the regulation of the health profession was conducted by each State and Territory passed their own laws in relation thereto.<sup>70</sup>
80. Whilst it is true to say that oral health therapists can practice as a dental therapist or dental hygienist, Satur describes them as being *“more broadly educated professionals than their tightly regulated predecessors”* and that *“They are educated to synthesise and apply knowledge to complex problems, understand and apply technology in more complex ways and to have well-developed research, communication and cultural sensitivity skills in keeping with the contemporary health professional role.”*<sup>69</sup>

## **G. Conclusion**

81. For the reasons set out in these submissions, the Commission should conclude that Schedule C is exhaustive in the sense that the Award was not intended to cover common professionals who had been omitted from the schedule, such as dentists and dental prosthetists.



BRUCE MILES

Frederick Jordan Chambers

14 October 2019

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<sup>70</sup> Eg [Dental Practice Amendment \(Oral Health Therapists\) Regulation 2007](#) NSW.

**IN THE FAIR WORK COMMISSION**

**Matter No: AM2016/31 formerly AM2014/204**

**Re: *Health Professionals and Support Services Award 2010***

**WITNESS STATEMENT OF EITHNE MARY IRVING**

**DATED 14 OCTOBER 2019**

**Introduction**

1. My full name is Eithne Mary Irving. I am currently employed by Australian Dental Association Inc. (**ADA Inc.**) in the position of Deputy CEO and General Manager of Policy.
2. I refer to my previous statement in these proceedings dated 23 May 2017 (**my previous statement**).

**Updates to the background of my previous statement**

3. In paragraph 3 of my previous statement, I stated that in my role as Deputy CEO and General Manager of Policy I was responsible for:

(a) editing ADA Inc.'s monthly magazine.

This responsibility no longer forms part of my current role.

4. At paragraph 4 of my previous statement, I stated that I represented ADA Inc. on a number of committees. I no longer sit on the following committees:

(a) the National Oral Health Monitoring Group; and

(b) the Standards Australia HE-028 Quality Management and Corresponding General Aspects of Medical Devices Committee.

5. In addition to the committees referenced at paragraph 4 of my previous statement:

(a) I currently sit on the Technical Advisory Committee for the Review of the Certificate III and Certificate IV in Dental Assisting; a subcommittee of the Dental Industry Reference Group of the Australian Industry Skills Council; and

(b) I am the Chair of the NSW Nursing and Midwifery Board.

6. I obtained my Master's in Business Administration from the Australian Institute of Business in 2018.

### **Developments in the private dental sector in Australia**

7. I refer to paragraphs 13 to 21 of my previous statement regarding the private dental sector in Australia.
8. A number of statistics referenced in those paragraphs are no longer current. I have included updated statistics, where applicable, based on recent data of which I am aware.
9. At paragraph 13 of my previous statement, I noted that a wide range of businesses make up the dental practice sector in Australia, ranging from sole traders to large operators with reference to the *ADA Inc. Practice Survey 2013 - 2014 (2013-2014 Practice Survey)*. The *2013-2014 Practice Survey* has been updated. According to most recent publication of this study:
  - (a) 53% of dentists are self-employed;
  - (b) 22% of dentists are employed in salaried positions; and
  - (c) 25% of dentists are working as contractorsA copy of the ADA Inc. Practice and Workforce Survey conducted in 2015 – 2016, the *2015-2016 ADA Practice Survey* is annexed to this statement and marked **Annexure 1**. The statistics referred to in this paragraph are contained at page 13 of this statement.
10. In paragraph 14 of my previous statement, I observed that many dental practices are small and provided certain figures. These figures have also been updated. In the *2015-2016 ADA Practice Survey*, it was found that an average of 6.6 full time equivalent staff perform work in a dental practice in Australia. This comprises:
  - (a) 1.4 principal dentists;
  - (b) 0.7 employed dentists;
  - (c) 2.5 chairside assistants (also known as dental assistants);
  - (d) 1 other allied dental practitioners, most commonly a dental hygienist; and
  - (e) 1.1 receptionists.

The statistics referred to in this paragraph are contained at page 31 of this statement.

11. According to the *2015-2016 ADA Practice Survey*, only 18% of practices employed dental hygienists and a lower proportion of practices employed dental therapists and dental technicians. Almost 10% of practices were reported to employ oral health therapists. The statistics referred to in this paragraph are contained at page 31 of this statement.

**The private and public dental sector in Australia and award coverage in the public sector**

12. I understand that in the *4 Yearly Review of Modern Awards – Health Professionals and Support Services Award 2010* [2018] FWCFB 7350, the Full Bench of the Fair Work Commission observed at paragraph 121 that:

"We note that the occupations Dental Therapist, Dental Hygienist and Oral Health Therapist are all covered by a recent award of the Industrial Relations Commission of NSW – *Health Employees Oral Health Therapists (State) Award 2018*".

13. Although dental therapists, dental hygienists and oral health therapists working in the New South Wales public sector are covered by the *Health Employees Oral Health Therapists (State) Award 2018*, the vast majority of dental hygienists and oral health therapists work in the private, and not the public, sector.
14. In my previous statement, I referred to statistics which came from the *2015 Australian Government Oral Health and Dental Care in Australia Report* (at paragraph 16) and the *Australian Institute of Health and Welfare Dental Workforce Report 2012* (at paragraph 44). The statistic referred to in these reports are now collected and collated by the Commonwealth Department of Health who assumed custodianship of the National Health Workforce Data set from the Australian Institute of Health and Welfare from 1 July 2016. Data from the National Health Workforce Data (**NHWD**) is reflected in an online version of the Australian Government Oral Health and Dental Care in Australia Report, but has also been collated into Individual Fact Sheets by profession and division to accompany the NHWD.
15. The *Commonwealth Department of Health Fact Sheets* contain the following statistics about work undertaken in the public versus private sector:
  - (a) 11.2% of all dentists reported working their principal role in the public sector (see *Dentists Fact Sheet* annexed to this statement and marked **Annexure 2** at page 63);

- (b) 10.8% of dental prosthetists reported working their principal role in the public sector (see *Dental Prosthetists Fact Sheet* annexed to this statement and marked **Annexure 3** at page 68);
  - (c) 28.5% of oral health therapists reported working their principal role in the public sector (see *Oral Health Therapists Fact Sheet* annexed to this statement and marked **Annexure 4** at page 73);
  - (d) 2.6% of dental hygienists reported working their principal role in the public sector (see *Dental Hygienists Fact Sheet* annexed to this statement and marked **Annexure 5** at page 78); and
  - (e) 71% of dental therapists reported working their principal role in the public sector (see *Dental Therapists Fact Sheet* annexed to this statement and marked **Annexure 6** at page 83).
16. Overall, 14.4% of dental practitioners (which includes dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) were reported working their principal role in the public sector as at 2017 (see *Dental Practitioners Fact Sheet* annexed to this statement and marked **Annexure 7** at page 88).

**Updated statistics on dentists, dental hygienists, dental therapists and oral health therapists**

17. I refer to paragraphs 25 to 60 of my previous statement regarding statistics for dentists, dental hygienists, dental therapists and oral health therapists.
18. A number of the statistics referenced in those paragraphs are no longer current. I have included updated statistics, where applicable, based on recent data of which I am aware.



## Dentists and Dental Specialists

19. According to latest Dental Board of Australia Registration Data statistics (**Dental Board statistics**), there are 17,744 dentists registered in Australia as at 30 June 2019. A copy of the latest Dental Board statistics is annexed to this statement and marked **Annexure 8**. A copy of the statistics referred to in this paragraph are contained at page 96.
20. The ADA Inc. has more than 16,000 members, 11,060 of these are practising dentists and specialist representing both employer dentists and employee dentists. The balance are students and retired dentists.
21. According to the most recent graduate salaries report published in 2017 *Grad Stats*, dentistry was ranked as having the highest median starting salary in the public health sector and the professional practice sector, with a median starting salary of \$78,300. Dentistry has consistently been included as a top-ranking field since 1977. A copy of the most recent *Grad Stats* report is annexed to this statement and marked **Annexure 9**. Information about the graduate salaries referred to in this paragraph are contained at page 113.
22. According to the 2015–2016 *ADA Practice Survey*, the average private dental practice in Australia has 6.6 personnel and generates a gross practice income of \$1,037,146 per annum (however, the survey does not ask if this is for one or multiple practices), and an average of \$222,250 for a dentist. On average, practice expenses accounted for 66% of the reported gross expenditure, being \$689,910 (see page 30). These figures are broadly consistent with data released by the Australian Taxation Office (**ATO**) analysing taxation data for the 2016-2017 financial year, although the average total expenditure according to the ATO's data ranges from 52 – 68% (for dental businesses with an annual turnover of between \$50,000 and \$435,000) to 74% (for dental businesses with annual turnover of more than \$815,000). A copy of this information is annexed to this statement and marked **Annexure 10** (see page 121 of this statement).
23. In the 2015-2016 *ADA Practice Survey*, we produced some information comparing the "Average Australian Dentist 2015/2016" to the "Employed General Practitioner". The average Australian Dentist works in private practice and earns on average \$202,000 as a General Practitioner and \$385,000 as a Dental Specialist (see page 16 of my statement). By contrast, the Employed Dentist 2015/2016 worked either in



private practice (51% in an owner led practice) or the public sector. The Employed Dentist earns on average \$127,000 (see page 19 of my statement).

24. The ADA Inc. represents not only employer dentists but employee dentists as well. As part of its brief, the ADA Inc. is required to represent the interests of both employer dentist and employee dentists. Our employee dentist members are overwhelming of the view that they do not want to be covered by modern awards, as there is a perception that it will lead to a decrease in their income in circumstances where they are able to negotiate conditions and wages which are well in excess of minimum entitlements.

### ***Dental Hygienists***

25. A dental hygienist can be registered to practice in the following ways:
- (a) the completion of a 2-year Advanced Diploma of Oral Health (Dental Hygiene), although this is only offered through limited providers, including TAFE SA; or
  - (b) the completion of a 3-year Bachelor of Oral Health.
26. Dental hygienists are currently required to work in a structured and professional relationship with a dentist. The Dental Board does not currently permit a dental hygienist to work independently, although the Dental Board has indicated that this will change for the future as outlined below at paragraph 38 of this statement.
27. A dental hygienist can own a dental practice but would have to engage a dentist to provide dental services (other than the limited services which can be provided by a dental hygienist as detailed above).
28. Dental hygienists are predominantly female, with many hygienists working on a part-time basis. The Commonwealth Department of Health Dental Hygienists Fact Sheet revealed that 94.6% of all dental hygienists are women and that dental hygienists worked an average of 28.0 hours per week. That information is contained at page 77 of this statement. .
29. The ADA Inc. does not represent dental hygienists, dental therapists and oral health therapists and accepts the position of those groups as to whether they wish to be covered by an award is a matter for them.

### ***Dental Therapist***

30. A dental therapist can be registered to practice by completing a 3-year Bachelor of Oral Health degree. There are no longer any specific dental therapist training courses available.
31. Dental therapists are also currently required to work in a structured and professional relationship with a dentist. The Dental Board does not currently permit a dental therapist to work independently, although the Dental Board has indicated that this will change for the future as outlined below at paragraph 38 of this statement.
32. Since 2009, the occupation of dental therapist has changed significantly. Dental therapy is now taught at a tertiary level by Bachelor of Oral Health and the vocational courses are no longer available. There has been a significant reduction in the number of registered dental therapists.

### ***Oral Health Therapist***

33. Oral health therapists are qualified both as dental hygienists and a dental therapists. The scope of practice for an oral health therapist is inclusive of both roles. However, the majority oral health therapists in the private sector work in principally in the area of dental hygiene, rather than dental therapy. This is demonstrated by the Department of Health Fact Sheets (see paragraph 15 of my statement).
34. An oral health therapist can be registered to practice following the completion of a three-year Bachelor of Oral Health degree at a recognised institution. Oral health therapy has been taught at tertiary institutions from 1996, when the University of Melbourne Dental School began offering a Diploma in Oral Health Therapy. The University of Queensland and Queensland University of Technology jointly offered the first Bachelor of Oral Health in 1998. Annexed to this statement and marked **Annexure 11** are the relevant extracts of Annetta Tsang (ed), *Oral Health Therapy Programs in Australia and New Zealand: Emergence and Development* (The Authors, 2010) which details developments in oral health therapy. For information about developments in qualifications see page 133 onwards in my statement.
35. Like Dental Hygienists and Dental Therapists; Oral Health Therapists are currently required to work in a structured and professional relationship with a dentist and the Dental Board does not currently permit a dental oral health therapists to work

independently. The Dental Board has indicated that this will change for the future, as outlined below at paragraph 38 of this statement.

36. 87.9% of oral health therapists are female, as outlined in the *Commonwealth Department of Health Oral Health Therapist Fact Sheet* in Annexure 4 at page 72 of my statement).
37. 66.5% of oral health therapists are working in private practice in their principal role as at 2017 according to the *Commonwealth Department of Health Oral Health Therapist Fact Sheet* in Annexure 4 at page 73 of my statement.

### **Proposed changes to the relationship between dentists, dental hygienists, dental therapists and oral health therapists**

38. Dental hygienists, dental therapists and oral health therapists are currently required to work within a "structured professional relationship" with a dentist. However, the Dental Board has proposed to remove the requirement of a structured professional relationship from the registration requirement for dental hygienists, dental therapists and oral health therapists in part, because of the new 3-year university Oral Health Therapist qualification. If the Dental Board follows through with this proposal, this would allow these professionals to practise independently of a dentist. A copy of the Dental Board's consultation paper titled *Consultation on a Proposed Revised Scope of Practice Registration Standard and Guidelines for Scope of Practice* is annexed to this and marked **Annexure 12**. This development is discussed at page 144 onwards in my statement.

### **Title, occupations and scope of responsibility of health practitioners in the dental sector**

39. The Full Bench expressed the view in *Re 4 Yearly Review of Modern Awards – Health Professional and Support Services Award 2010* [2018] FWCFB 7350 that it was their preliminary view that '*it was undesirable to constrain the coverage by an inflexible list of occupations*' (at paragraph 113).
40. I understand that in their submissions in this matter, the HSU has claimed that the titles (as opposed to the occupations) held by health professionals in Australia regularly change. In the case of the dental professions, the titles of dentist, dental prosthetist, dental hygienist, dental therapist and oral health therapist are protected under the *Health Practitioner National Law*.

There is also reference to these titles in other legislative frameworks. I do not expect that there will be any change to these titles in the foreseeable future. However, as it is proposed that in future dental hygienists, dental therapists and oral health therapists will not require a dentist in their practice, as a consequence, they will assume greater autonomy and be able to work independently.

41. The occupations in the dental industry are relatively static and I do not anticipate that there will be changes in the occupations in the dental industry.

**Signature:**



**Date: 14 October 2019**

# **ANNEXURE 1**



FY 2015-2016

# DENTAL WORKFORCE AND PRACTICE SURVEY

Covering member profiles, employment types, productivity and incomes, as well as practice ownership structures, technologies used, workloads, employment activities and finances

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## 1. Background

The Australian Dental Association Inc. (ADA) has once again commissioned the Australian Dental Workforce and Practice Survey to understand key workforce and practice demographics and trends. This survey is primarily focused on the financial year 2015-16 and activity as of 30 June 2016.

This report will cover the following areas:

- Age, graduation specifics, gender and income of members.
- Practice demographics for both general practitioners and specialists.
- Productivity of dentists.
- Practice service provision.
- Financial specifics for private practices.

### 1.1 Survey Implementation

- A total of 11,060 active ADA members were invited to part take in the online survey during a 4 week period commencing on 18<sup>th</sup> October 2017. All members were sent an invitation and two follow-up reminders during November 2017. All members were assured of the confidentiality of the research and were not required to provide their contact details in the survey.
- All responses were checked, analysed and reports were generated by ACA Research, a market research firm based in Sydney, NSW.

### 1.2 Member Response

- Similar to what was achieved in FY 2013/14, there was a 17% response rate with 1,929 usable responses. Of those 1,884 were currently working and were invited to complete the survey in full.
- The distribution of responses by state and dentist type (general practitioner vs specialist), closely reflected the distribution of ADA members.
- There was a greater than 14% response rate for all states and territories.
- Response rate details are included in Table 0 in the appendix.

### 1.3 Sample Distribution

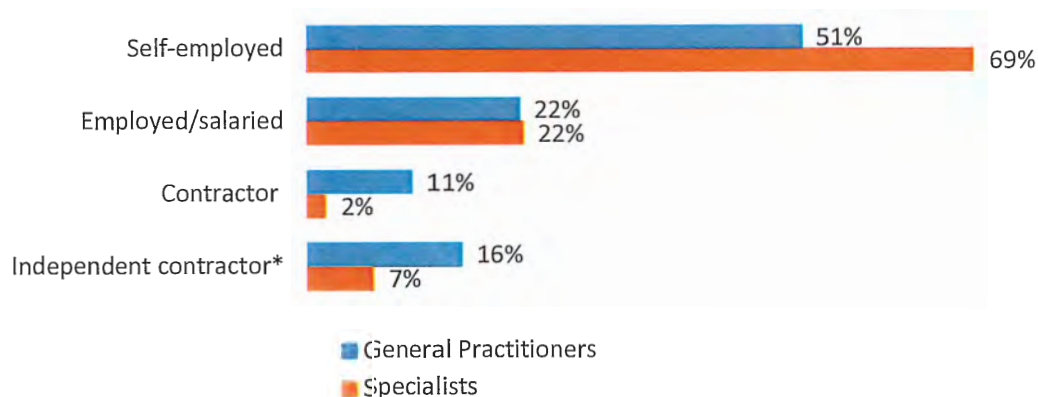
- 89% of dentists were general practitioners and 11% were specialists.
  - 4% of those that participated were orthodontists, 1% periodontists, 1% paediatric dentists, 1% prosthodontists, 1% endodontists, and 1% were oral and maxillofacial surgeons.
- Just over half the dentists, 53%, were self-employed, 15% were independent contractors, 10% were non-independent contractors, and 22% were employed/salaried.
- Almost three quarters (73%) of self-employed dentists worked full time, whereas only half (51%) of employed or contractor dentists worked full time.
- Of the self-employed dentists, 46% were sole practitioners, 34% were owners employing other dentists and 20% were partners in their practices.
- Self-employed dentists owned 1.2 practices on average, with the 10% who owned more than one practice owning an average of 2.6 practices.
- Two thirds (65%) of all dentists were male and one third (35%) were female.
- 68% of members' principal practices were located in a metropolitan or state capital areas. Locations of members' principal practices are shown in more detail in Table 1.



## 1.4 Sample Distribution Specifics

- A greater proportion of general practitioners, relative to specialists, were female (36% vs 21%).
- A greater proportion of general practitioners, relative to specialists, worked part time (38% vs 31%).
- Of the male dentists, just less than two thirds (63%) were self-employed and the remainder (37%) were employed or contractors.
- The opposite was seen for female dentists, for whom approximately one third (35%) were self-employed and two thirds (65%) were employed or contractors.
- A greater proportion of male dentists, relative to female dentists, were specialists (14% vs 7%).
- A greater proportion of female dentists, relative to male dentists, were working part time (51% vs 30%).

### Employment Types: General Practitioners and Specialists



*\*Independent contractor status is determined by a number of factors and, in most cases, will not apply to dentists. For more information, members can go to [www.ada.au/hr](http://www.ada.au/hr) or call the ADA HR Advisory Service on 1300 232 462*

## 2. Dentist Profiles

BUILDING A PROFILE OF THE DENTIST OF 2015/2016 AND  
PROFILING KEY GROUPS OF DENTISTS PRACTISING TODAY



## 2.1 The 'Average' Australian Dentist 2015/2016:



IS A GENERAL PRACTITIONER  
(89%)

IS MALE  
(65%)

WAS BORN IN 1967 &  
GRADUATED IN 1991

WAS BORN IN  
AUSTRALIA (56%)

COMPLETED EDUCATION AT AN AUSTRALIAN  
UNIVERSITY  
(77%)

WORKS IN A METRO  
LOCATION (68%)



WORKS IN ONE PRACTICE ONLY  
(72%)

IS SELF-EMPLOYED (68% incl.  
53% Self-Employed &  
15% Independent Contractors)

IF OWNS A PRACTICE, OWNS  
ONE PRACTICE ONLY  
(88% OF OWNERS)

WORKS FULL TIME  
(68%)



SPENDS 4.1 DAYS/ 34.3 HOURS  
WORKING PER WEEK WITH 28.8  
HOURS CHAIRSIDE

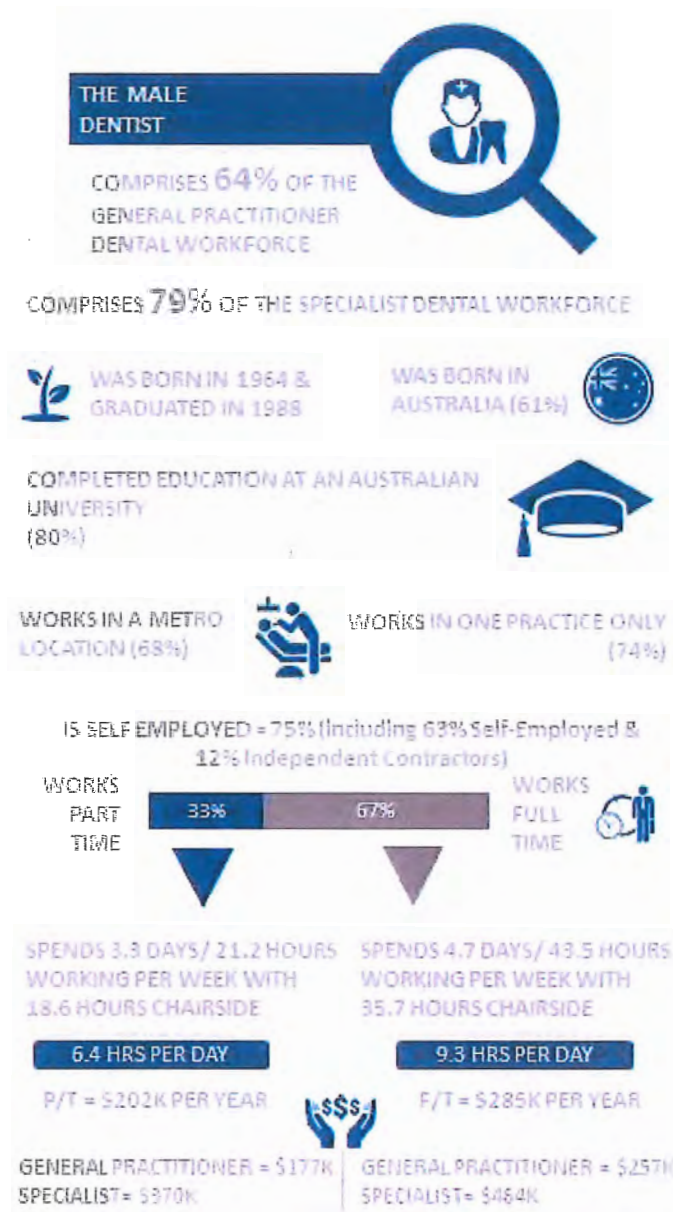


8.4 HRS PER  
DAY

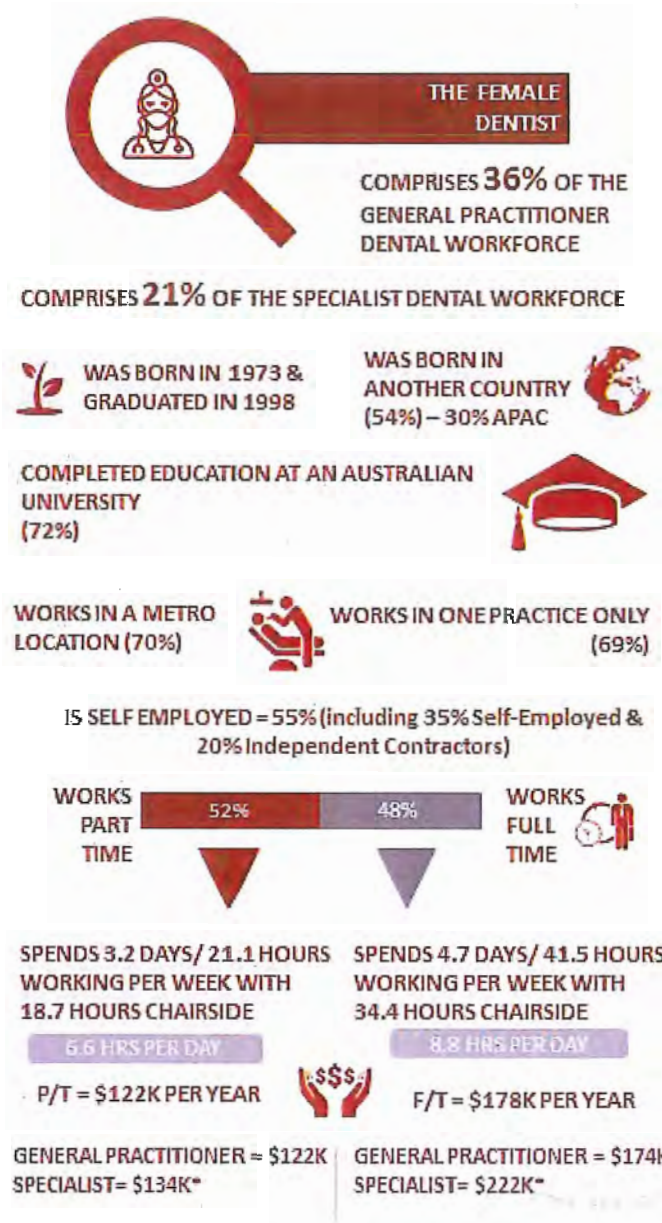


EARNS \$202K PER YEAR AS A GENERAL  
PRACTITIONER OR \$385K AS A SPECIALIST

## 2.2 The Male Dentist:

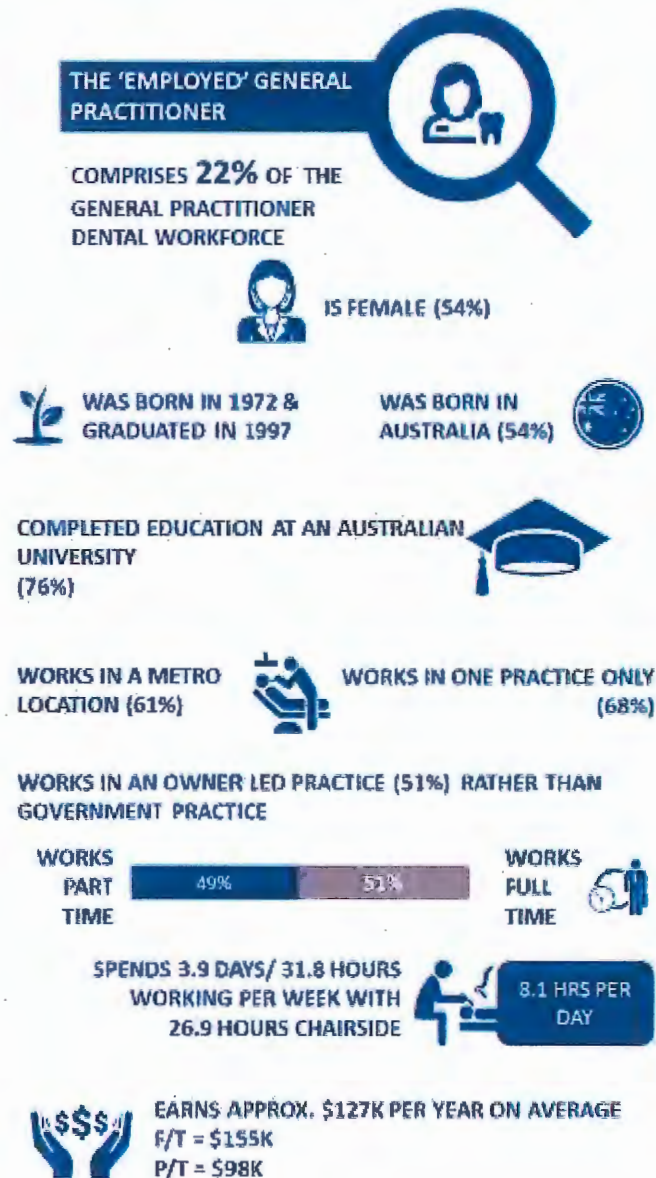


## 2.3 The Female Dentist:

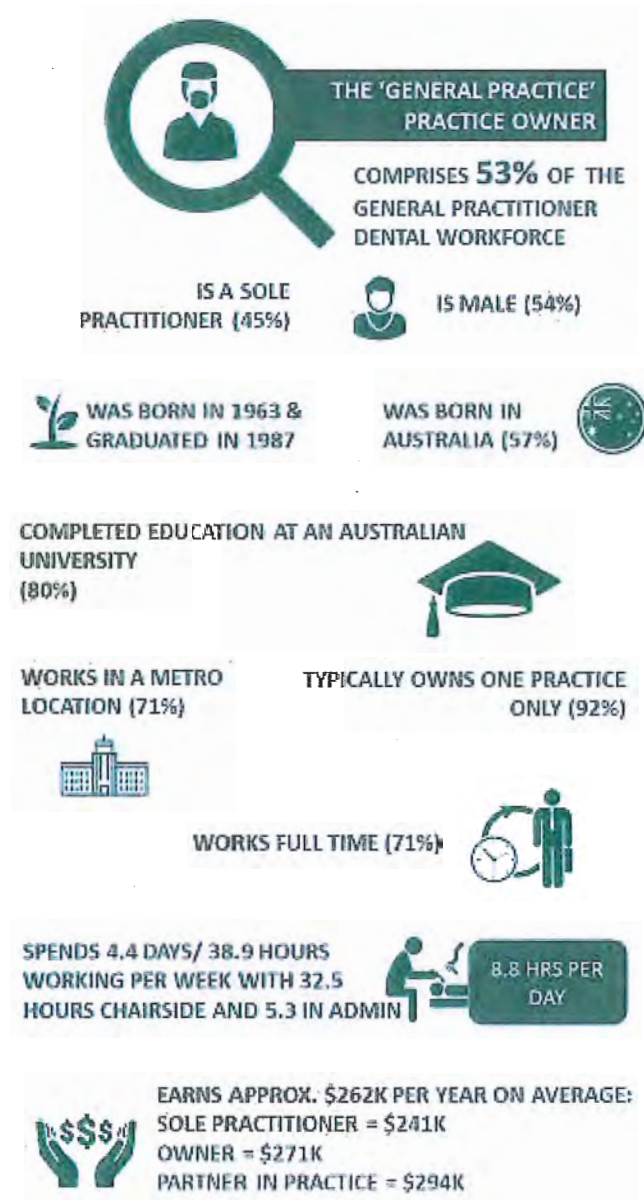




## 2.4 The 'Employed' General Practitioner:



## 2.5 The 'General Practice' Practice Owner:



## 2.6 The Specialist:





### 3. A Snapshot of the Dentists

#### 3.1 Age and Year of Graduation

- ADA members are now, on average, 49.8 years old (at time of survey).
- The youngest members are to be found in the Northern Territory (average 42.3 years) and Western Australia (average 46.6 years).
- The greatest difference in average ages between sub-groups was observed when gender was considered and those who were self-employed tended, on average to be older than those who were either contracting or in employment.

Metropolitan	Regional/Rural
50.1 years	49.5 years

Male dentists	Female dentists
53.1 years	43.6 years

General practitioners	Specialists
49.3 years	53.9 years

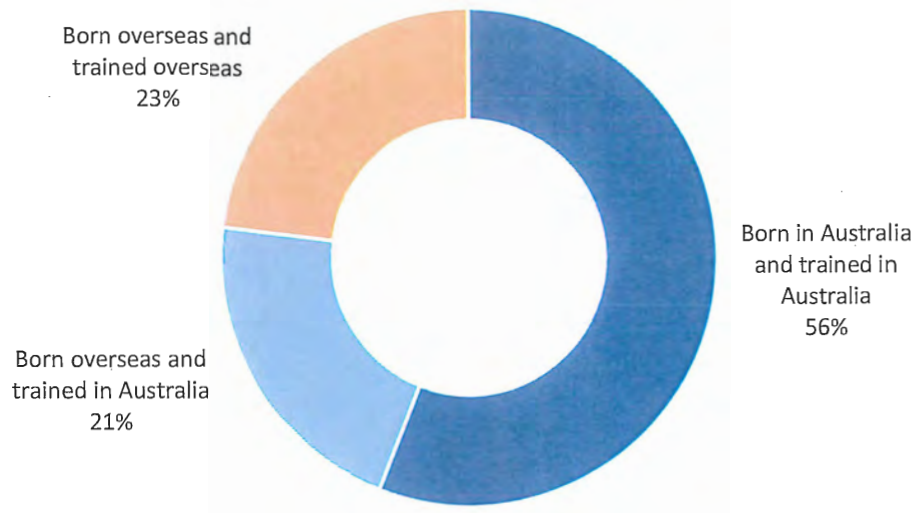
Self-employed	Employed/salaried	Independent contractor	Contractor
53.5 years	46.1 years	45.6 years	44.1 years

- The average age at graduation was 24.1 years, with little variability across different demographics or work profiles.

#### 3.2 Country of Birth and Place of Graduation

- 56% of working members were Australian born with 44% of members born overseas
  - 21% were born in Asia, 7% in United Kingdom and Ireland, 5% in other countries in Europe and 4% in North Africa/the Middle East.
- However, in spite of almost half being born overseas, only a quarter of members (23%) graduated from an overseas university with a number of overseas students moving to Australia for their studies.
- Overall, members were most likely to have graduated from universities in:
  - New South Wales (24%)
  - Countries outside Australia (23%)
  - Queensland (17%)
  - Victoria (16%).

### Country Of Birth And Graduation/Training Location



### 3.3 Eligibility to Practice as a Dentist

- Of the working members who graduated overseas, just over half (54%) became eligible to practice dentistry in Australia through the Australian Dental Council (the most used route across all states and territories), while 26% went through the Automatic Recognition agreement and 19% went through the Trans-Tasman agreement.

### 3.4 Employment Type, Dentist Type and Ownership Structure Type

- Similar to that reported in FY 2013/14, over half the dentists (53%) were self-employed.
  - 24% of all dentists are sole practitioners.
  - 18% are owners employing other dentists.
  - 11% are partners in their practice.
- 1 in 5 dentists (22%) were employed/salaried and a quarter were contractors.

Of those who were employed/salaried or on a contract, 72% worked in a private practice (owned by dentists or non-dentists) and almost a quarter (23%) worked in government run practices.

## Employment Types For Self-Employed Dentists

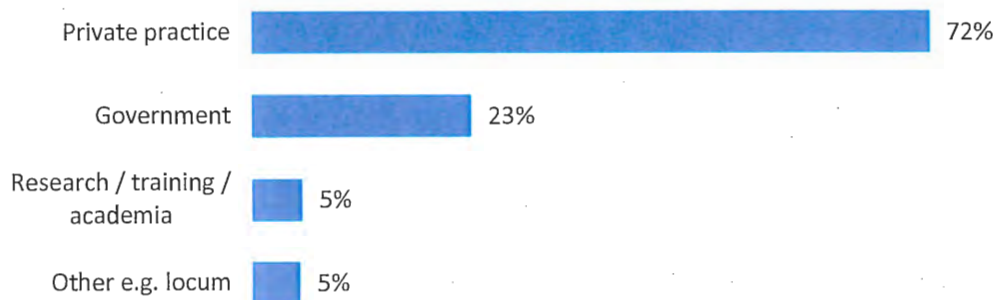


- For those employed/salaried and contractor dentists who worked in a private practice, almost three quarters (74%) stated that their practice was independent, 17% stated it was part of

a corporate chain and 8% stated it was part of a health fund.

- By contrast, almost all self-employed dentists (97%), unsurprisingly, stated that their practice was independent.
- Breakdowns of members' employment and practice types are shown in Tables 2, 3, 4 and 5.

## Practice Types Of Employed/Salaried Or Contractor Dentists



*This was a multiple response question so the total may not sum to 100%.*

### 3.5 Number of Practices Worked In

- 72% of dentists work in one practice only
- 28% work in multiple practices.
  - Specialists (51%), Contractors (48%) and Independent Contractors (42%) are most likely to work in multiple practices
- 31% of female dentists and 26% of male dentists work in multiple practices

### 3.6 Working Hours and Days

- On average, dentists worked 4.1 days or 35.7 hours a week, which represents a slight decrease from the 4.2 days or 36.9 hours reported in the FY 2013/14 report. This equates to an average of 8.6 hours worked per day, slightly down from 8.8 hours worked per day as reported in FY 2013/14.
- Self-employed dentists reported longer working hours per week than employed/salaried and contractor dentists.



- How that time is spent also differed between groups:

Hours per week	Self-employed	Employed/Salaried	Independent Contractor	Contractor
Chairside	32.1	25.4	28.9	29.3
Lab	1.1	0.4	0.7	0.6
Admin	5.1	4.5	1.8	1.6
Other tasks	0.7	1.4	0.6	0.3

Percentage distribution	Self-employed	Employed/Salaried	Independent Contractor	Contractor
Chairside	82%	80%	90%	92%
Lab	3%	1%	2%	2%
Admin	13%	14%	6%	5%
Other tasks	2%	4%	2%	1%

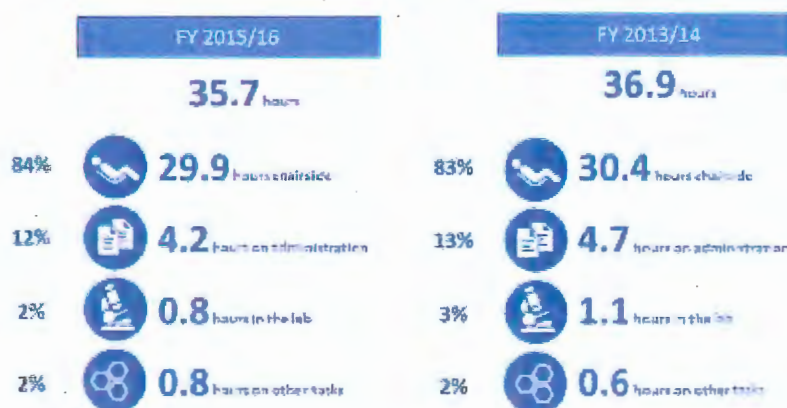


- Male dentists reported longer working hours per week than female dentists.
  - Male dentists: 4.3 days per week, 37.6 hours per week and 8.8 hours per day.
  - Female dentists: 3.9 days per week, 31.9 hours per week and 8.1 hours per day
- Specialists worked fewer days than general practitioners (3.9 vs 4.2 days), but worked more hours per week (37.7 vs 35.4 hours for general practitioners).
  - Overall, specialists worked 9.6 hours per day, compared to 8.5 hours per day for general practitioners.



- The distribution of time spent on tasks in a typical week has not changed significantly over the last 2 years.

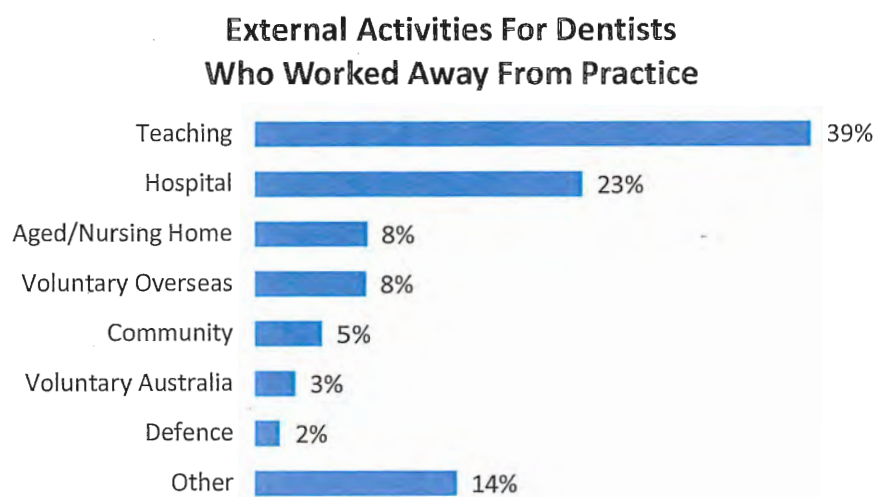
### Distribution of Working Hours per Week by Task



- Complete breakdowns of the average number of days and hours dentists worked during a week are shown in Table 6.
- In regards to after-hours provisions, on average, dentists spent 4.2 hours per week working after 6:00pm.

### 3.7 Working Away from the Practice

- Almost one in ten members (9%) spent time working away from the practice in the financial year 2016/17.
  - For those who worked away, an average of 31.8 days were spent working away from the practice, including:
    - 12.3 days for teaching
    - 7.3 days for hospital work (of which 6.6 hours were spent in GA sessions)
    - 2.5 days working with/ in aged/nursing homes



- Self-employed dentists reported that their primary practices were open for an average of 5.3 days per week.
  - General practitioners practices were open for 5.5 days on average and Specialists practices for 4.4 days.

### 3.8 Days Absent from Work (2016/17)

- In the financial year 2016/2017, dentists were absent (including annual leave and for continuing professional development activities) for an average of 33.2 days.
- Almost two thirds of total absent days (20.5 days) were taken as holiday in the financial year 2016/17.
- 5.8 days, on average, were taken for continuing professional development activities
  - Specialists took more continuing professional development days, 7.8 days on average, than general practitioners who took 5.5 days on average.
  - Those who were self-employed took 2.3 more CPD days over the year than those who classed themselves as employed/salaried (6.7 days vs. 4.4 days).

### 3.9 Agreement with Private Health Insurer

- Similar to results obtained in previous years, just over a third of dentists (36%) have a Preferred Provider Agreement with a Private Health Insurer.
- Who has these agreements does vary:
  - 41% of general practitioners have these agreements, compared to only 3% of specialists.
  - 60% of contractors and 55% of independent contractors have these agreements, compared to 32% of self-employed dentists and 24% of employed/salaried staff.
  - Of the self-employed dentists, 38% of owners who employ staff have these agreements, compared to 31% of sole practitioners and 22% of those who are partners in a practice.
- Members located in Western Australia (52%) and South Australia (48%) were more likely to have an agreement with a private health insurer compared to New South Wales (30%) and ACT (28%).

#### Preferred Provider Agreements with Private Health Insurers



### 3.10 Personal Income

- In the FY 2015/2016, Specialists earned \$384,415 and General Practitioners earned \$202,397, on average.
- Member dentists provided their own personal income data. On analysis it is clear that there are some differences between these figures and those provided in the previous FY 2013/2014 report, largely due to the expansion of this study to include a greater workforce focus. This has led to the inclusion of more single practice owners, and not as many multi-practice owners.
- Caution should be used if comparing to previous data.

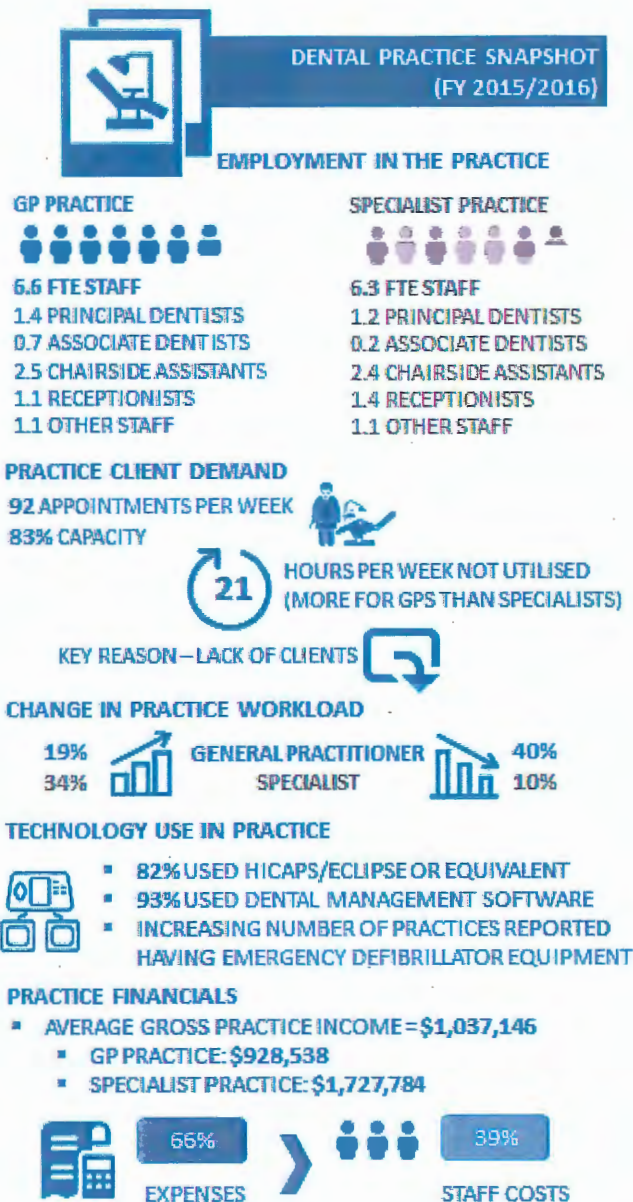
Average Personal Income Data for 2015/2016	General Practitioner	Specialist
<b>Overall</b>	<b>\$202,397</b>	<b>\$384,415</b>
Self-employed	\$261,581	\$456,618
Not Self-Employed (NET)	\$140,895	\$222,298
<i>Employed/Salaried</i>	<i>\$126,381</i>	<i>\$196,217</i>
<i>Contractor</i>	<i>\$149,478</i>	*
<i>Independent Contractor</i>	<i>\$156,738</i>	*

\* Sample too small to report on

Sample based on all those that provided income figures  
Please refer to Table 7 in the appendix for more details



## 4. Dental Practice Profile

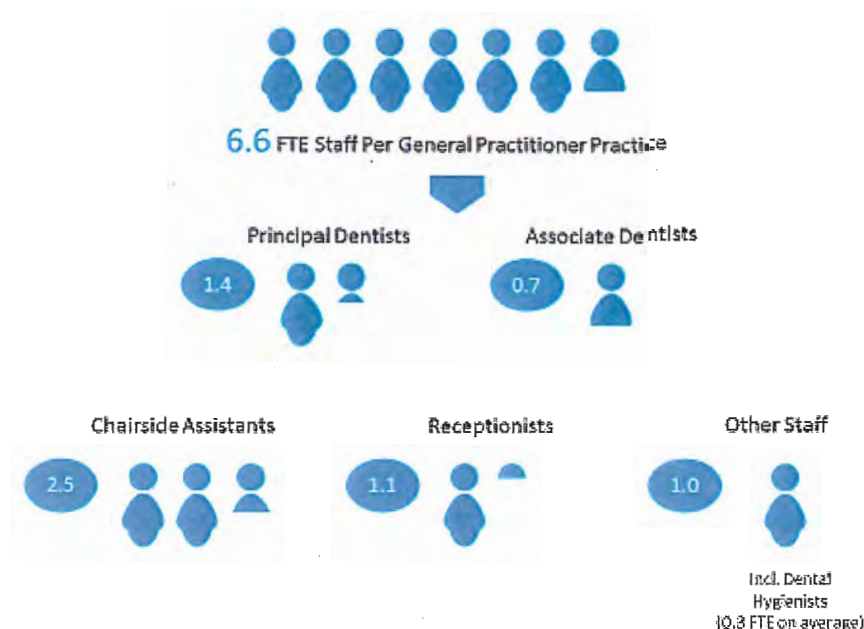


## 5. Practice Dynamics: Employment

- Staff employment activities and employment difficulties were reported by self-employed dentists only, and since staff can be either full time or part time, the numbers of staff referred to in this section (Section 4: Employment at Practice) are based on the Full Time Equivalents (FTEs).
- The composition of practice staff varies between general practitioners' practices and specialists' practices, so they have been analysed separately, in sections 4.1 and 4.2, respectively.

### 5.1 Staff Employed at General Practitioners' Practices

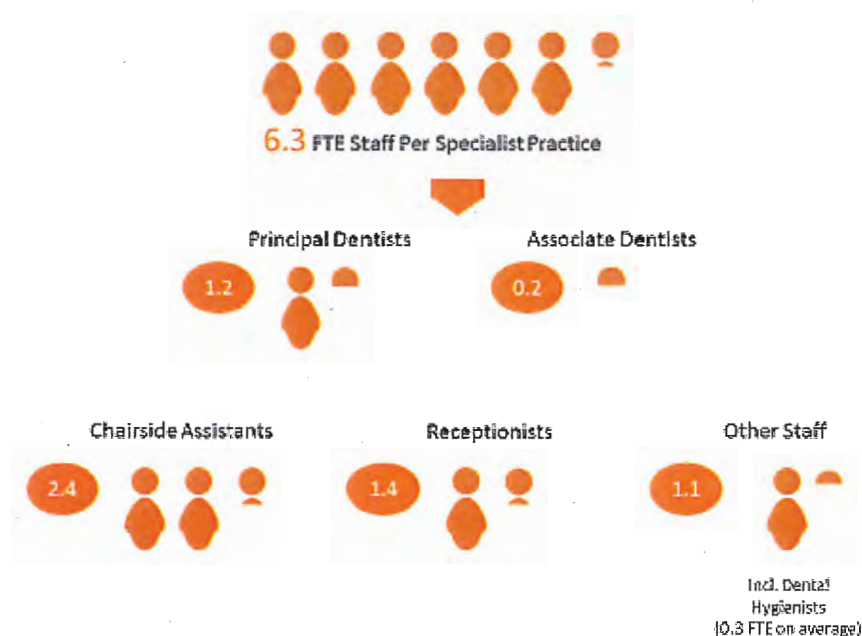
- For this section (4.1), 'practices' refers to all practices in which the self-employed general practitioners worked/managed during FY 2015/16.
- On average, practices employed a total of 6.6 FTE staff, including:



- On average, country areas had more FTE staff per practice (7.8) than metropolitan areas (6.2).
- On average, sole practitioners' practices employed fewer staff per practice (4.3) than owners' practices (8.9) and practices run by partners (8.9).
- Almost all practices (97%) had a dentist principal, and just under half (46%) had salaried/associate dentists, with those practices employing an average of 1.5 associate dentists per practice.
- Dental hygienists were employed in 18% of practices.
- Those working in partnership led practices were more likely to have employed dental hygienists (30%) than practices where the owner employed other dentists (24%) and sole practitioners' practices (10%).
- One in ten practices (10%) employed oral health therapists, and even fewer employed Dental Therapists (4%) or Dental Technicians (2%).

## 5.2 Staff Employed at Specialists' Practices

- For this section (4.2), 'practices' refers to all practices in which the self-employed specialists worked/managed during the financial year 2015/16.
- On average, practices employed a total of 6.3 FTE staff, including:



- On average, country areas had fewer staff per practice (5.4) than metropolitan areas (6.5).
- On average, sole practitioners' practices employed fewer staff per practice (4.8) than practices where the owner dentist employed other dentists (6.7) and partnership practices (9.1).
- Most practices (89%) had a dentist principal, and around a third (32%) had salaried/associate dentists, with those practices employing an average of 0.6 associate dentists per practice (FTE).
- Dental hygienists were employed in 29% of practices.
- Partnership practices were more likely to have employed dental hygienists (39%) than owners' practices (29%) and sole practitioners' practices (25%).
- Partners whose practices had employed dental hygienists had employed an average of 1.6 dental hygienists per practice.
- Less than one in ten practices (8%) employed oral health therapists, and even fewer employed Dental Therapists (5%) or Dental Technicians (4%).

### 5.3 Employment of Additional Staff Within The Next 2 Years

- At an overall level, almost one third of self-employed dentists (30%) indicated plans to employ additional staff at their practice within the next 2 years.
- Unsurprisingly these near-term employment plans were more likely among self-employed dentists who considered their practice workload to be increasing (58%) or to be static (28%) rather than decreasing (17%).
- Self-employed dentists who anticipate employing more staff seem to be planning to employ dentists and chairside assistants at their practices more than any other staff type.
  - Approximately one in five dentists (20%) plan to employ an average of 1.2 dentists and a similar number (21%) plan to employ an average of 1.4 chairside assistants.
- Similarly to FY 2013/14, very few practices plan to employ more/any dental hygienists (6%), dental therapists (2%), dental technicians (1%), oral health therapists (2%) and practice managers (2%) in the next 2 years.

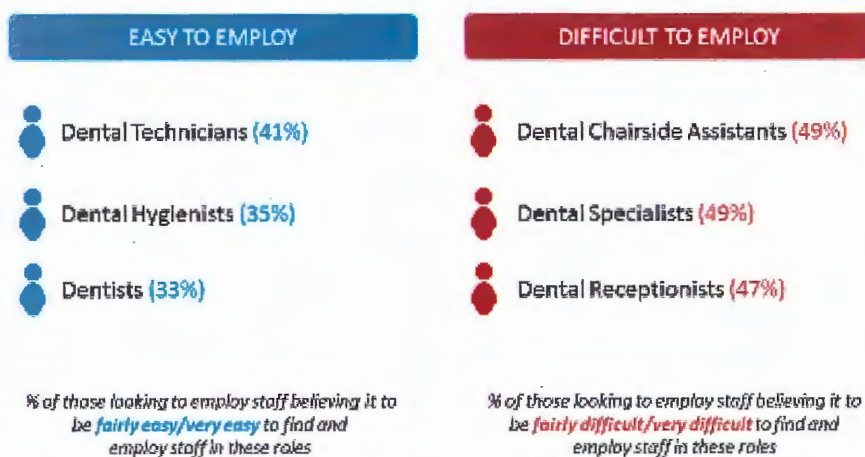
#### Employment Of Additional Staff Within Next 2 Years



## 5.4 Challenges in Employing Dental Staff

- The staff types most commonly employed in the financial year 2015/16 were dental chairside assistants (83%), dental reception staff (70%) and dentists (41%).
- The ease of identifying and employing different staff types can vary from being relatively straight-forward to quite challenging.

### Employment Difficulty Across All Practices





## 6. Practice Dynamics: Patient Flow and Practice Workload

- Patient flow and practice workload questions were reported by self-employed dentists only i.e. those that are either sole practitioners, owners of practices that employ others or partners within a practice
- Employees/salaried staff and contractors were not required to answer these questions

### 6.1.1 Patient Flow

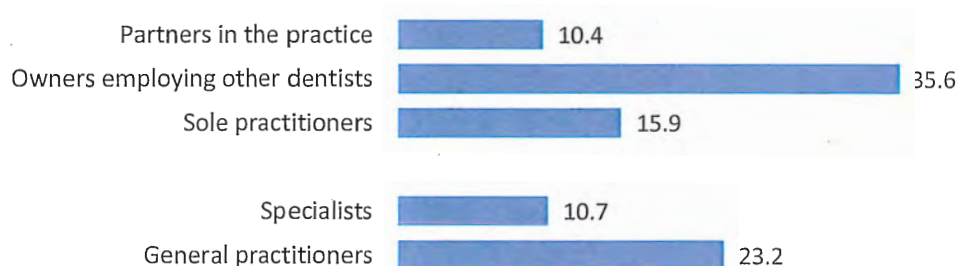
#### 1. Patient appointments

- These dentists reported that their practices provided an average of 92.1 patient appointments per week, which is an 11% increase from the 83 appointments per week reported in 2015.
- These dentists also reported that their practices *could* have accommodated an average of 111.5 potential appointments per week, with the 92.1 appointments representing an average take-up of 83%.
- The proportion of self-employed dentists who reported that their practices had ‘usual clinical appointment times’ that were not utilised during the day was approximately two thirds (66%, up from 60% in FY 2013/14).
- However, almost all dentists (94%) (including self-employed, employed and contractor dentists) reported that their practices were able to offer any patient an emergency appointment on the same or next day, which is very similar to the 96% reported for the financial year 2013/14.

#### 2. Working hours not utilised

- On average, self-employed dentists reported a total of 21.4 working hours not utilised per week. Of those dentists:
  - General practitioners reported more working hours not utilised per week than specialists (23.2 hours vs 10.7 hours), on average.
  - Practice owners employing other dentists reported more working hours not utilised per week than sole practitioners and those who were partners in their practice.

#### Working Hours Not Utilised Per Week For Self-Employed Dentists

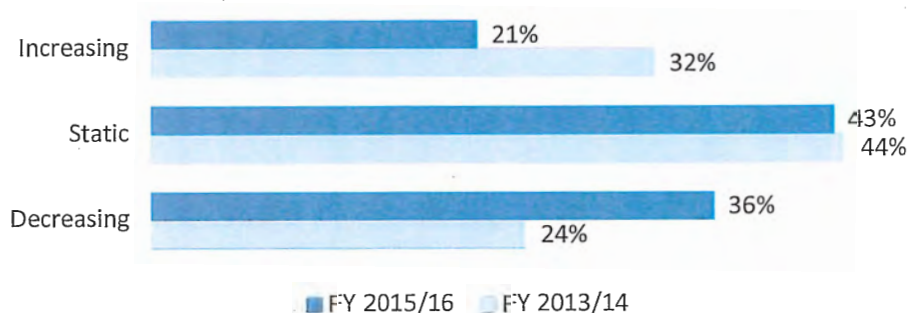


### 3. Patient demand

- Lack of business accounted for over half of the working hours not utilised (13.3 hours out of the 21.4 hours not utilised, on average).
    - 4.8 hours were lost per week due to patients not turning up for their appointments
  - Almost half (47%) reported that their practices did not have as many patients as they would have liked, up slightly from the 44% reported for the financial year 2013/14.
  - This was higher for general practitioners (50%) than specialists (24%), and it was higher for sole practitioners (51%) and owners employing other dentists (48%) than for those who were partners in their practice (34%).
- Breakdowns of capacity and provision of appointments, and underutilisation of working hours are shown in Table 9.

#### 6.1.2 Practice Workload

**Practice Workload Trends Perceived  
By Self-Employed Dentists**



- Whilst almost half believe that their workload had been static, just over a third report that it is declining and only 21% reported that their workload was increasing, a shift in the trend seen in previous years.
- Of those self-employed dentists, specialists were more likely to think their practice workload was increasing than general practitioners (34% vs 19%).
- In spite of having a greater number of working hours not utilised, owners employing other dentists were more likely to think their practice workload was increasing than sole practitioners and those who were partners in their practice (28% vs 17%).
- Overall, only 8% of self-employed dentists' practices were too busy to accommodate patients.
- 50.8% of sole practitioners and 47.5% of owners (employing other dentists) stated that their practice did not have enough patients, compared to 34.4% in partner run practices
- Further detailed responses regarding workload trends are shown in Tables 10, 11a and 11b.

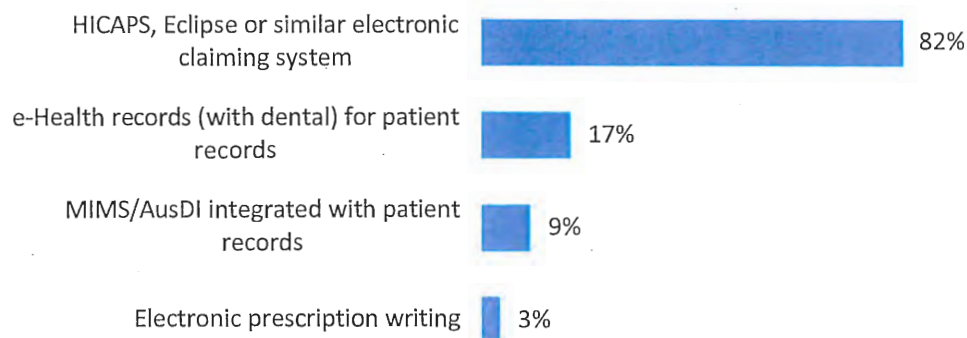
## 7. Practice Dynamics: Technology Used at Practice

- Technology and installed based questions were answered by self-employed dentists only i.e. those that are either sole practitioners, owners of practices that employ others or partners within a practice.
- Employees/salaried staff and contractors were not required to answer these questions.

### 7.1.1 Use of Electronic Record Management and Communication

- The majority of dentists (82%) stated that they use HICAPS, Eclipse or similar electronic claiming systems as part of their practice software.
  - However, reported use was much lower for e-Health records (17%), MIMS integrated with patient records (9%) and Electronic prescription writing (3%). These usage rates are all very similar to those reported in FY 2013/14.
  - Breakdowns of practices' usage of electronic record management are shown in Table 12.

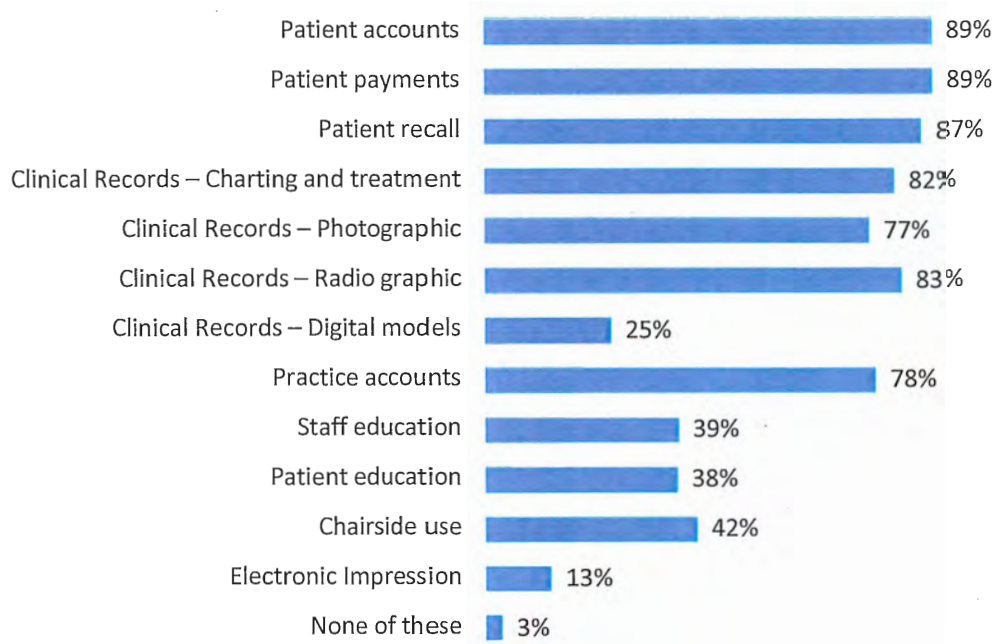
#### Record Management And Communication Systems Used In Practices



- The functions most commonly handled electronically were patient payments (89%), patient accounts (89%) and patient recalls (87%).
- Electronic tasks at the chairside were carried out by 42%.



### Electronic Functions Most Used In Practices



- The proportion of dentists handling these functions electronically was very similar to those reported in FY 2013/14, except for two notable differences:
  - An increase for charting and treatment clinical records, from 76% (FY 2013/14) to 82% (FY 2015/16).
  - A decrease for chairside use from 52% (FY 2013/14) to 42%.
- Similar to that reported for FY 2013/14, the majority of dentists (93%) stated that their practices used dental practice management software, with the top 3 most commonly used programs remaining as:
  1. D4W (36%)
  2. Oasis (19%)
  3. Exact (15%)

### 7.1.2 Dentist Chairs Installed at Practices

- Self-employed dentists reported that their primary practices had an average of 2.7 chairs installed. This number declined for subsequent practices:



- On average, more chairs were installed in those primary practices which were owned under a partnership arrangement (3.7 chairs) than those in owner/employer practices (3.1 chairs) and in sole practitioner practices (2.0 chairs).
- Specialists in their primary practice had 3.0 chairs installed whilst general practitioners have 2.7 chairs on average.

### 7.1.3 Use of Emergency Equipment

- Similar to that reported in FY 2013/14, just over two thirds of all dentists (68%) reported that their practices had emergency oxygen equipment.
- Less than half of all dentists (44%) reported that their practices had emergency defibrillator equipment, but this is an improvement from the 34% reported in FY 2013/14.
- 12% of dentists reported that their practices used offshore prosthetics services, a slight decrease from the 15% reported in FY 2013/14.

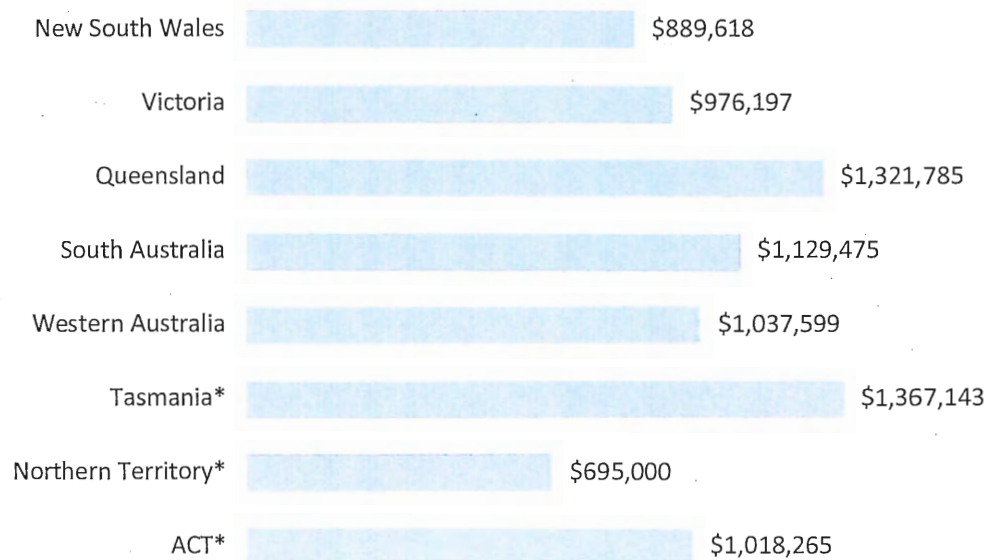
## 8. Practice Dynamics: Financial Aspects

- The following sections of the report (5.1 and 5.2) present practice incomes (gross and net) and practice expenses for the financial year 2015/16, based on the 574 self-employed dentists who provided partial or full financial details of their practices.
- Of those, just over half were sole practitioners (51%), a third (33%) were owners employing other dentists, and the remaining 17% were partners in the practice. Additionally, approx. one in eight (14%) were specialists, while the majority (86%) were general practitioners.
- For these sections (5.1 and 5.2), 'practices' refers to all practices in which these self-employed dentists worked during the financial year 2015/16.

### 8.1 Income of Practice, Principal Dentists and Employed Dentists

- In the financial year 2015/16, the average private dental practice in Australia employed 6.6 personnel, and generated a **gross** practice income of \$1,037,146 per year.
- Given the expansion of this study to include a greater workforce focus and hence inclusion of more single practice owners, and not as many multi-practice owners, caution should be taken if comparing these figures to previous data.

#### Gross Annual Income Per Practice By State



*Please note: The sample sizes for Tasmania, Northern Territory and ACT are very small (<15 dentists). Caution should be advised regarding how these figures are interpreted and used.*

- The average **net** practice income was \$334,650, a decline from the \$379,560 reported in in the FY 2013/14. Practices were fairly evenly split in terms of whether their 2015/16 **net** practice income was higher than (33%), the same as (33%) or lower than (34%) that for the previous financial year (2014/15). The most cited percentage change (increase or decrease) in net practice income remained at 10%.

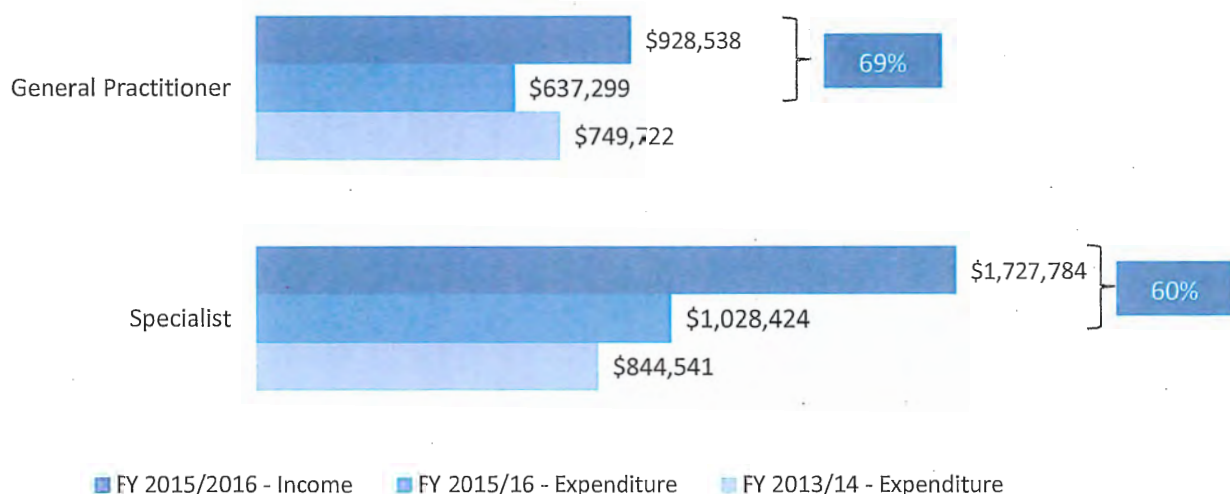
- Unsurprisingly both **gross** and **net** average practice incomes were highest for partnership practices and lowest for sole practitioners' practices.
  - On average, dentists who were partners in a practice reported higher **gross** practice incomes (\$1,905,891) than sole practitioners (\$606,884) and owners employing other dentists (\$1,260,712), and, on average, partners also reported higher **net** practice incomes (\$734,355) than sole practitioners (\$219,612) and owners employing other dentists (\$311,935).
- Specialists reported higher **gross** practice incomes than general practitioners (\$1,727,784 vs. \$928,538), and higher **net** practice incomes (\$675,254 vs. \$281,496).
- Total gross and net practice incomes are shown in Table 8.

## 8.2 Expenses of Practice

### 8.2.1 Gross Annual Expenditure

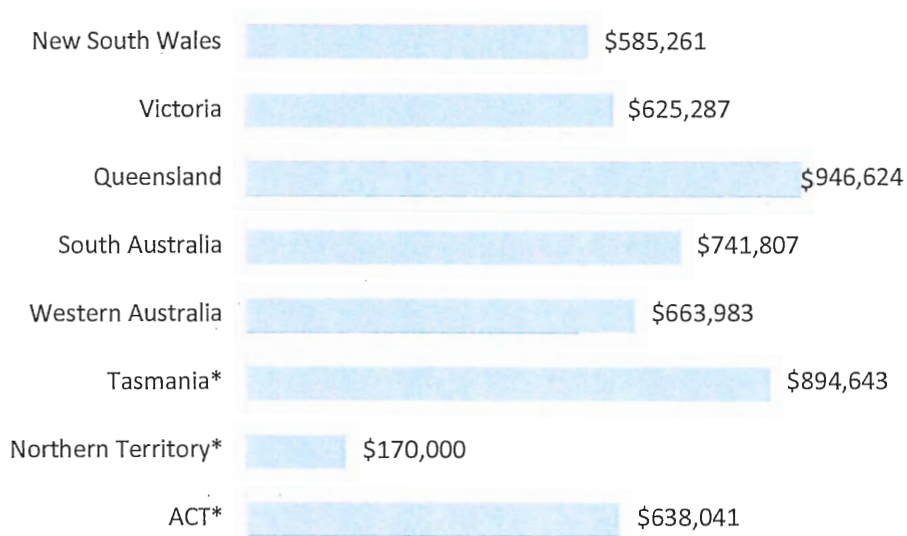
- On average, practice expenses were \$689,910, negating 66% of the average gross practice income. This is proportionally very similar to that reported for the financial year 2013/14, where 68% on average, of the gross practice income was expenses.
- The proportion of gross practice income that was considered an expense was also higher amongst general practitioners (68%) than specialists (59%), and it was higher amongst owners (73%) than sole practitioners (63%) or than those in partnership practices (60%).
- In terms of absolute values, total annual practice expenses were:
  - Higher among specialists (\$1,028,424) than general practitioners (\$637,299).
  - Higher amongst those in partnership businesses (\$1,167,272) and owners employing other dentists (\$931,750) than sole practitioners (\$381,254).
  - Highest in Queensland (\$946,624), Tasmania (\$894,643) and South Australia (\$741,807).

### Gross Income And Expenditure By Dentist Type



- Details of practice expenses are shown in Table 8.

### Gross Annual Expenditure Per Practice By State

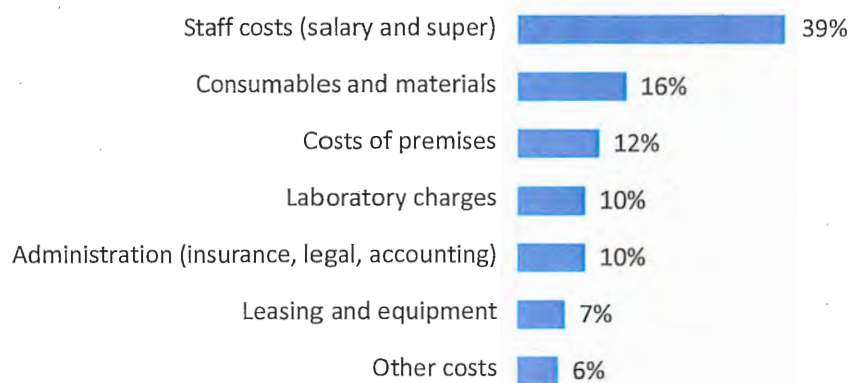


Please note: The sample sizes for Tasmania, Northern Territory and ACT are very small (<15 dentists). Caution should be advised regarding how these figures are interpreted and used.

#### 8.2.2 Gross Annual Expenditure Specifics

- Staff costs were the biggest expense, accounting for an average of 39% of the total annual practice expenditure.
- Other major expenses included:

#### Proportions Of Total Annual Practice Expenditure





## 9. Appendix

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**Table 0: Response rate**

		Total Sample Email Out	Usable Responses	% Response Rate	% of Total Usable Sample
<b>Total FY 2013/14</b>		<b>11,216</b>	<b>2,054</b>	<b>18.3%</b>	<b>100%</b>
<b>Total FY 2015/16</b>		<b>11,060</b>	<b>1,929</b>	<b>17.4%</b>	<b>100%</b>
<b>State / Territory</b>	New South Wales	3,399	596	17.5%	30.8%
	Victoria	2,765	502	18.2%	25.0%
	Queensland	2,217	403	18.2%	20.1%
	South Australia	743	108	14.5%	6.7%
	Western Australia	1,530	227	14.8%	13.8%
	Tasmania	144	33	22.9%	1.3%
	Northern Territory	54	13	24.1%	0.5%
	ACT	196	47	24.0%	1.8%
<b>Type of Dentist</b>	General Practitioner	9,809	1,714	17.5%	88.9%
	Specialist	1,251	215	17.2%	11.1%
<b>Employment Status (if self- employed)</b>	Sole Practitioner		456		45.8%
	Owner Employing Dentists		338		34.0%
	Partner in the Practice		201		20.2%



**Table 1: Locations of members' primary practices.**

		Sample N=	Metro/ State Capital 'Metropolitan'	Regional/ Rest of State 'Country'
<b>Total FY 2015/16</b>		<b>1822</b>	<b>68.4%</b>	<b>31.6%</b>
<b>State / Territory</b>	NSW	559	63.7%	36.3%
	VIC	486	77.0%	23.0%
	QLD	379	58.6%	41.4%
	SA	97	80.4%	19.6%
	WA	210	78.1%	21.9%
	TAS	33	42.4%	57.6%
	NT	12	25.0%	75.0%
	ACT	46	76.1%	23.9%
<b>Location</b>	Metropolitan	1246	100.0%	0.0%
	Country	576	0.0%	100.0%
<b>Gender</b>	Male	1189	67.6%	32.4%
	Female	633	69.8%	30.2%
<b>Type of Dentist</b>	General Practitioner	1619	66.5%	33.5%
	Specialist	203	83.7%	16.3%
<b>Employment Type</b>	Self-employed	975	73%	27%
	Not Self-Employed (NET)	847	63%	37%
	Employed/Salaried	402	64%	36%
	Contractor	184	61%	39%
	Independent Contractor	261	63%	37%
<b>Employment Hours</b>	Full Time (>=35 hrs/week)	1140	68.8%	31.2%
	Part Time (<35 hrs/week)	675	67.9%	32.1%
<b>Employment Status (if self- employed)</b>	Sole practitioner	448	75.4%	24.6%
	Owner employing dentists	330	70.0%	30.0%
	Partner in the practice	196	73.0%	27.0%

Table 2: Employment types of all members.

		Sample N=	Self- employed	Not Self- Employed (NET)	Employed/ Salaried	Contractor	Independent Contractor
<b>Total FY 2015/16</b>		<b>1884</b>	<b>53.2%</b>	<b>46.8%</b>	<b>22.0%</b>	<b>10.1%</b>	<b>14.7%</b>
State / Territory	NSW	581	59.4%	40.6%	15.7%	8.6%	16.4%
	VIC	495	52.1%	47.9%	23.4%	9.9%	14.5%
	QLD	391	49.9%	50.1%	25.8%	11.3%	13.0%
	SA	106	57.5%	42.5%	17.9%	9.4%	15.1%
	WA	219	45.7%	54.3%	26.9%	13.2%	14.2%
	TAS	33	57.6%	42.4%	30.3%	3.0%	9.1%
	NT	13	30.8%	69.2%	53.8%	7.7%	7.7%
	ACT	46	43.5%	56.5%	26.1%	13.0%	17.4%
Location	Metropolitan	1246	57.1%	42.9%	20.5%	9.1%	13.2%
	Country	576	45.7%	54.3%	25.3%	12.3%	16.7%
Gender	Male	1230	62.9%	37.1%	16.6%	8.6%	11.9%
	Female	654	34.9%	65.1%	32.3%	12.8%	20.0%
Type of Dentist	General Practitioner	1674	51.2%	48.8%	22.0%	11.1%	15.7%
	Specialist	210	69.0%	31.0%	22.4%	1.9%	6.7%
Employment Hours	Full Time (>=35 hrs/week)	1140	62.6%	37.4%	18.4%	8.0%	11.0%
	Part Time (<35 hrs/week)	675	38.4%	61.6%	28.1%	13.8%	19.7%
Employment Status (if self-employed)	Sole practitioner	456	100.0%	0.0%	0.0%	0.0%	0.0%
	Owner employing dentists	338	100.0%	0.0%	0.0%	0.0%	0.0%
	Partner in the practice	201	100.0%	0.0%	0.0%	0.0%	0.0%



**Table 3: Employment status of self-employed members.**

		Sample N=	Sole practitioner	Owner employing dentists	A Partner in the practice
<b>Total for FY 2015/16</b>		<b>995</b>	<b>45.8%</b>	<b>34.0%</b>	<b>20.2%</b>
<b>State / Territory</b>	NSW	341	51.0%	29.6%	19.4%
	VIC	257	45.9%	35.8%	18.3%
	QLD	194	43.3%	32.5%	24.2%
	SA	60	28.3%	45.0%	26.7%
	WA	100	43.0%	41.0%	16.0%
	TAS	19	31.6%	47.4%	21.1%
	NT	4	75.0%	25.0%	0.0%
	ACT	20	55.0%	20.0%	25.0%
<b>Location</b>	Metropolitan	712	47.5%	32.4%	20.1%
	Country	262	42.0%	37.8%	20.2%
<b>Gender</b>	Male	769	46.9%	32.4%	20.7%
	Female	226	42.0%	39.4%	18.6%
<b>Type of Dentist</b>	General Practitioner	852	44.6%	37.3%	18.1%
	Specialist	143	53.1%	14.0%	32.9%
<b>Employment Hours</b>	Full Time (>=35 hrs/week)	714	43.8%	36.3%	19.9%
	Part Time (<35 hrs/week)	258	51.9%	27.5%	20.5%

**Table 4: Practice types of employed/salaried and contractor dentists.**

		Sample N=	Private practice*	Government services	Research / training / academia	Other**
<b>Total for FY 2015/16</b>		<b>879</b>	<b>71.9%</b>	<b>23.1%</b>	<b>5.2%</b>	<b>5.0%</b>
<b>State / Territory</b>	NSW	236	75.8%	17.4%	3.0%	5.5%
	VIC	237	69.2%	29.5%	4.2%	5.1%
	QLD	196	71.4%	21.4%	8.2%	4.1%
	SA	45	73.3%	15.6%	15.6%	6.7%
	WA	119	74.8%	21.8%	3.4%	4.2%
	TAS	14	50.0%	50.0%	7.1%	0.0%
	NT	9	22.2%	66.7%	0.0%	22.2%
	ACT	26	76.9%	19.2%	3.8%	3.8%
<b>Location</b>	Metropolitan	534	72.8%	24.2%	5.2%	4.7%
	Country	313	71.2%	22.7%	4.8%	5.1%
<b>Gender</b>	Male	456	72.1%	21.5%	5.7%	5.3%
	Female	426	71.6%	24.9%	4.7%	4.7%
<b>Type of Dentist</b>	General Practitioner	817	74.1%	22.2%	3.8%	4.5%
	Specialist	65	44.6%	35.4%	23.1%	10.8%
<b>Employment Type</b>	Self- employed	0				
	Not Self- Employed (NET)	882	71.9%	23.1%	5.2%	5.0%
	Employed/ Salaried	415	48.0%	45.1%	10.8%	5.5%
	Contractor	190	91.6%	5.3%	0.5%	4.7%
	Independent Contractor	277	94.2%	2.5%	0.0%	4.3%
<b>Employment Hours</b>	Full Time (>=35 hrs/week)	426	68.8%	29.3%	4.0%	5.2%
	Part Time (<35 hrs/week)	416	76.2%	18.0%	5.8%	4.3%

\* Private practices were classified as practices owned by dentists and/or non-dentists.

\*\* Others included locum work, practices that were part of a corporate chain, cooperative practices, Aboriginal Community Controlled Health Services and charity organisations (e.g. the Royal Flying Doctor Service).



**Table 5: Practice funding structures of self-employed members and those employed/salaried and contractor members who work in private practices.**

		Sample N=	Independent	Part of a corporate chain	Part of a health fund	Other*
<b>Total for FY 2015/16</b>		<b>1671</b>	<b>86.1%</b>	<b>8.1%</b>	<b>3.7%</b>	<b>2.1%</b>
<b>State / Territory</b>	NSW	532	88.7%	6.4%	3.2%	1.7%
	VIC	433	88.9%	5.8%	3.0%	2.3%
	QLD	342	82.2%	12.6%	3.2%	2.0%
	SA	95	83.2%	8.4%	7.4%	1.1%
	WA	194	82.5%	9.3%	5.2%	3.1%
	TAS	26	96.2%	3.8%	0.0%	0.0%
	NT	8	62.5%	12.5%	25.0%	0.0%
	ACT	41	75.6%	14.6%	4.9%	4.9%
<b>Location</b>	Metropolitan	1123	86.7%	7.3%	4.1%	1.9%
	Country	501	85.8%	9.8%	2.4%	2.0%
<b>Gender</b>	Male	1119	87.8%	7.1%	3.4%	1.7%
	Female	552	82.4%	10.3%	4.3%	2.9%
<b>Type of Dentist</b>	General Practitioner	1494	85.5%	8.8%	3.7%	1.9%
	Specialist	177	90.4%	2.8%	3.4%	3.4%
<b>Employment Type</b>	Self-employed	996	96.7%	1.8%	0.8%	0.7%
	Not Self- Employed (NET)	675	70.4%	17.5%	8.0%	4.1%
	Employed/ Salaried	221	79.2%	5.0%	8.1%	7.7%
	Contractor	183	64.5%	27.3%	6.6%	1.6%
	Independent Contractor	271	67.2%	21.0%	8.9%	3.0%
<b>Employment Hours</b>	Full Time (>=35 hrs/week)	1027	88.1%	7.1%	2.9%	1.9%
	Part Time (<35 hrs/week)	592	83.4%	9.8%	4.7%	2.0%
<b>Employment Status (if self- employed)</b>	Sole practitioner	456	96.1%	1.3%	1.1%	1.5%
	Owner employing dentists	338	98.8%	0.9%	0.3%	0.0%
	Partner in the practice	201	95.0%	4.0%	1.0%	0.0%

*\*Others included locum work, part of a small group of privately owned practices (but not a corporate chain), Aboriginal Community Controlled Health Services and charity organisations (e.g. the Royal Flying Doctor Service).*

Table 6: Days and hours worked per week for all members.

		Sample N=	Average days worked per week	Average hours worked per week				Average hours worked per day	
				Total	Chair side	Laboratory	Administration		Other*
<b>Average for FY 2013/14</b>		<b>1635</b>	<b>4.2</b>	<b>36.9</b>	<b>30.5</b>	<b>1.1</b>	<b>4.7</b>	<b>0.6</b>	<b>8.8</b>
<b>Average for FY 2015/16</b>		<b>1815</b>	<b>4.1</b>	<b>35.7</b>	<b>29.9</b>	<b>0.8</b>	<b>4.2</b>	<b>0.8</b>	<b>8.6</b>
State / Territory	NSW	557	4.1	36.6	30.3	1.1	4.3	0.9	8.8
	VIC	483	4.2	35.0	29.6	0.7	4.1	0.5	8.4
	QLD	379	4.1	35.6	29.5	0.7	4.4	1.0	8.7
	SA	97	3.9	33.3	28.2	0.5	4.0	0.6	8.6
	WA	210	4.3	36.1	30.6	0.6	3.8	0.9	8.4
	TAS	33	4.3	38.3	31.8	0.8	4.5	1.3	8.8
	NT	12	4.6	33.5	28.0	1.4	2.6	1.4	7.3
	ACT	44	4.2	33.8	29.2	0.9	3.4	0.4	8.1
Location	Metropolitan	1242	4.1	35.8	29.6	0.8	4.6	0.8	8.6
	Country	573	4.1	35.3	30.4	0.9	3.2	0.7	8.5
Gender	Male	1184	4.3	37.6	31.3	0.9	4.5	0.9	8.8
	Female	631	3.9	31.9	27.2	0.6	3.5	0.6	8.1
Type of Dentist	General Practitioner	1613	4.2	35.4	30.2	0.8	3.9	0.5	8.5
	Specialist	202	3.9	37.7	27.6	0.6	6.5	2.9	9.6
Employment Type	Self-employed	973	4.4	39.1	32.1	1.1	5.1	0.7	8.9
	Not Self-Employed (NET)	842	3.9	31.7	27.3	0.5	3.0	0.9	8.2
	Employed/Salaried	400	3.8	31.6	25.4	0.4	4.5	1.4	8.4
	Contractor	184	4.0	31.8	29.3	0.6	1.6	0.3	7.9
	Independent Contractor	258	4.0	31.9	28.9	0.7	1.8	0.6	8.1



Employment Hours	Full Time ( $\geq 35$ hrs/week)	1140	4.7	43.0	35.4	1.0	5.5	1.0	9.2
	Part Time ( $< 35$ hrs/week)	675	3.3	23.3	20.6	0.4	1.9	0.4	7.2
Employment Status (if self-employed)	Sole practitioner	447	4.4	38.0	30.9	1.2	5.0	0.9	8.6
	Owner employing dentists	330	4.3	40.5	33.0	1.1	5.8	0.6	9.3
	Partner in the practice	195	4.3	39.1	33.3	0.8	4.4	0.5	9.1

*\*Other activities included: diagnoses, treatment planning, patient reports and referrals; academic research and teaching; clinical supervision of students; cleaning, repairs and maintenance of equipment; travel time between workplaces, meetings or home visits; and networking and social media.*

**Table 7: Gross personal income 2015/2016.**

		Total		General Practitioner		Specialist	
		Sample N=	Average	Sample N=	Average	Sample N=	Average
<b>Average for FY 2015/16</b>		<b>1,577</b>	<b>\$222,250</b>	<b>1,405</b>	<b>\$202,397</b>	<b>172</b>	<b>\$384,415</b>
<b>State / Territory</b>	NSW	477	\$231,862	427	\$210,830	50	\$411,470
	VIC	417	\$208,994	367	\$186,615	50	\$373,256
	QLD	338	\$222,488	295	\$199,766	43	\$378,372
	SA	83	\$209,966	76	\$207,989	7	\$231,429
	WA	184	\$216,348	169	\$202,427	15	\$373,200
	TAS	29	\$290,793	28	\$293,321	1	\$220,000
	NT	12	\$206,500	12	\$206,500	0	
	ACT	37	\$253,830	31	\$200,539	6	\$529,167
<b>Location</b>	Metropolitan	1,072	\$225,034	930	\$205,175	142	\$355,101
	Country	505	\$216,338	475	\$196,959	30	\$523,167
<b>Gender</b>	Male	1,031	\$260,569	895	\$233,732	136	\$437,184
	Female	546	\$149,892	510	\$147,409	36	\$185,064
<b>Type of Dentist</b>	General Practitioner	1,405	\$202,397	1,405	\$202,397	0	
	Specialist	172	\$384,415	0		172	\$384,415
<b>Employment Type</b>	Self-employed	835	\$289,376	716	\$261,581	119	\$456,618
	Not Self-Employed (NET)	742	\$146,709	689	\$140,895	53	\$222,298
	Employed/Salaried	359	\$133,384	323	\$126,381	36	\$196,217
	Contractor	157	\$149,797	153	\$149,478	4	\$162,000
	Independent Contractor	226	\$165,731	213	\$156,738	13	\$313,077
<b>Employment Hours</b>	Full Time (>= 35 hrs/week)	1,000	\$255,915	882	\$233,833	118	\$420,966
	Part Time (<35 hrs/week)	576	\$163,929	522	\$149,382	54	\$304,543
<b>Employment Status (if self-employed)</b>	Sole practitioner	389	\$274,862	327	\$241,457	62	\$451,048
	Owner employing dentists	281	\$273,957	263	\$270,929	18	\$318,194
	Partner in the practice	164	\$348,328	126	\$294,293	38	\$527,500



**Table 8: Gross and net annual incomes and expenditure per practice for self-employed dentists' practices.**

		'Total gross annual income per practice		'Total gross annual expenditure per practice		'Total net annual income per practice		Proportion of gross income expensed
		Sample N=	Average	Sample N=	Average	Sample N=	Average	
<b>Average for FY 2013/14</b>		<b>614</b>	<b>\$1,112,804</b>	<b>601</b>	<b>\$760,608</b>	<b>591</b>	<b>\$379,560</b>	<b>68.4%</b>
<b>Average for FY 2015/16</b>		<b>574</b>	<b>\$1,037,146</b>	<b>565</b>	<b>\$689,910</b>	<b>563</b>	<b>\$334,650</b>	<b>66.5%</b>
<b>State / Territory</b>	NSW	201	\$889,618	198	\$585,261	196	\$286,678	65.8%
	VIC	144	\$976,197	139	\$625,287	139	\$339,573	64.1%
	QLD	111	\$1,321,785	110	\$946,624	110	\$362,962	71.6%
	SA	34	\$1,129,475	34	\$741,807	34	\$381,490	65.7%
	WA	54	\$1,037,599	54	\$663,983	54	\$377,826	64.0%
	TAS	14	\$1,367,143	14	\$894,643	14	\$409,643	65.4%
	NT	2	\$695,000	2	\$170,000	2	\$170,000	24.5%
	ACT	14	\$1,018,265	14	\$638,041	14	\$403,152	62.7%
<b>Location</b>	Metropolitan	423	\$1,016,873	415	\$672,130	414	\$339,169	66.1%
	Country	151	\$1,093,938	150	\$739,103	149	\$322,092	67.6%
<b>Gender</b>	Male	465	\$1,104,800	460	\$730,108	458	\$361,393	66.1%
	Female	109	\$748,532	105	\$513,807	105	\$217,997	68.6%
<b>Type of Dentist</b>	General Practitioner	496	\$928,538	489	\$637,299	487	\$281,496	68.6%
	Specialist	78	\$1,727,784	76	\$1,028,424	76	\$675,254	59.5%
<b>Employment Hours</b>	Full Time (>=35 hrs/week)	428	\$1,108,889	420	\$732,315	419	\$362,728	66.0%
	Part Time (<35 hrs/week)	145	\$829,085	144	\$569,451	143	\$252,801	68.7%
<b>Employment Status (if self-employed)</b>	Sole practitioner	291	\$606,884	288	\$381,254	287	\$219,612	62.8%
	Owner employing dentists	187	\$1,260,712	184	\$931,750	183	\$311,935	73.9%
	Partner in the practice	96	\$1,905,891	93	\$1,167,271	93	\$734,355	61.2%

Table 9: Capacity and provision of patient appointments and underutilisation of working hours in self-employed dentists' practices.

	Maximum number of possible appointments per week		Number of appointments actually provided per week		Proportion of possible appointments provided	Average number of working hours not utilised per week					
	Sample N=	Average	Sample N=	Average		Sample N=	Total	Due to lack of business	Due to patients failing to attend	Due to other reasons*	
<b>Average for FY 2013/14</b>	<b>1005</b>	<b>103.8</b>	<b>1003</b>	<b>83.2</b>	<b>80.2%</b>	<b>947</b>	<b>11.5</b>	<b>6.8</b>	<b>3.4</b>	<b>1.3</b>	
<b>Average for FY 2015/16</b>	<b>798</b>	<b>111.5</b>	<b>797</b>	<b>92.1</b>	<b>82.6%</b>	<b>801</b>	<b>21.4</b>	<b>13.3</b>	<b>4.8</b>	<b>3.6</b>	
State / Territory	NSW	270	103.5	269	82.8	79.9%	269	17.4	11.8	5.1	0.7
	VIC	211	96.8	211	82.0	84.7%	213	13.7	8.1	4.2	1.5
	QLD	161	135.0	161	108.5	80.4%	162	21.0	15.2	3.8	2.1
	SA	44	151.0	44	130.3	86.3%	44	9.6	5.6	3.2	0.9
	WA	76	95.5	76	85.3	89.3%	76	15.0	9.3	4.2	1.6
	TAS	17	143.9	17	122.9	85.4%	18	215.0	107.7	4.4	102.8
	NT	3	106.7	3	82.0	76.9%	3	183.0	92.7	90.3	0.0
	ACT	16	139.1	16	115.3	82.9%	16	9.7	5.9	7.6	1.1
Location	Metropolitan	579	107.6	578	87.5	81.3%	580	24.2	15.4	4.8	4.2
	Country	219	121.9	219	104.4	85.6%	221	14.0	7.8	4.6	1.9
Gender	Male	636	117.5	635	97.6	83.0%	637	23.6	14.5	5.1	4.2
	Female	162	88.0	162	70.7	80.4%	164	12.9	8.6	3.3	1.2
Type of Dentist	General Practitioner	683	102.0	682	84.0	82.4%	686	23.2	14.4	4.9	4.1
	Specialist	115	168.4	115	140.6	83.5%	115	10.7	6.4	3.8	0.6



Employment Hours	Full Time (>=35 hrs/week)	591	115.7	590	95.8	82.8%	593	24.0	14.5	4.9	4.6
	Part Time (<35 hrs/week)	206	99.3	206	81.3	81.9%	207	13.9	9.7	4.3	0.6
Employment Status (if self-employed)	Sole practitioner	380	69.8	380	55.7	79.9%	381	15.9	11.3	4.3	0.6
	Owner employing dentists	265	130.9	264	107.2	81.9%	266	35.6	20.1	6.1	9.6
	Partner in the practice	153	181.7	153	156.6	86.2%	154	10.4	6.3	3.5	0.6

*\*Other reasons: equipment malfunctions or repairs, staff planned or unplanned absences, late notice patient cancellations or rescheduling, meetings with sales reps, and dedicated study time.*

Table 10: Workload trends and patient demand at self-employed members' practices.

		Workload trend perceptions			Patient demand perceptions				
		Sample N=	Increasing	Static	Declining	Sample N=	Practice too busy*	Good balance of patients**	Not enough patients***
Average for FY 2013/14		1002	23.9%	44.1%	32.0%	1002	8.5%	46.1%	45.4%
Average for FY 2015/16		799	20.8%	43.4%	35.8%	799	7.9%	45.6%	46.6%
State / Territory	NSW	270	21.5%	41.9%	36.7%	270	7.8%	45.2%	47.0%
	VIC	212	21.7%	47.2%	31.1%	212	10.8%	50.0%	39.2%
	QLD	161	17.4%	38.5%	44.1%	161	4.3%	40.4%	55.3%
	SA	44	25.0%	54.5%	20.5%	44	0.0%	59.1%	40.9%
	WA	76	18.4%	38.2%	43.4%	76	11.8%	34.2%	53.9%
	TAS	17	29.4%	52.9%	17.6%	17	5.9%	58.8%	35.3%
	NT	3	0.0%	66.7%	33.3%	3	0.0%	0.0%	100.0%
	ACT	16	25.0%	50.0%	25.0%	16	12.5%	56.3%	31.3%
Location	Metropolitan	580	20.0%	44.8%	35.2%	580	6.7%	46.2%	47.1%
	Country	219	22.8%	39.7%	37.4%	219	11.0%	43.8%	45.2%
Gender	Male	636	19.0%	44.5%	36.5%	636	7.7%	44.2%	48.1%
	Female	163	27.6%	39.3%	33.1%	163	8.6%	50.9%	40.5%
Type of Dentist	General Practitioner	684	18.6%	41.4%	40.1%	684	6.0%	43.7%	50.3%
	Specialist	115	33.9%	55.7%	10.4%	115	19.1%	56.5%	24.3%
Employment Hours	Full Time (>=35 hrs/week)	591	22.7%	44.2%	33.2%	591	8.3%	48.1%	43.7%
	Part Time (<35 hrs/week)	207	15.0%	41.5%	43.5%	207	6.8%	38.2%	55.1%
Employment Status (if self-employed)	Sole practitioner	380	17.1%	43.4%	39.5%	380	6.3%	42.9%	50.8%
	Owner employing dentists	265	27.9%	40.0%	32.1%	265	8.7%	43.8%	47.5%
	Partner in the practice	154	17.5%	49.4%	33.1%	154	10.4%	55.2%	34.4%

\*Practice too busy: some patients obtained their appointments elsewhere due to long appointment lists.

\*\*Good balance of patients: a good balance between patient demand and practice capacity.

\*\*\*Not enough patients: The practice had fewer patients than desired.



**Table 11a: Correlation between workload trends and patient demand at self-employed members' practices – FY 2015/16.**

	Sample N=	Workload trend perceptions		
		Increasing (n=239)	Static (n=442)	Declining (n=321)
<b>Average for FY 2015/16</b>	<b>799</b>	<b>20.8%</b>	<b>43.4%</b>	<b>35.8%</b>
Practice too busy*	63	54.0%	38.1%	7.9%
Good balance of patients**	364	29.4%	55.2%	15.4%
Not enough patients***	372	6.7%	32.8%	60.5%

**Table 11b: Correlation between workload trends and patient demand at self-employed members' practices – FY 2013/14.**

	Sample N=	Workload trend perceptions		
		Increasing (n=166)	Static (n=347)	Declining (n=286)
<b>Average for FY 2013/14</b>	<b>1002</b>	<b>23.9%</b>	<b>44.1%</b>	<b>32.0%</b>
Practice too busy*	85	49.4%	41.2%	9.4%
Good balance of patients**	462	34.2%	53.7%	12.1%
Not enough patients***	455	8.6%	34.9%	56.5%

*\*Practice too busy: some patients obtained their appointments elsewhere due to long appointment lists.*

*\*\*Good balance of patients: a good balance between patient demand and practice capacity.*

*\*\*\*Not enough patients: The practice had fewer patients than desired.*

**Table 12: Usage of electronic record management.**

		Sample N=	Electronic prescription writing	MIMS/AusDI integrated with patient records	e-Health records (with dental) for patient records	HICAPS, Eclipse or similar electronic claiming system
<b>Average for FY 2013/14</b>		<b>1565</b>	<b>2.4%</b>	<b>11.0%</b>	<b>13.7%</b>	<b>82.3%</b>
<b>Average for FY 2015/16</b>		<b>1606</b>	<b>3.4%</b>	<b>9.4%</b>	<b>17.3%</b>	<b>82.1%</b>
<b>State / Territory</b>	NSW	485	5.2%	8.5%	15.7%	79.4%
	VIC	426	2.3%	12.9%	20.9%	82.4%
	QLD	346	2.9%	6.6%	17.3%	84.1%
	SA	81	2.5%	9.9%	16.0%	96.3%
	WA	187	1.1%	5.9%	13.9%	82.9%
	TAS	30	3.3%	23.3%	13.3%	86.7%
	NT	12	25.0%	16.7%	8.3%	58.3%
	ACT	39	5.1%	10.3%	23.1%	66.7%
<b>Location</b>	Metropolitan	1095	3.0%	8.4%	17.8%	82.4%
	Country	511	4.3%	11.5%	16.2%	81.6%
<b>Gender</b>	Male	1055	3.4%	9.3%	16.0%	81.5%
	Female	551	3.4%	9.6%	19.8%	83.3%
<b>Type of Dentist</b>	General Practitioner	1432	3.5%	9.6%	17.6%	87.6%
	Specialist	174	2.9%	7.5%	14.9%	37.4%
<b>Employment Type</b>	Self-employed	869	1.7%	6.6%	13.5%	84.9%
	Not Self-Employed (NET)	737	5.4%	12.8%	21.8%	78.8%
	Employed/Salaried	355	6.5%	15.8%	24.8%	61.4%
	Contractor	158	5.7%	10.1%	20.3%	96.2%
	Independent Contractor	224	3.6%	9.8%	18.3%	94.2%
<b>Employment Hours</b>	Full Time (>=35 hrs/week)	1023	3.7%	9.6%	17.2%	81.1%
	Part Time (<35 hrs/week)	581	2.9%	9.1%	17.6%	83.8%
<b>Employment Status (if self- employed)</b>	Sole practitioner	405	1.7%	4.4%	11.6%	76.5%
	Owner employing dentists	291	0.7%	7.9%	12.7%	96.2%
	Partner in the practice	172	3.5%	9.3%	19.2%	86.0%







# ANNEXURE 2



# Dentists



## 2017 Factsheet

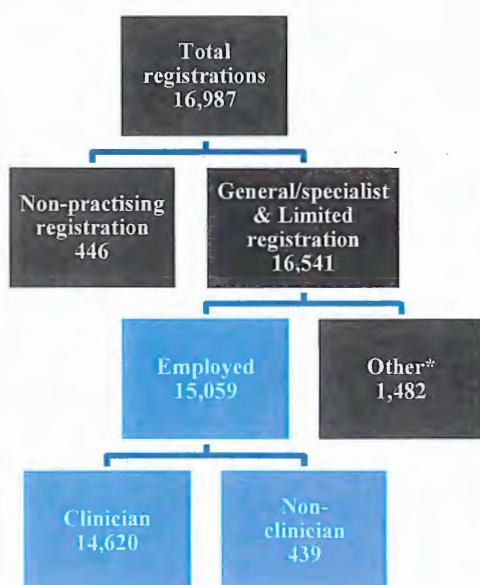
Dentists are registered healthcare practitioners who may practise all parts of dentistry within their competency and training. They provide assessment, diagnosis, treatment, management and preventive services to patients of all ages.

To gain registration as a dentist, a practitioner must complete a minimum four year undergraduate, or four year postgraduate master program of study approved by the Dental Board of Australia. Further training is required for specialisation.

The following analysis is drawn from the number of dentists with general, specialist or limited registration who were employed (15,059 in 2017) unless otherwise stated.

## Workforce

Figure 1: Dental registrations, 2017



\*\*Other\* includes: working but on long leave, working outside the profession, looking for work, overseas, and retired.

\*Non-clinician\* includes roles reported by survey respondents that did not fit predefined survey categories.

The number of registered dentists increased by 7.8% from 15,764 in 2014 to 16,978 in 2017 (average annual increase of 2.5%). The number of employed dentists increased by 8.2% from 13,919 to 15,059 over the same period (an average annual increase of 2.7%).

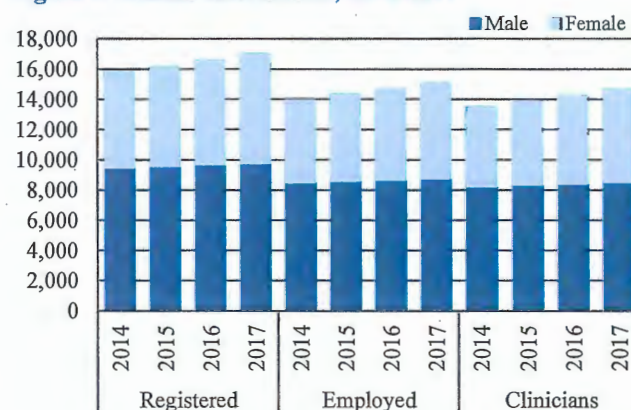
Table 1: Dentists, 2014-2017

	2014	2015	2016	2017	Avg. annual growth
Registered	15,764	16,123	16,549	16,987	2.5%
Employed	13,919	14,311	14,636	15,059	2.7%
Clinicians	13,472	13,843	14,205	14,620	2.8%

## Demographics

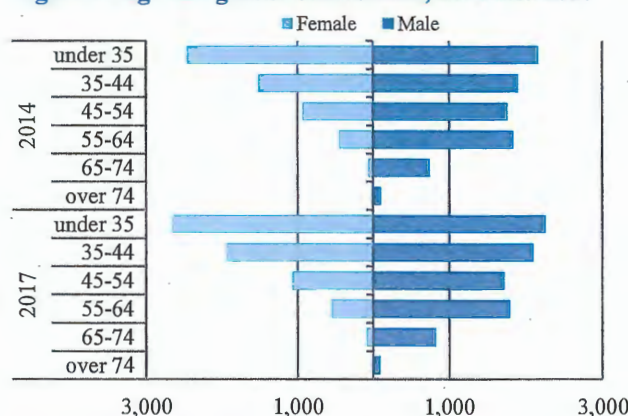
In 2017, 41.8% of dentists were female, an increase from 39.0% in 2014.

Figure 2: Gender distribution, 2014-2017



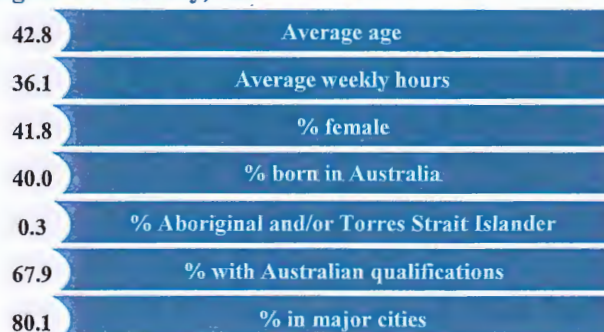
In 2017, the average age of dentists was 42.8 years, a decrease from 43.0 years in 2014. Between 2014 and 2017, the proportion of female dentists aged 35-44 years increased from 10.9% to 12.8%.

Figure 3: Age and gender distribution, 2014 and 2017



## Quick Facts - 2017

Figure 4: Summary, 2017



## Endorsements

In 2017, 87 dentists held an endorsement for conscious sedation, up from 82 in 2014.



## Replacement Rate

In 2017, there were 1.9 new registrants for every Dentist that did not renew their registration from 2016.

## Hours Worked

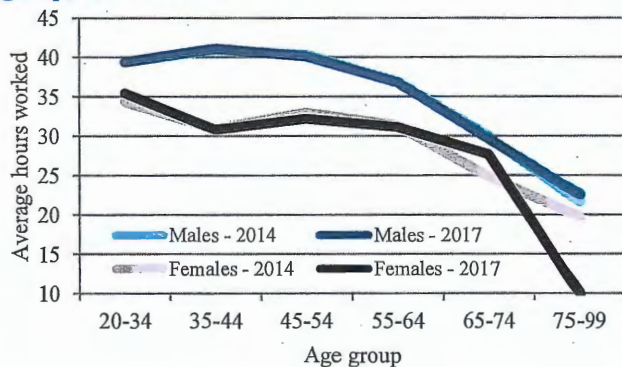
In 2017, dentists worked an average of 36.1 hours per week in total, with an average of 3.7 hours per week in non-clinical roles.

**Table 2: Average hours per week, 2014-2017**

Average hours worked	2014	2015	2016	2017
Clinical	32.3	32.2	32.5	32.4
Non-clinical	3.9	3.8	3.8	3.7
<b>Total</b>	<b>36.2</b>	<b>36.0</b>	<b>36.2</b>	<b>36.1</b>

In 2017, male dentists worked an average of 38.3 hours per week, decreasing from 38.4 hours in 2014. Female dentists worked an average of 33.0 hours per week, increasing from 32.8 hours in 2014. Males aged 35-44 worked the longest hours per week, at 41.1 hours on average.

**Figure 5: Average hours per week by gender and age group, 2014 and 2017**



## Principal Role

In 2017, 97.1% of dentists worked as clinicians in their principal role, an increase from 96.8% in 2014.

**Table 3: Principal role, 2014 and 2017**

Principal role	2014		2017	
	Head count	%	Head count	%
Clinician	13,472	96.8	14,620	97.1
Administrator	145	1.0	176	1.2
Teacher or educator	187	1.3	156	1.0
Researcher	73	0.5	46	0.3
Other	42	0.3	61	0.4
<b>Total</b>	<b>13,919</b>	<b>100</b>	<b>15,059</b>	<b>100</b>

## Second job

In 2017, 19.2% of dentists reported a second job role in dentistry, an increase from 19.1% in 2014.

**Table 4: Second job role, 2014 and 2017**

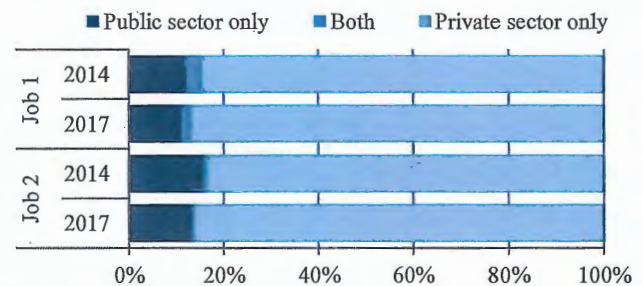
Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	1,965	14.1	2,309	15.3
Administrator	188	1.4	150	1.0
Teacher or educator	374	2.7	363	2.4
Researcher	79	0.6	31	0.2
Other	47	0.3	45	0.3
<b>Total</b>	<b>2,653</b>	<b>19.1</b>	<b>2,898</b>	<b>19.2</b>

## Principal work sector

In 2017, 11.2% of dentists reported that in their principal role, they worked only in the public sector, a decrease from 12.0% in 2014.

Of those dentists reporting a second job role in 2017, 13.4% reported they worked only in the public sector, a decrease from 15.9% in 2014.

**Figure 6: Sector in which clinical hours were worked, 2014 and 2017**



Note: 'Not applicable' responses are excluded from the chart

## Principal Work Setting

**Table 5: Principal work setting, 2014 and 2017**

Principal work setting	2014		2017	
	Principal role	Second job	Principal role	Second job
Group private practice	7,543	1,450	8,533	1,737
Solo private practice	3,892	385	4,114	644
Public clinic	895	172	842	169
Hospital	703	273	689	277
Tertiary educ facility	213	243	194	223
Defence forces	127	23	142	21
Locum private practice	154	60	130	57
Other	139	51	126	49
Commercial/ business service	59	16	81	18
Other community health care service	58	0	73	23
Aboriginal health service	61	19	60	13
Remaining work settings	75	52	75	53
<b>Total</b>	<b>13,919</b>	<b>2,796</b>	<b>15,059</b>	<b>3,337</b>

Note: In this instance the principal work setting headcount for the reported second job does not equal the principal role for the reported second job. This occurs when the survey respondent indicates a second job work setting but not a second job principal role.



In 2017, 84.0% of dentists worked in a Group or Solo private practice setting in their principal role, an increase from 82.2% in 2014, and 5.6% worked in a Public clinic setting, a decrease from 6.4% in 2014.

In 2017, dentists working in Solo private practice reported the highest average weekly hours (38.0) and those in Residential health care facilities (included in 'Remaining work settings') reported the lowest average weekly hours (21.8).

### Primary Speciality

Although the number of dentists that reported a primary speciality increased from 1,442 to 1,496 between 2014 and 2017, this represented a decrease in the proportion of all employed dentists reporting a primary speciality from 10.2% to 9.9%.

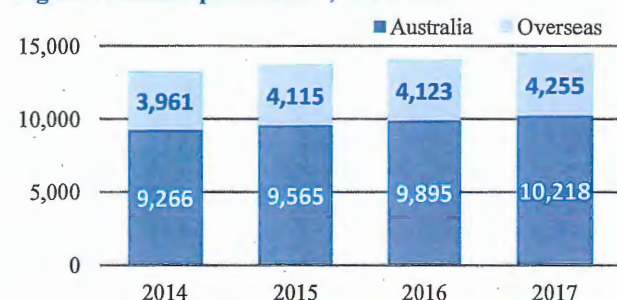
In 2014 and 2017, orthodontics was the most commonly reported primary speciality, while the number of dentists reporting the primary specialities of Oral medicine, Forensic odontology, Public health dentistry and oral pathology all decreased over the same period.

**Table 6: Headcounts by primary speciality 2014 and 2017**

Primary Speciality	Headcount		
	2014	2017	Growth
Orthodontics	527	530	0.6%
Periodontics	194	201	3.6%
Prostodontics	193	201	4.1%
Oral and maxillofacial surgery	153	170	11.1%
Endodontics	137	156	13.9%
Paediatric dentistry	102	122	19.6%
Oral surgery	24	27	12.5%
Oral medicine	27	25	-7.4%
Forensic odontology	26	21	-19.2%
Special needs dentistry	13	16	23.1%
Dento-maxillofacial radiology	8	11	37.5%
Public health dentistry	12	11	-8.3%
Oral pathology	6	5	-16.7%
<b>Total</b>	<b>1,422</b>	<b>1,496</b>	<b>5.2%</b>

### Initial Qualification

**Figure 7: Initial qualification, 2014-2017**



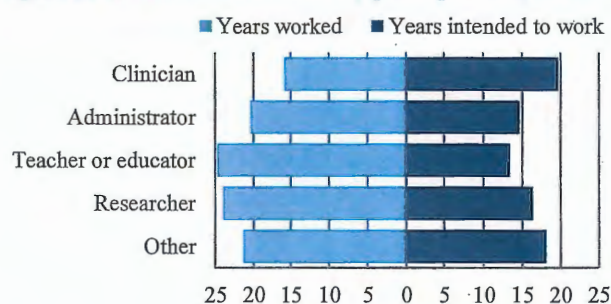
Note: 'Not stated/Unknown' responses are excluded from this chart

The workforce survey asks dentists where they obtained their initial qualification. In 2017, 67.9% of dentists obtained their initial qualification in Australia and 28.3% obtained their initial qualification overseas.

### Working Intentions

In 2017, dentists had, on average, worked 16 years in the profession and intended to work for another 20 years. In 2014, dentists had worked 16 years on average, and intended to work for another 19 years.

**Figure 8: Workforce intentions by principal role, 2017**



### Distribution

#### State and Territory

In 2017, the jurisdictions with the highest rates of full-time equivalent dentists per 100,000 population (FTE rate) were the ACT and QLD.

**Table 7: Distribution by state/ territory, 2017**

State / Territory	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
NSW	4,904	4,722.4	36.6	60.1
VIC	3,678	3,425.0	35.4	54.2
QLD	3,122	3,026.9	36.8	61.4
SA	1,097	1,007.6	34.9	58.5
WA	1,637	1,517.2	35.2	58.9
TAS	227	221.4	37.1	42.4
ACT	287	276.8	36.7	67.2
NT	98	99.8	38.7	40.3
<b>Total</b>	<b>15,059</b>	<b>14,305.4</b>	<b>36.1</b>	<b>58.2</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

Between 2014 and 2017 the total FTE rate increased from 56.5 to 58.2 and the ACT and QLD had the largest FTE rate increase (both 2.9).

In 2017, dentists in the NT worked the most hours per week on average (38.7 hours) and those in SA worked the fewest (34.9 hours).

### Remoteness Area

In 2017, 93.6% of dentists worked in either major cities or inner regional locations, compared with 93.3% in 2014.



Between 2014 and 2017, the largest shift in average hours worked was in very remote areas, decreasing from 43.2 hours per week in 2014 37.5 hours in 2017. However, the FTE rate in very remote areas increased by 2.6 due to the increase in the number of dentists in these areas.

**Table 8: Distribution by remoteness area, 2017**

Remoteness Area	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
Major cities	12,068	11,417.2	36.0	64.6
Inner regional	2,024	1,954.5	36.7	44.5
Outer regional	832	798.9	36.5	39.0
Remote	93	94.1	38.5	32.2
Very remote	34	33.6	37.5	16.7
<b>Total</b>	<b>15,059</b>	<b>14,305.4</b>	<b>36.1</b>	<b>58.2</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

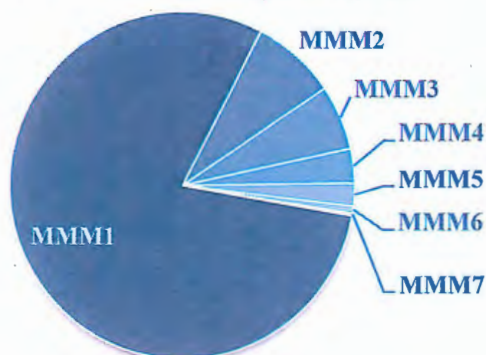
### Other Work Location Outside of Major Cities

In 2017, 4.6% of dentists reported that they had worked in a regional, rural or remote location, in addition to their principal or second job location. Of these respondents, 74.6% had worked in an inner regional or outer regional location, and 11.0% had worked in either remote or very remote locations.

### Modified Monash Model

In 2017, the majority (79.8%) of FTE dentists were located in a major city or a location considered as MMM1 under the Modified Monash Model (MMM) classification system, an increase from 79.4% in 2014.

**Figure 9: FTE Distribution by MMM, 2017**



MMM1 locations had the highest FTE rate of dentists (65.0) followed by MMM3 (55.2). The lowest FTE rate was in MMM5 locations (16.7).

(See [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au) for more information on the MMM).

### Tele-Health

The workforce survey asks dentists to report their hours practiced via tele-health in dentistry in the previous year.

Note: Tele-health is the use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

A total of 1,000 dentists (6.6%) provided a response to the Tele-Health question in 2017. On average, these respondents practiced via Tele-Health for 19.1 hours per week, with the majority (81.0%) of Tele-Health services provided by practitioners based in a major city.

**Table 9: Tele-health dentists by remoteness location, 2017**

Major cities	Inner regional	Outer regional	Remote	Very remote
81.0%	12.6%	4.8%	0.9%	0.6%

Note: The tele-health workforce remoteness location refers to the location of the Practitioner, not the location of the person receiving the service.

### References

- 1) National Health Workforce Dataset (NHWDS): Allied Health Practitioners 2014-2017.
- 2) ABS - 3218.0 - Regional Population Growth, Australia, 2016-17, Released 31/08/18.

### Notes

- 1) 'NP' denotes figures that are not published (suppressed) for confidentiality reasons
- 2) The 2013-2016 NHWDS have been revised due to an error in recoding the missing values for job role. As such the figures may not match those that were previously published.
- 3) FTE number measures the number of standard-hour workloads worked by employed health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work. FTE number is calculated based on the total hours worked in a 'standard working week'. The standard working week is assumed to be 38 hours, equivalent to 1 FTE for all practitioners with the exception of medical practitioners where it is assumed to be 40 hours.

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# ANNEXURE 3



# Dental Prosthetists



## 2017 Factsheet

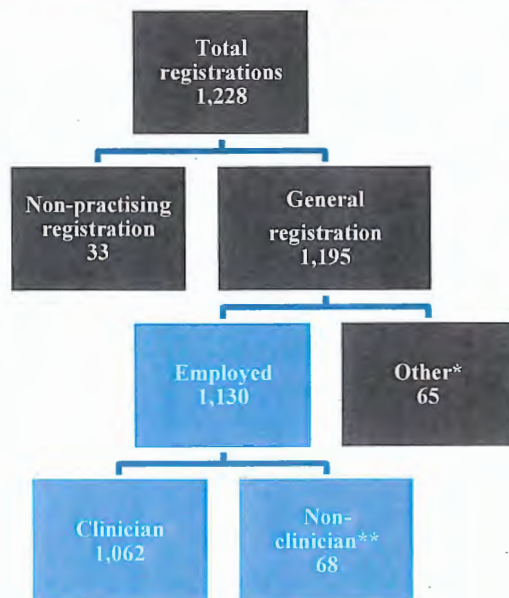
Dental prosthetists are registered healthcare practitioners who provide education, assessment, treatment, management and provision of removable dentures, and flexible, removable mouthguards used for sporting activities. Dental prosthetists collaborate with referring dentists and specialist dentists to ensure proper fitting and maintenance of dental prostheses.

To gain registration as a dental prosthetist, practitioners must complete a minimum three year undergraduate, or one year postgraduate program of study approved by the Dental Board of Australia.

The following analysis is drawn from the number of dental prosthetists with general registration who were employed (1,130 in 2017) unless otherwise stated.

## Workforce

Figure 1: Dental prosthetists registrations, 2017



\*Other\* includes: working but on long leave, working outside the profession, looking for work, overseas, and retired.

\*\*Non-clinician\* includes roles reported by survey respondents that did not fit predefined survey categories.

The number of registered dental prosthetists increased by 0.4% from 1,223 in 2014 to 1,228 in 2017 (average annual increase of 0.1%).

Table 1: Dental prosthetist, 2014-2017

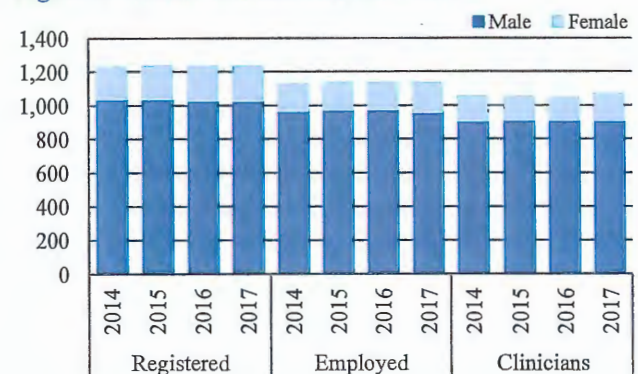
	2014	2015	2016	2017	Avg. annual growth
Registered	1,223	1,230	1,228	1,228	0.1%
Employed	1,124	1,130	1,131	1,130	0.2%
Clinicians	1,047	1,050	1,042	1,062	0.5%

The number of employed dental prosthetists increased by 0.5% from 1,124 to 1,130 over the same period (an average annual decrease of 0.2%).

## Demographics

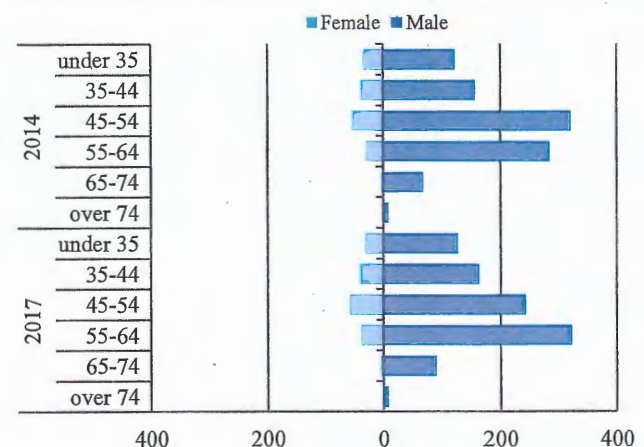
In 2017, 15.2% of dental prosthetists were female, an increase from 14.1% in 2014.

Figure 2: Gender distribution, 2014-2017



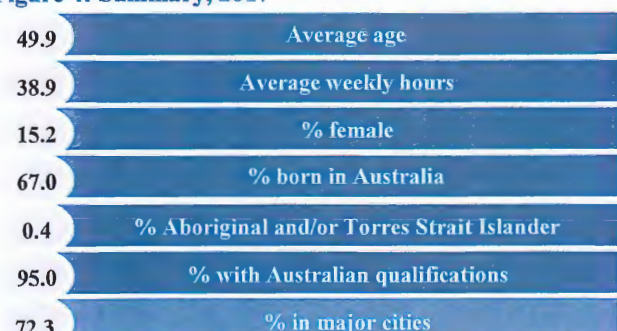
In 2017, the average age of dental prosthetists was 49.9 years, an increase from 49.2 years in 2014. Between 2014 and 2017, the proportion aged over 54 years has increased from 35.1% to 41.4%.

Figure 3: Age and gender distribution, 2014 and 2017



## Quick Facts - 2017

Figure 4: Summary, 2017





## Hours Worked

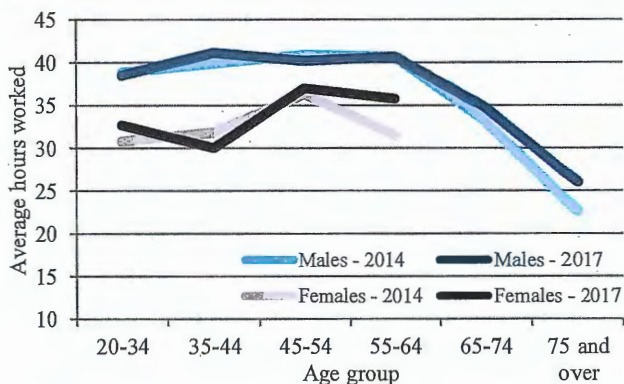
In 2017, dental prosthetists worked an average of 38.9 hours per week in total, with an average of 9.9 hours per week in non-clinical roles.

**Table 2: Average hours per week, 2014-2017**

Average hours worked	2014	2015	2016	2017
Clinical	29.6	28.6	29.1	29.0
Non-clinical	9.2	10.1	9.8	9.9
<b>Total</b>	<b>38.7</b>	<b>38.7</b>	<b>39.0</b>	<b>38.9</b>

In 2017, male dental prosthetists worked an average of 39.7 hours per week, remaining unchanged from 2014. Female dental prosthetists worked an average of 34.6 hours per week, increasing from 33.1 hours in 2014. Males aged 35-44 years worked the longest hours per week, at 41.2 hours on average.

**Figure 5: Average hours per week by gender and age group, 2014 and 2017**



## Principal Role

In 2017, 94.0% of dental prosthetists worked as clinicians in their principal role, an increase from 93.1% in 2014.

**Table 3: Principal role, 2014 and 2017**

Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	1,047	93.1	1,062	94.0
Non clinician	77	6.9	68	6.0
<b>Total</b>	<b>1,124</b>	<b>100</b>	<b>1130</b>	<b>100</b>

## Second job

In 2017, 13.2% of dental prosthetists reported a second job role in dental prosthetics, an increase from 12.8% in 2014.

**Table 4: Second job role, 2014 and 2017**

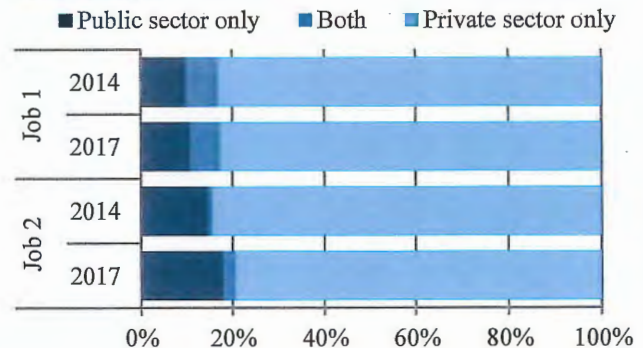
Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	88	7.8	98	8.7
Non clinician	56	5.0	51	4.5
<b>Total</b>	<b>144</b>	<b>12.8</b>	<b>149</b>	<b>13.2</b>

## Principal work sector

In 2017, 10.8% of dental prosthetists reported that in their principal role, they worked only in the public sector, an increase from 9.9% in 2014.

Of those dental prosthetists reporting a second job role in 2017, 1.7% reported they worked only in the public sector, an increase from 1.3% in 2014.

**Figure 6: Sector in which clinical hours were worked, 2014 and 2017**



Note: 'Not applicable' responses are excluded from the chart

## Principal Work Setting

In 2017, 67.2% of dental prosthetists worked in a Solo private practice setting in their principal role, a decrease from 70.4% in 2014, and 19.1% worked in a Group private practice setting, an increase from 17.3% in 2014.

In 2017, dental prosthetists working in Commercial/ business service reported the highest average weekly hours (44.2) and those in Other community health care service (included in 'Remaining work settings') reported the lowest average weekly hours (18.0).

**Table 5: Principal work setting, 2014 and 2017**

Principal work setting	2014		2017	
	Principal role	Second job	Principal role	Second job
Solo private practice	791	49	759	61
Group private practice	195	32	216	55
Public clinic	29	14	52	15
Hospital	54	NP	52	12
Commercial/ business service	9	NP	11	0
Tertiary education facility	16	10	11	5
Remaining work settings	28	26	29	23
<b>Total</b>	<b>1,124</b>	<b>137</b>	<b>1,130</b>	<b>171</b>

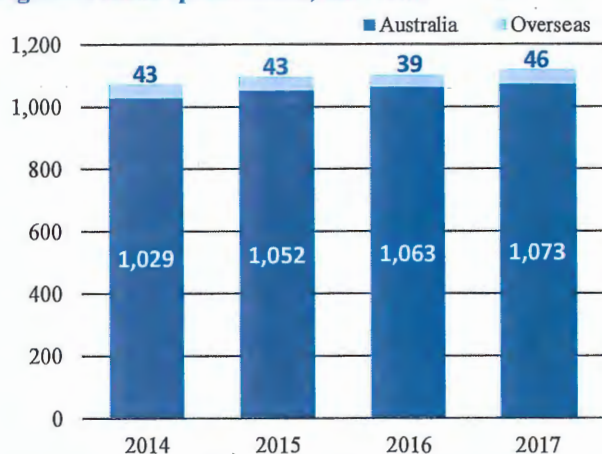
Note: In this instance the principal work setting headcount for the reported second job does not equal the principal role for the reported second job. This occurs when the survey respondent indicates a second job work setting but not a second job principal role.



## Initial Qualification

The workforce survey asks dental prosthetists where they obtained their initial qualification. In 2017, 95.0% of dental prosthetists obtained their initial qualification in Australia and 4.1% obtained their initial qualification overseas.

**Figure 7: Initial qualification, 2014-2017**



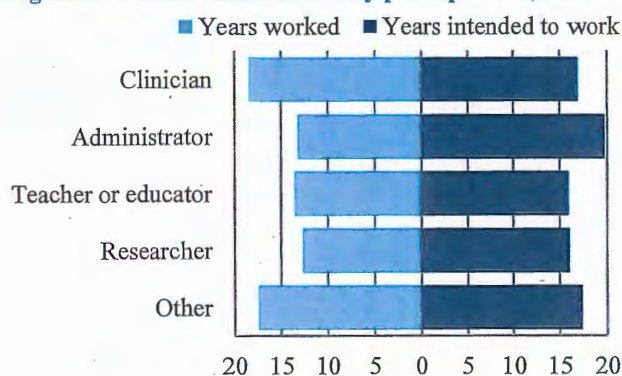
Note: 'Not stated/Unknown' responses are excluded from this chart

## Working Intentions

In 2017, dental prosthetists had, on average, worked 18 years in the profession and intended to work for another 17 years. In 2014, dental prosthetists had worked 19 years on average, and had intended to work for another 16 years.

Note: The workforce survey ask how many years have you worked and intend to work as a 'dental practitioner'. Therefore all years reported may not refer to the dental prosthetic division.

**Figure 8: Workforce intentions by principal role, 2017**



## Distribution

### State and Territory

In 2017, the jurisdiction with the highest rates of full-time equivalent dental prosthetists per 100,000 population (FTE rate) was TAS. Between 2014 and 2017 the total FTE rate decreased from 4.9 to 4.7 and the ACT had the largest FTE rate decrease (1.0).

In 2017, dental prosthetists in TAS worked the most hours per week on average (42.4 hours) and those in the NT worked the fewest (36.5 hours).

**Table 6: Distribution by state/ territory, 2017**

State / Territory	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
NSW	363	371.0	38.8	4.7
VIC	321	316.9	37.5	5.0
QLD	248	257.5	39.5	5.2
SA	60	61.8	39.2	3.6
WA	78	83.4	40.6	3.2
TAS	44	49.1	42.4	9.4
ACT	12	12.9	40.9	3.1
NT	4	3.8	36.5	1.6
<b>Total</b>	<b>1,130</b>	<b>1,156.4</b>	<b>38.9</b>	<b>4.7</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

## Remoteness Area

In 2017, 94.1% of dental prosthetists worked in either major cities or inner regional locations, compared with 94.4% in 2014.

Between 2014 and 2017, the largest shift in average hours worked was in outer regional areas, decreasing from 41.0 hours per week in 2014 to 38.8 hours in 2017. However the FTE rate in outer regional areas remained stable due to an increase in the number of dental prosthetists in these areas.

**Table 7: Distribution by remoteness area, 2017**

Remoteness Area	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
Major cities	817	818.4	38.1	4.6
Inner regional	246	269.1	41.6	6.1
Outer regional	64	65.3	38.8	3.2
Remote & very remote	3	3.6	46.0	0.7
<b>Total</b>	<b>1,130</b>	<b>1,156.4</b>	<b>38.9</b>	<b>4.7</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

## Other Work Location Outside of Major Cities

In 2017, 6.6% of dental prosthetists reported that they had worked in a regional, rural or remote location, in addition to their principal or second job location. Of these respondents, 80.0% had worked in an inner regional or outer regional location, and 2.7% had worked in either remote or very remote locations.



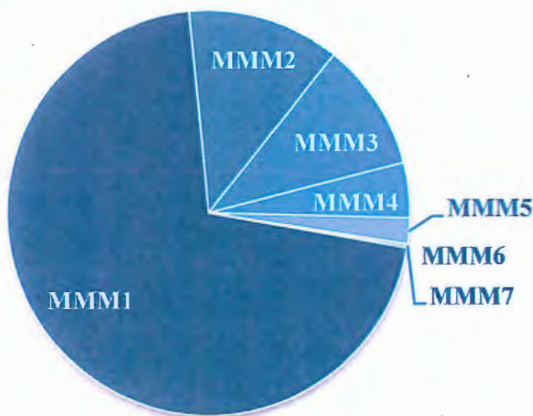
## Modified Monash Model

In 2017, the majority (70.8%) of FTE dental prosthetists were located in a major city or a location considered as MMM1 under the Modified Monash Model (MMM) classification system, a decrease from 72.4% in 2014.

(See [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au) for more information on the MMM).

MMM3 locations had the highest FTE rate of dental prosthetists (7.6) followed by MMM2 (6.2). The lowest FTE rate was in MMM6 locations (0.2).

**Figure 9: FTE Distribution by MMM, 2017**



## Tele-Health

The workforce survey asks dental prosthetists to report their hours practiced via tele-health in dental prosthetics in the previous year.

Note: Tele-health is the use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

A total of 94 dental prosthetists (8.3%) provided a response to the Tele-Health question in 2017. On average, these respondents practiced via Tele-Health for 21.8 hours per week, with the majority (83.0%) of Tele-Health services provided by practitioners based in a major city.

**Table 8: Tele-health workforce remoteness location, 2017**

Major cities	Inner regional	Outer regional	Remote	Very remote
83.0%	11.7%	5.3%	0.0%	0.0%

Note: The tele-health workforce remoteness location refers to the location of the Practitioner, not the location of the person receiving the service.

## References

- 1) National Health Workforce Dataset (NHWDS): Allied Health Practitioners 2014-2017.
- 2) ABS - 3218.0 - Regional Population Growth, Australia, 2016-17, Released 31/08/18.

## Notes

- 1) 'NP' denotes figures that are not published (supressed) for confidentiality reasons
- 2) The 2013-2016 NHWDS have been revised due to an error in recoding the missing values for job role. As such the figures may not match those that were previously published.
- 3) FTE number measures the number of standard-hour workloads worked by employed health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work. FTE number is calculated based on the total hours worked in a 'standard working week'. The standard working week is assumed to be 38 hours, equivalent to 1 FTE for all practitioners with the exception of medical practitioners where it is assumed to be 40 hours.

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# ANNEXURE 4



# Oral Health Therapists



Australian Government  
Department of Health

## 2017 Factsheet

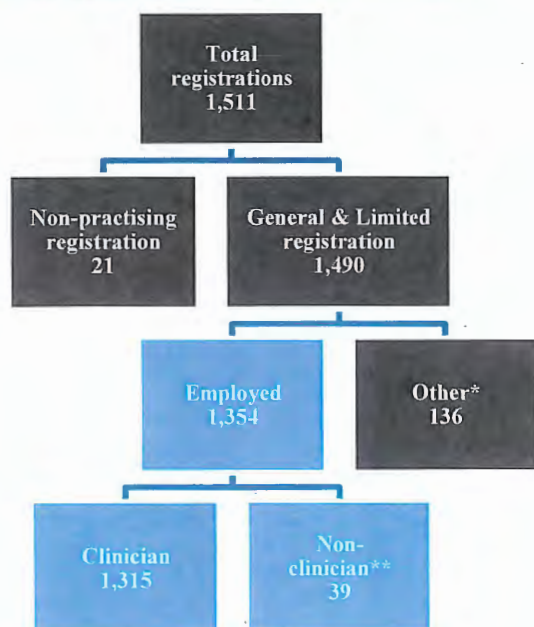
Oral Health Therapists are registered healthcare practitioners with dual qualifications as a dental therapist and dental hygienist. They work within a structured professional relationship with a dentist to provide oral health assessment, diagnosis, treatment, management and preventive services. This may include fillings, tooth extraction, oral health promotion, periodontal/gum treatment, and other care to promote healthy oral behaviours. Oral Health Therapists generally treat patients under the age of 18, unless they have completed further training.

To gain registration as an oral health therapist, practitioners must complete a minimum three year undergraduate program of study approved by the Dental Board of Australia.

The following analysis is drawn from the number of oral health therapists with general or limited registration who were employed (1,354 in 2017) unless otherwise stated.

## Workforce

Figure 1: Oral health therapy registrations, 2017



\*'Other' includes: working but on long leave, working outside the profession, looking for work, overseas, and retired.

\*\*'Non-clinician' includes roles reported by survey respondents that did not fit predefined survey categories.

The number of registered oral health therapists increased by 34.9% from 1,120 in 2014 to 1,511 in 2017 (average annual increase of 10.5%). The number of employed oral health therapists increased by 31.7% from 1,028 to 1,354 over the same period (an average annual increase of 9.6%).

Table 1: Oral health therapists, 2014-2017

	2014	2015	2016	2017	Avg. annual growth
Registered	1,120	1,280	1,434	1,511	10.5%
Employed	1,028	1,156	1,292	1,354	9.6%
Clinicians	1,007	1,127	1,258	1,315	9.3%

## Demographics

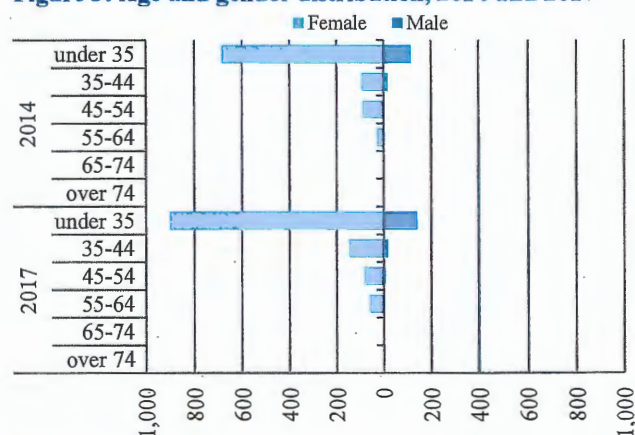
In 2017, 87.9% of oral health therapists were female, an increase from 87.0% in 2014.

Figure 2: Gender distribution, 2014-2017



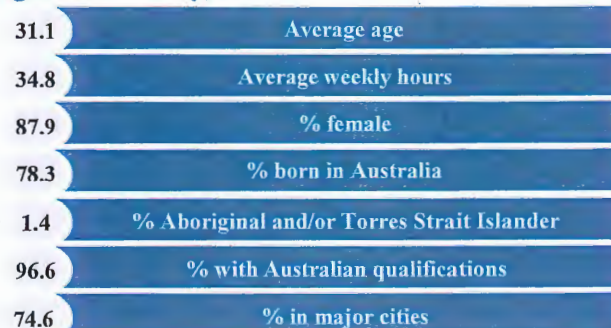
In 2017, the average age of oral health therapists was 31.1 years, an increase from 30.2 years in 2014. In 2017, only 10.9% of oral health therapists were over the age of 45 years.

Figure 3: Age and gender distribution, 2014 and 2017



## Quick Facts - 2017

Figure 4: Summary, 2017





## Hours Worked

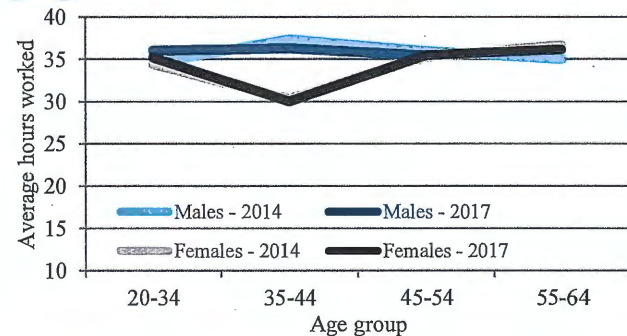
In 2017, oral health therapists worked an average of 34.8 hours per week in total, with an average of 2.3 hours per week in non-clinical roles.

**Table 2: Average hours per week, 2014-2017**

Average hours worked	2014	2015	2016	2017
Clinical	31.8	32.2	32.1	32.5
Non-clinical	2.4	2.6	2.5	2.3
<b>Total</b>	<b>34.3</b>	<b>34.8</b>	<b>34.6</b>	<b>34.8</b>

In 2017, male oral health therapists worked an average of 36.0 hours per week, increasing from 34.9 hours in 2014. Female oral health therapists worked an average of 34.6 hours per week, increasing from 34.2 hours in 2014. Males aged 35-44 years worked the longest hours per week, at 36.3 hours on average.

**Figure 5: Average hours per week by gender and age group, 2014 and 2017**



## Job Role

### Principal Role

In 2017, 97.1% of oral health therapists worked as clinicians in their principal role, a decrease from 98.0% in 2014.

**Table 3: Principal role, 2014 and 2017**

Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	1,007	98.0	1,315	97.1
Non clinician	21	2.0	39	2.9
<b>Total</b>	<b>1,028</b>	<b>100.0</b>	<b>1,354</b>	<b>100.0</b>

### Second job

In 2017, 23.6% of oral health therapists reported a second job role in oral health therapy, a decrease from 26.9% in 2014.

**Table 4: Second job role, 2014 and 2017**

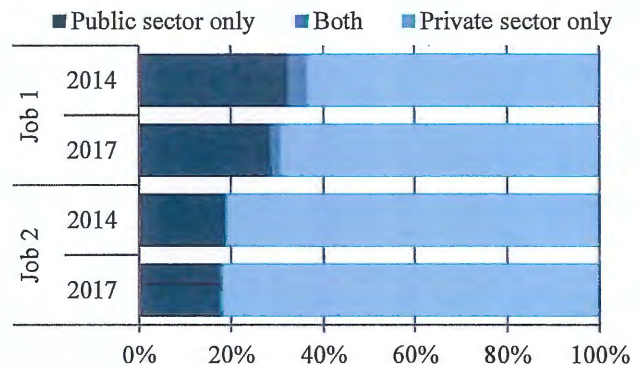
Second job	2014		2017	
	Headcount	%	Headcount	%
Clinician	234	22.8	274	20.2
Non clinician	43	4.2	46	3.4
<b>Total</b>	<b>277</b>	<b>26.9</b>	<b>320</b>	<b>23.6</b>

## Principal work sector

In 2017, 28.5% of oral health therapists reported that in their principal role, they worked only in the public sector, a decrease from 32.5% in 2014.

Of those oral health therapists reporting a second job role in 2017, 17.7% reported they worked only in the public sector, a decrease from 18.7% in 2014.

**Figure 6: Sector in which clinical hours were worked, 2014 and 2017**



Note: 'Not applicable' responses are excluded from the chart

## Principal Work Setting

In 2017, 66.5% of oral health therapists worked in a Group or Solo private practice setting in their principal role, an increase from 64.7% in 2014, and 24.4% worked in a Public clinic setting, remaining stable from 24.5% in 2014.

In 2017, oral health therapists working in Other community health care service reported the highest average weekly hours (40.0) and those in Locum private practice reported the lowest average weekly hours (23.5). Both are included in 'Remaining work settings'.

**Table 5: Principal work setting, 2014 and 2017**

Principal work setting	2014		2017	
	Principal role	Second job	Principal role	Second job
Group private practice	372	92	457	115
Solo private practice	293	123	443	175
Public clinic	252	51	331	46
Hospital	59	NP	60	NP
Aboriginal health service	10	NP	16	NP
Tertiary educational facility	12	21	13	31
Remaining work settings	30	12	34	14
<b>Total</b>	<b>1,028</b>	<b>306</b>	<b>1,354</b>	<b>393</b>

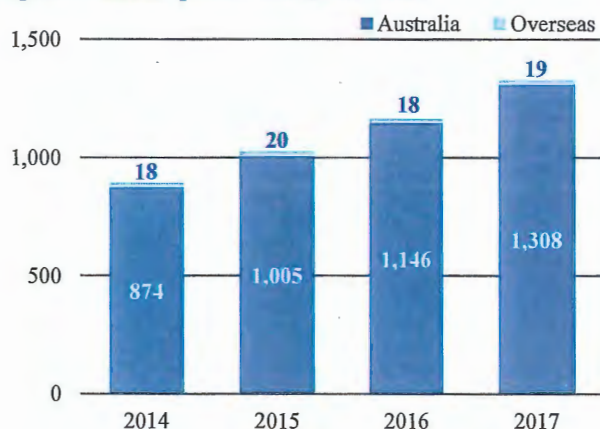
Note: In this instance the principal work setting headcount for the reported second job does not equal the principal role for the reported second job. This occurs when the survey respondent indicates a second job work setting but not a second job principal role.



## Initial Qualification

The workforce survey asks oral health therapists where they obtained their initial qualification. In 2017, 96.6% of oral health therapists obtained their initial qualification in Australia and 1.4% obtained their initial qualification overseas.

**Figure 7: Initial qualification, 2014-2017**



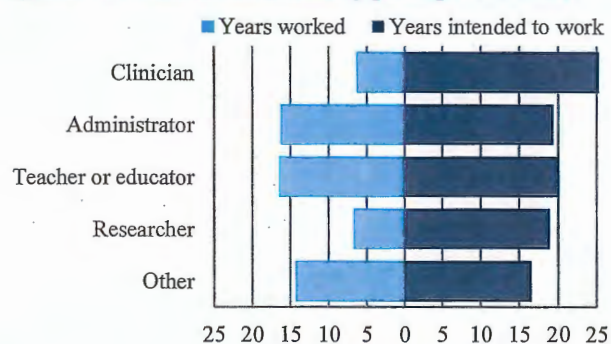
Note: 'Not stated/Unknown' responses are excluded from this chart

## Working Intentions

In 2017, oral health therapists had, on average, worked 7 years in the profession and intended to work for another 26 years. In 2014, oral health therapists had worked 7 years on average, and had intended to work for another 25 years.

Note: The workforce survey asks how many years have you worked and intend to work as a 'dental practitioner'. Therefore all years reported may not refer to the oral health therapist division.

**Figure 8: Workforce intentions by principal role, 2017**



## Distribution

### State and Territory

In 2017, the jurisdictions with the highest rates of full-time equivalent oral health therapists per 100,000 population (FTE rate) were SA and the NT. Between 2014 and 2017 the total FTE rate increased from 4.0 to 5.0 and the NT had the largest FTE rate increase (3.2).

In 2017, oral health therapists in TAS worked the most hours per week on average (38.6 hours) and those in the ACT worked the fewest (32.4 hours).

**Table 6: Distribution by state/territory, 2017**

State / Territory	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
NSW	339	311.3	34.9	4.0
VIC	328	312.4	36.2	4.9
QLD	350	303.3	32.9	6.2
SA	157	142.3	34.5	8.3
WA	131	124.7	36.2	4.8
TAS	15	15.2	38.6	2.9
ACT	17	14.5	32.4	3.5
NT	17	16.1	36.0	6.5
<b>Total</b>	<b>1,354</b>	<b>1,239.8</b>	<b>34.8</b>	<b>5.0</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

## Remoteness Area

In 2017, 90.9% of oral health therapists worked in either major cities or inner regional locations, compared with 92.2% in 2014.

Between 2014 and 2017, the largest shift in average hours worked was in remote areas, increasing from 33.6 to 36.9 hours per week. Consequently, the FTE rate in remote areas increased by 2.3 over the same period.

**Table 7: Distribution by remoteness area, 2017**

Remoteness Area	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
Major cities	1,010	917.0	34.5	5.2
Inner regional	221	203.1	34.9	4.6
Outer regional	103	100.4	37.0	4.9
Remote	14	13.6	36.9	4.6
Very remote	6	5.7	36.2	2.8
<b>Total</b>	<b>1,354</b>	<b>1,239.8</b>	<b>34.8</b>	<b>5.0</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

## Other Work Location Outside of Major Cities

In 2017, 7.7% of oral health therapists reported that they had worked in a regional, rural or remote location, in addition to their principal or second job location. Of these respondents, 68.3% had worked in an inner regional or outer regional location, and 16.3% had worked in either remote or very remote locations.



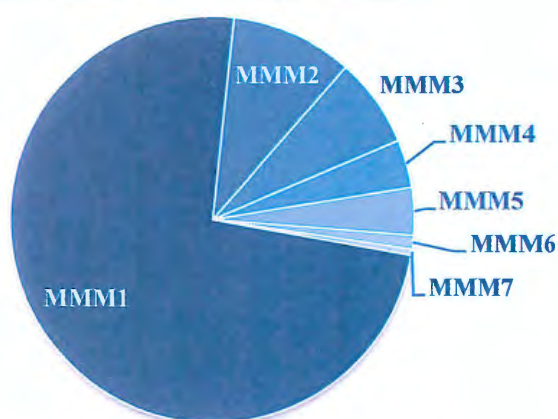
## Modified Monash Model

In 2017, the majority (74.0%) of FTE oral health therapists were located in a major city or a location considered as MMM1 under the Modified Monash Model (MMM) classification system, a decrease from 74.6% in 2014.

(See [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au) for more information on the MMM).

MMM3 locations had the highest FTE rate of oral health therapists (5.7) followed by MMM2 and MMM4 (both 5.3). The lowest FTE rate was in MMM5 locations (2.6).

**Figure 9: FTE Distribution by MMM, 2017**



## Tele-Health

The workforce survey asks oral health therapists to report their hours practiced via tele-health in oral health therapy in the previous year.

Note: Tele-health is the use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

A total of 99 oral health therapists (7.3%) provided a response to the Tele-Health question in 2017. On average, these respondents practiced via Tele-Health for 21.2 hours per week, with the majority (82.8%) of Tele-Health services provided by practitioners based in a major city.

**Table 8: Tele-health oral health therapists by remoteness location, 2017**

Major cities	Inner regional	Outer regional	Remote	Very remote
82.8%	7.1%	9.1%	0.0%	1.0%

Note: The tele-health workforce remoteness location refers to the location of the Practitioner, not the location of the person receiving the service.

## References

- 1) National Health Workforce Dataset (NHWDS): Allied Health Practitioners 2014-2017.
- 2) ABS - 3218.0 - Regional Population Growth, Australia, 2016-17, Released 31/08/18.

## Notes

- 1) 'NP' denotes figures that are not published (supressed) for confidentiality reasons
- 2) The 2013-2016 NHWDS have been revised due to an error in recoding the missing values for job role. As such the figures may not match those that were previously published.
- 3) FTE number measures the number of standard-hour workloads worked by employed health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work. FTE number is calculated based on the total hours worked in a 'standard working week'. The standard working week is assumed to be 38 hours, equivalent to 1 FTE for all practitioners with the exception of medical practitioners where it is assumed to be 40 hours.

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# ANNEXURE 5



# Dental Hygienists



Australian Government  
Department of Health

## 2017 Factsheet

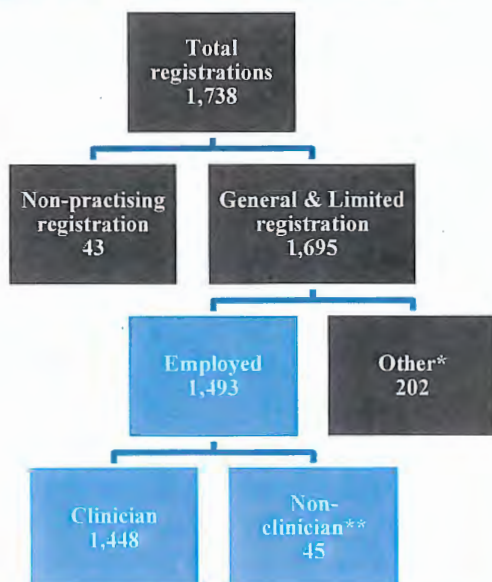
Dental Hygienists are registered healthcare practitioners who work within a structured professional relationship with a dentist to provide oral health assessment, diagnosis, treatment, management, and education for the prevention of oral disease. This may include periodontal/gum treatment, preventive services and other oral care.

To gain registration as a dental hygienist, practitioners must complete a minimum two year advanced diploma, or three year undergraduate program of study approved by the Dental Board of Australia.

The following analysis is drawn from the number of dental hygienists with general or limited registration who were employed (1,493 in 2017) unless otherwise stated.

## Workforce

Figure 1: Dental hygienist registrations, 2017



\*'Other' includes: working but on long leave, working outside the profession, looking for work, overseas, and retired

\*\*'Non-clinician' includes roles reported by survey respondents that did not fit predefined survey categories.

The number of registered dental hygienists increased by 4.2% from 1,668 in 2014 to 1,738 in 2017 (average annual increase of 1.4%).

Table 1: Dental hygienists, 2014-2017

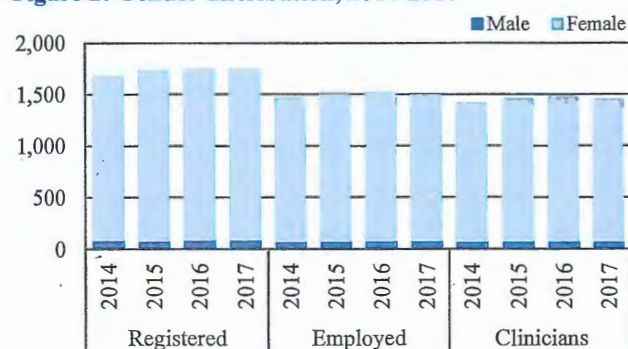
	2014	2015	2016	2017	Avg. annual growth
Registered	1,668	1,721	1,740	1,738	1.4%
Employed	1,451	1,494	1,514	1,493	1.0%
Clinicians	1,409	1,451	1,469	1,448	0.9%

The number of employed dental hygienists increased by 2.9% from 1,451 to 1,493 over the same period (an average annual increase of 1.0%).

## Demographics

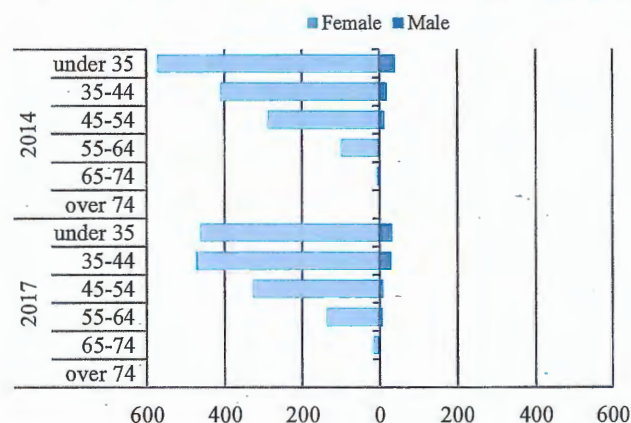
In 2017, 94.6% of dental hygienists were female, a decrease from 94.8% in 2014.

Figure 2: Gender distribution, 2014-2017



In 2017, the average age of dental hygienists was 40.5 years, an increase from 38.7 years in 2014. Between 2014 and 2017, the proportion aged 45 years and over increased from 28.3% to 33.3%.

Figure 3: Age and gender distribution, 2014 and 2017



## Quick Facts - 2017

Figure 4: Summary, 2017

40.5	Average age
28.0	Average weekly hours
94.6	% female
65.9	% born in Australia
1.1	% Aboriginal and/or Torres Strait Islander
85.0	% with Australian qualifications
85.3	% in major cities



## Hours Worked

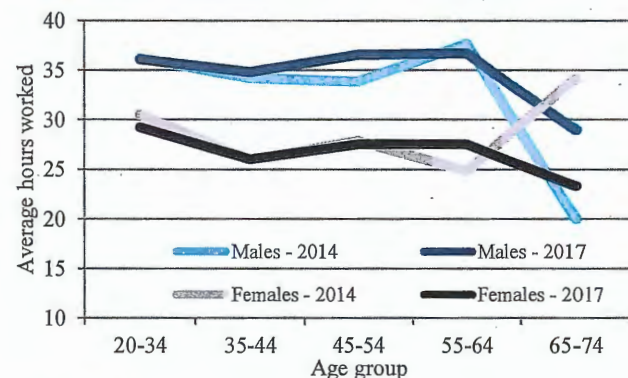
In 2017, dental hygienists worked an average of 28.0 hours per week in total, and worked an average of 1.8 hours per week in non-clinical roles.

**Table 2: Average hours per week, 2014-2017**

Average hours worked	2014	2015	2016	2017
Clinical	26.7	26.6	26.4	26.1
Non-clinical	1.9	1.6	1.9	1.8
<b>Total</b>	<b>28.6</b>	<b>28.2</b>	<b>28.3</b>	<b>28.0</b>

In 2017, male dental hygienists worked an average of 35.6 hours per week, increasing from 35.2 hours in 2014. Female dental hygienists worked an average of 27.5 hours per week, decreasing from 28.2 hours in 2014. Males aged 55-64 worked the most, at 36.7 hours per week on average.

**Figure 5: Average hours per week by gender and age group, 2014 and 2017**



## Job Role

### Principal Role

In 2017, 97.0% of dental hygienists worked as clinicians in their principal role, a decrease from 97.1% in 2014.

**Table 3: Principal role, 2014 and 2017**

Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	1,409	97.1	1,448	97.0
Non-clinician	42	2.9	45	3.0
<b>Total</b>	<b>1,451</b>	<b>100</b>	<b>1,493</b>	<b>100</b>

### Second job role

In 2017, 17.8% of dental hygienists reported a second job role in dental hygiene, a decrease from 22.3% in 2014.

**Table 4: Second job role, 2014 and 2017**

Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	277	19.1	227	15.2
Non-clinician	46	3.2	39	2.6
<b>Total</b>	<b>323</b>	<b>22.3</b>	<b>266</b>	<b>17.8</b>

## Clinical Role Sector

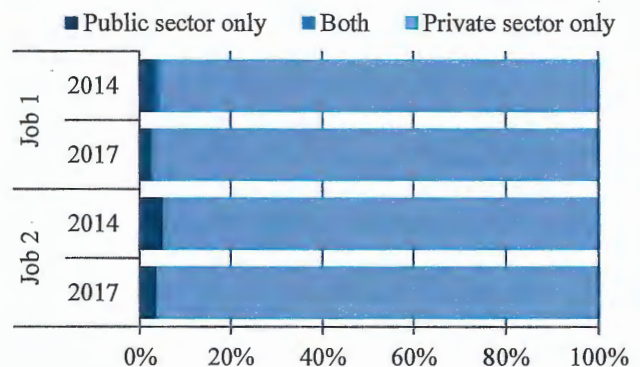
### Principal role

In 2017, 2.6% of dental hygienists reported that in their principal role, they worked only in the public sector, a decrease from 3.3% in 2014.

### Second job

Of those dental hygienists reporting a second job role in 2017, 3.8% reported they worked only in the public sector, a decrease from 5.1% in 2014.

**Figure 6: Sector in which clinical hours were worked, 2014 and 2017**



Note: 'Not applicable' responses are excluded from the chart

## Principal Work Setting

In 2017, 93.6% of dental hygienists worked in a Group or Solo private practice setting in their principal role and 1.3% worked in an Hospital setting, all unchanged from 2014.

In 2017, dental hygienists working in a Tertiary educational facility reported the highest average weekly hours (31.7) and those in Locum private practice (included in 'Remaining work settings') reported the lowest average weekly hours (17.3).

**Table 5: Principal work setting, 2014 and 2017**

Principal work setting	2014		2017	
	Principal role	Second job	Principal role	Second job
Group private practice	768	144	750	134
Solo private practice	588	153	648	159
Hospital	18	18	19	8
Public clinic	14	14	14	10
Tertiary educational facility	19	18	14	10
Defence forces	16	NP	14	6
Remaining work settings	28	NP	34	17
<b>Total</b>	<b>1,451</b>	<b>363</b>	<b>1,493</b>	<b>344</b>

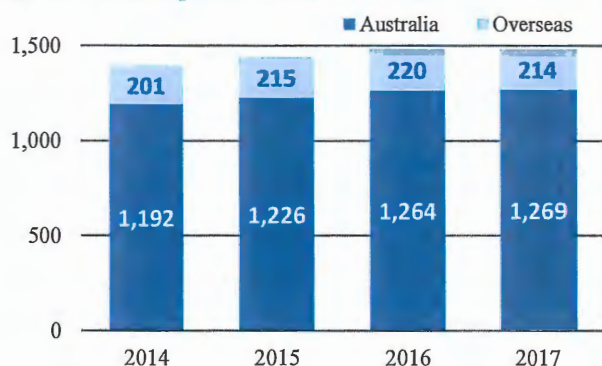
Note: In this instance the principal work setting headcount for the reported second job does not equal the principal role for the reported second job. This occurs when the survey respondent indicates a second job work setting but not a second job principal role.



## Initial Qualification

The workforce survey asks dental hygienists where they obtained their initial qualification. In 2017, 85.0% of dental hygienists obtained their initial qualification in Australia and 14.3% obtained their initial qualification overseas.

Figure 7: Initial qualification, 2014-2017



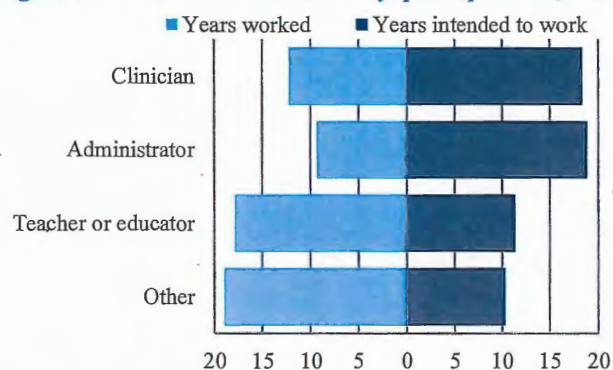
Note: 'Not stated/Unknown' responses are excluded from this chart

## Working Intentions

In 2017, dental hygienists had, on average, worked 12 years in the profession and intended to work for another 18 years. In 2014, dental hygienists had worked 11 years on average, and had intended to work for another 18 years.

Note: The workforce survey ask how many years have you worked and intend to work as a 'dental practitioner'. Therefore all years reported may not refer to the dental hygiene division.

Figure 8: Workforce intentions by principal role, 2017



## Distribution

### State and Territory

In 2017, the jurisdictions with the highest rates of full-time equivalent dental hygienists per 100,000 population (FTE rate) were SA and the ACT. Between 2014 and 2017, the total FTE rate decreased from 4.6 to 4.5, and WA had the largest FTE rate decrease (0.9).

In 2017, dental hygienists in the NT worked the most hours per week on average (36.4 hours) and those in SA worked the fewest (26.5 hours).

Table 6: Distribution by state/ territory, 2017

State / Territory	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
NSW	396	303.9	29.2	3.9
VIC	277	204.0	28.0	3.2
QLD	234	173.9	28.2	3.5
SA	272	189.6	26.5	11.0
WA	241	168.6	26.6	6.5
TAS	18	14.8	31.2	2.8
ACT	44	33.3	28.8	8.1
NT	11	10.5	36.4	4.3
<b>Total</b>	<b>1,493</b>	<b>1,098.6</b>	<b>28.0</b>	<b>4.5</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

### Remoteness Area

In 2014 and 2017, 94.7% of dental hygienists worked in either major cities or inner regional locations.

Between 2014 and 2017, the largest shift in average hours worked was in remote areas, decreasing from 35.0 to 29.6 hours per week. However, the FTE rate in remote areas remained stable due to the increase in the number of dental hygienists in these areas.

Table 7: Distribution by remoteness area, 2017

Remoteness Area	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
Major cities	1,274	935.7	27.9	5.3
Inner regional	138	101.1	27.8	2.3
Outer regional	74	56.5	29.0	2.8
Remote	7	5.5	29.6	1.9
Very remote	0	0	0	0
<b>Total</b>	<b>1,493</b>	<b>1,098.6</b>	<b>28.0</b>	<b>4.5</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

### Other Work Location Outside of Major Cities

In 2017, 2.2% of dental hygienists reported that they had worked in a regional, rural or remote location, in addition to their principal or second job location. Of these respondents, 57.6% had worked in an inner regional or outer regional location, and 12.1% had worked in either remote or very remote locations.



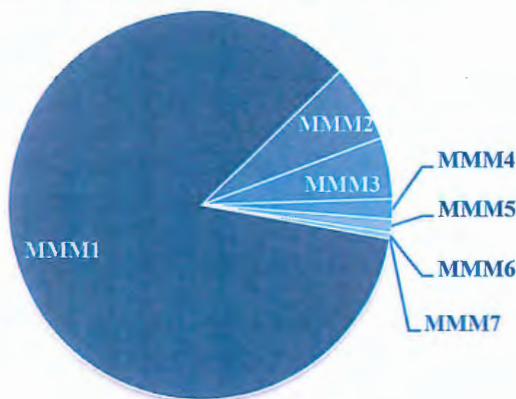
## Modified Monash Model

In 2017, the majority (85.2%) of FTE dental hygienists were located in a major city or a location considered as MMM1 under the Modified Monash Model (MMM) classification system, remaining unchanged from 85.3% in 2014.

MMM1 locations had the highest FTE rate of dental hygienists (5.3) followed by MMM3 (3.6). The lowest FTE rate was in MMM5 locations (0.7), noting there were no dental hygienists in MMM7.

(See [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au) for more information on the MMM).

**Figure 9: FTE Distribution by MMM, 2017**



## Tele-Health

The workforce survey asks dental hygienists to report their hours practiced via tele-health in dental hygiene in the previous year.

Note: Tele-health is the use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

A total of 153 dental hygienists (10.3%) provided a response to the Tele-Health question in 2017. On average, these respondents practiced via Tele-Health for 21.4 hours per week, with the majority (88.2%) of Tele-Health services provided by practitioners based in a major city.

**Table 8: Tele-health dental hygienists by remoteness location, 2017**

Major cities	Inner regional	Outer regional	Remote	Very remote
88.2%	7.2%	4.6%	0.0%	0.0%

Note: The tele-health workforce remoteness location refers to the location of the Practitioner, not the location of the person receiving the service.

## References

- 1) National Health Workforce Dataset (NHWDS): Allied Health Practitioners 2014-2017.
- 2) ABS - 3218.0 - Regional Population Growth, Australia, 2016-17, Released 31/08/18.

## Notes

- 1) 'NP' denotes figures that are not published (suppressed) for confidentiality reasons
- 2) The 2013-2016 NHWDS have been revised due to an error in recoding the missing values for job role. As such the figures may not match those that were previously published.
- 3) FTE number measures the number of standard-hour workloads worked by employed health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work. FTE number is calculated based on the total hours worked in a 'standard working week'. The standard working week is assumed to be 38 hours, equivalent to 1 FTE for all practitioners with the exception of medical practitioners where it is assumed to be 40 hours.

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# ANNEXURE 6

# Dental Therapists



## 2017 Factsheet

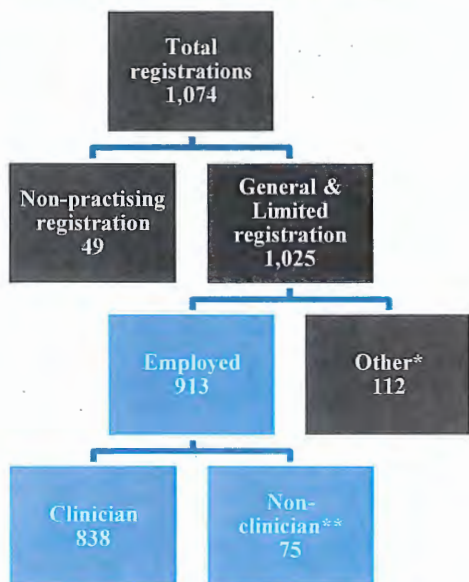
Dental therapists are registered healthcare practitioners who work within a structured professional relationship with a dentist to provide oral health assessment, diagnosis, treatment, management and preventive services. This may include performing and interpreting dental x-rays, dental examinations, making dental impressions and routine dental treatment. Dental Therapists generally treat patients under the age of 18, unless they have completed further training.

To gain registration as a dental therapist, practitioners must complete a minimum three year undergraduate program of study approved by the Dental Board of Australia.

The following analysis is drawn from the number of dental therapists with general or limited registration who were employed (913 in 2017) unless otherwise stated.

## Workforce

Figure 1: Dental therapy registrations, 2017



\*\*Other\* includes: working but on long leave, working outside the profession, looking for work, overseas, and retired.

\*\*\*Non-clinician\* includes roles reported by survey respondents that did not fit predefined survey categories.

The number of registered dental therapists decreased by 10.5% from 1,200 in 2014 to 1,074 in 2017 (average annual decrease of 3.6%).

Table 1: Dental therapists, 2014-2017

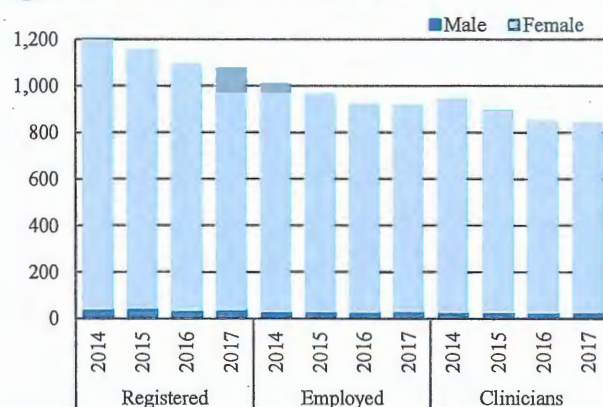
	2014	2015	2016	2017	Avg. annual growth
Registered	1,200	1,152	1,091	1,074	-3.6%
Employed	1,008	960	917	913	-3.2%
Clinicians	938	893	846	838	-3.7%

The number of employed dental therapists decreased by 9.4% from 1,008 to 913 over the same period (an average annual decrease of 3.2%).

## Demographics

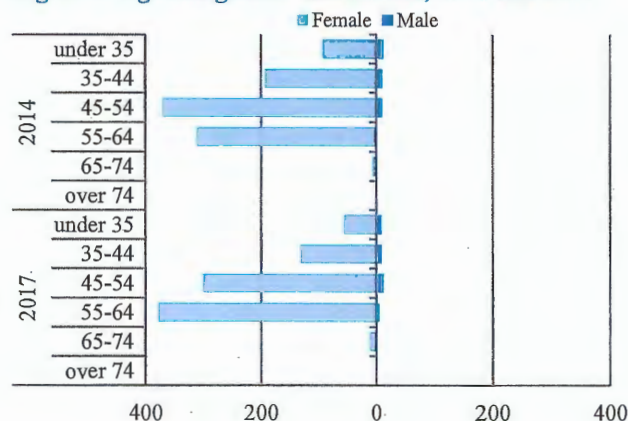
In 2017, 96.4% of dental therapists were female, a decrease from 96.8% in 2014.

Figure 2: Gender distribution, 2014-2017



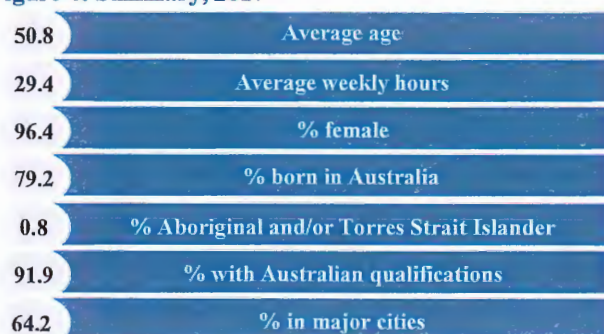
In 2017, the average age of dental therapists was 50.8 years, an increase from 48.4 years in 2014. Between 2014 and 2017, the proportion aged 55 years and over increased from 31.6% to 43.3%.

Figure 3: Age and gender distribution, 2014 and 2017



## Quick Facts – 2017

Figure 4: Summary, 2017





## Hours Worked

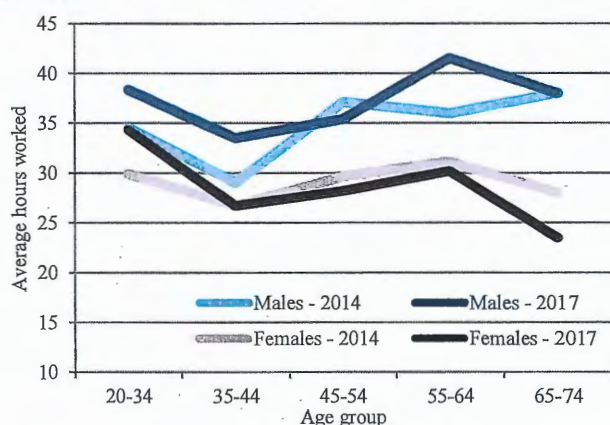
In 2017, dental therapists worked an average of 29.4 hours per week in total, and worked an average of 4.2 hours per week in non-clinical roles.

**Table 2: Average hours per week, 2014-2017**

Average hours worked	2014	2015	2016	2017
Clinical	25.4	25.1	25.0	25.2
Non-clinical	4.2	4.5	4.6	4.2
<b>Total</b>	<b>29.7</b>	<b>29.7</b>	<b>29.6</b>	<b>29.4</b>

In 2017, female dental therapists worked an average of 29.2 hours per week, a decrease from 29.5 hours in 2014. Male dental therapists worked an average of 36.5 hours per week, increasing from 33.9 hours in 2014. In 2017, males in the 55-64 age group worked the most hours, at 41.5 hours per week on average.

**Figure 5: Average hours per week by gender and age group, 2014 and 2017**



## Job Role

### Principal role

In 2017, 91.8% of dental therapists worked as clinicians in their principal role, a decrease from 93.1% in 2014.

**Table 3: Principal role, 2014 and 2017**

Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	938	93.1	838	91.8
Non-clinician	70	6.9	75	8.2
<b>Total</b>	<b>1,008</b>	<b>100</b>	<b>913</b>	<b>100</b>

### Second job role

**Table 4: Second job role, 2014 and 2017**

Second job role	2014		2017	
	Headcount	%	Headcount	%
Clinician	82	8.1	56	6.1
Non-clinician	25	2.5	16	1.8
<b>Total</b>	<b>107</b>	<b>10.6</b>	<b>72</b>	<b>7.9</b>

In 2017, 7.9% of dental therapists reported a second job role in dental therapy, a decrease from 10.6% in 2014.

## Work Sector

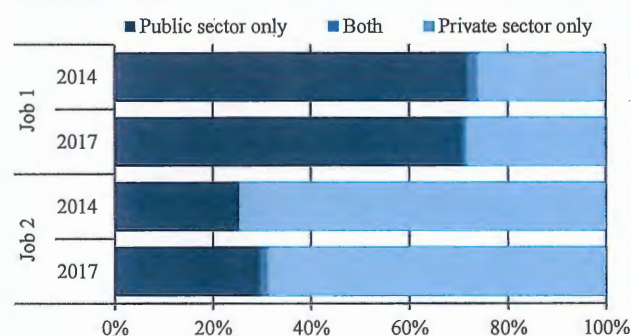
### Principal work sector

In 2017, 71.0% of dental therapists reported that in their principal role, they worked only in the public sector - a decrease from 72.1% in 2014.

### Second job role - sector

Of those dental therapist reporting a second job role in 2017, 68.8% reported they worked only in the private sector, a decrease from 74.7% in 2014.

**Figure 6: Sector in which clinical hours were worked, 2014 and 2017**



Note: 'Not applicable' responses are excluded from the chart

## Work Setting

### Principal Work Setting

In 2017, 58.4% of dental therapists worked in a Public clinic setting in their principal role, a decrease from 60.8% in 2014, and 17.7% worked in a Group private practice setting, an increase from 14.0% in 2014.

**Table 5: Principal work setting, 2014 and 2017**

Principal work setting	2014		2017	
	Principal role	Second job	Principal role	Second job
Public clinic	613	17	533	18
Group private practice	141	35	162	21
Solo private practice	112	28	90	25
Hospital	45	13	56	5
Tertiary educational facility	33	12	25	8
Remaining work settings	64	10	47	7
<b>Total</b>	<b>1,008</b>	<b>67</b>	<b>913</b>	<b>49</b>

Note: In this instance the principal work setting headcount for the reported second job does not equal the principal role for the reported second job. This occurs when the survey respondent indicates a second job work setting but not a second job principal role.

In 2017, dental therapists working in Health promotion services reported the highest average weekly hours (36.7) and those in Commercial/

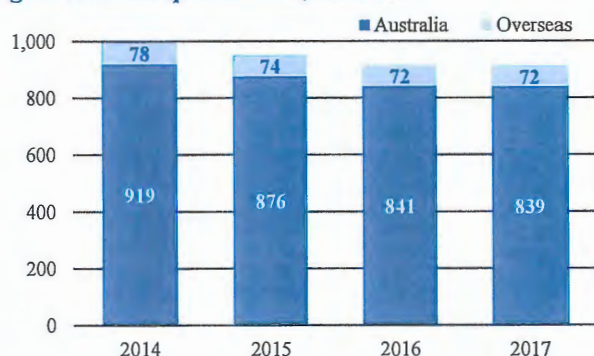


business services reported the lowest average weekly hours (24.3). Both of these settings are included in 'Remaining work settings' in the table.

## Initial Qualification

The workforce survey asks dental therapists where they obtained their initial qualification. In 2017, 91.9% of dental therapists obtained their initial qualification in Australia and 7.9% obtained their initial qualification overseas.

**Figure 7: Initial qualification, 2014-2017**



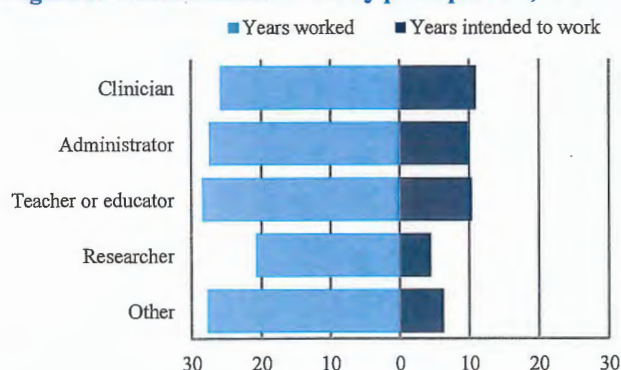
Note: 'Not stated/Unknown' responses are excluded from this chart

## Working Intentions

In 2017, dental therapists had, on average, worked 26 years in the profession and intended to work for another 11 years. In 2014, dental therapists had worked 23 years on average, and had intended to work for another 12 years.

Note: the workforce survey asks how many years have you worked and intend to work as a 'dental practitioner'. Therefore all years reported may not refer to the dental therapy division.

**Figure 8: Workforce intentions by principal role, 2017**



## Distribution

### State and Territory

In 2017, the jurisdictions with the highest rates of full-time equivalent dental therapists per 100,000 population (FTE rate) were WA and TAS. Between 2014 and 2017, the total FTE rate decreased from 3.4 to 2.9 and the WA had the largest FTE rate increase (1.1).

In 2017, dental therapists in NT worked the most hours per week on average (33.0 hours) and those in WA worked the fewest (27.4 hours).

**Table 6: Distribution by state/ territory, 2017**

State / Territory	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
NSW	170	131.6	29.4	1.7
VIC	139	106.6	29.1	1.7
QLD	171	141.3	31.4	2.9
SA	85	66.8	29.9	3.9
WA	270	195.0	27.4	7.6
TAS	45	37.5	31.7	7.2
ACT	14	11.8	32.0	2.9
NT	18	15.6	33.0	6.3
<b>Total</b>	<b>913</b>	<b>707.2</b>	<b>29.4</b>	<b>2.9</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

## Remoteness Area

In 2017, 86.2% of dental therapists worked in either major cities or inner regional locations, compared with 85.1% in 2014.

Between 2014 and 2017, the largest shift in average hours worked was in very remote areas, decreasing from 35.6 hours per week in 2014 to 29.7 hours in 2017. However, the FTE rate in very remote areas increased 1.1 due to the increase in the number of dental therapists in these areas.

**Table 7: Distribution by remoteness area, 2017**

Remoteness Area	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
Major cities	586	448.6	29.1	2.5
Inner regional	201	158.3	29.9	3.6
Outer regional	99	78.4	30.1	3.8
Remote	15	12.6	31.9	4.3
Very remote	12	9.4	29.7	4.7
<b>Total</b>	<b>913</b>	<b>707.2</b>	<b>29.4</b>	<b>2.9</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

## Other Work Location Outside of Major Cities

In 2017, 8.8% of dental therapists reported that they had worked in a regional, rural or remote location, in addition to their principal or second job location. Of these respondents, 55.0% had worked in an inner regional or outer regional location, and 23.8% had worked in either remote or very remote locations.



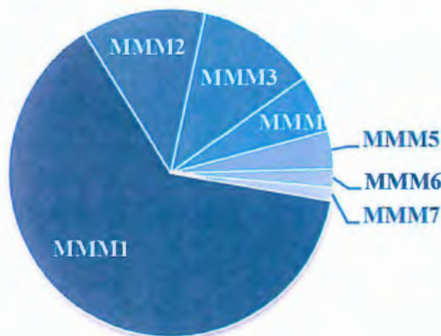
## Modified Monash Model

In 2017, the majority (63.4%) of FTE dental therapists were located in a major city or a location considered as MMM1 under the Modified Monash Model (MMM) classification system, a small increase from 61.9% in 2014.

(See [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au) for more information on the MMM).

MMM3 locations had the highest FTE rate of dental therapists (5.3) followed by MMM4 and MMM7 (both 4.5). The lowest FTE rate was in MMM5 locations (1.5).

**Figure 9: FTE Distribution by MMM, 2017**



## Tele-Health

The workforce survey asks dental therapists to report their hours practiced via tele-health in dental therapy in the previous year.

A total of 57 dental therapists (6.2%) provided a response to the Tele-Health question in 2017. On average, respondents practiced via Tele-Health for 19.7 hours per week, with the majority (70.2%) of Tele-Health services provided by practitioners based in a major city.

Note: Tele-health is the use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance.

**Table 8: Tele-health dental therapists by remoteness location, 2017**

Major cities	Inner regional	Outer regional	Remote	Very remote
70.2%	17.5%	8.8%	1.8%	1.8%

Note: The tele-health workforce remoteness location refers to the location of the Practitioner, not the location of the person receiving the service.

## References

- 1) National Health Workforce Dataset (NHWDS): Allied Health Practitioners 2014-2017.
- 2) ABS - 3218.0 - Regional Population Growth, Australia, 2016-17, Released 31/08/18.

## Notes

- 1) 'NP' denotes figures that are not published (suppressed) for confidentiality reasons
- 2) The 2013-2016 NHWDS have been revised due to an error in recoding the missing values for job role. As such the figures may not match those that were previously published.
- 3) FTE number measures the number of standard-hour workloads worked by employed health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work. FTE number is calculated based on the total hours worked in a 'standard working week'. The standard working week is assumed to be 38 hours, equivalent to 1 FTE for all practitioners with the exception of medical practitioners where it is assumed to be 40 hours.

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# ANNEXURE 7



# Dental Practitioners



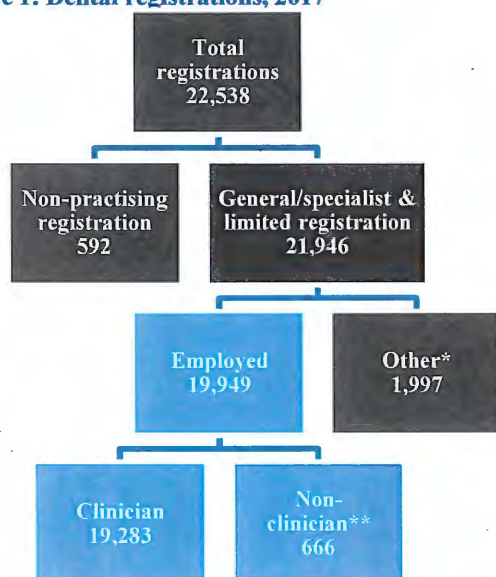
## 2017 Factsheet

The Dental Board of Australia registers Dentists, Oral Health Therapists, Dental Hygienists, Dental Therapists and Dental Prosthetists. These divisions are collectively presented in this factsheet as Dental Practitioners. The qualifications required for each division of Dental Practitioners are included in the individual division's factsheet.

The following analysis is drawn from the number of dental practitioners with general, specialist or limited registration that were employed (19,949 in 2017) unless otherwise stated.

## Workforce

Figure 1: Dental registrations, 2017



\*'Other' includes: working but on long leave, working outside the profession, looking for work, overseas, and retired.

\*\*'Non-clinician' includes roles reported by survey respondents that did not fit predefined survey categories.

The number of registered dental practitioners increased by 7.5% from 20,975 in 2014 to 22,538 in 2017 (average annual increase of 2.4%). The number of employed dental practitioners increased by 7.7% from 18,530 to 19,949 over the same period (an average annual increase of 2.5%).

Table 1: Dental practitioners, 2014-2017

	2014	2015	2016	2017	Avg Annual growth
Registered	20,975	21,506	22,042	22,538	2.4%
Employed	18,530	19,051	19,490	19,949	2.5%
Clinicians	17,873	18,364	18,820	19,283	2.6%

## Demographics

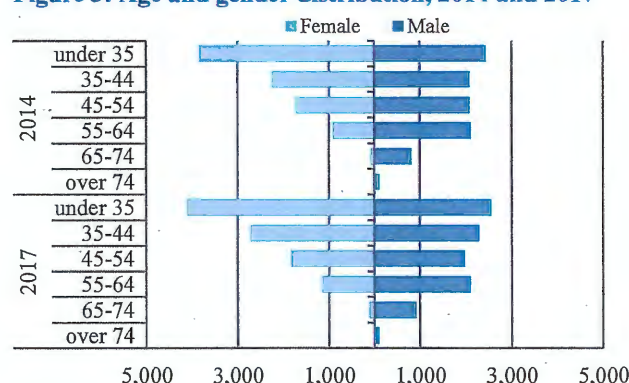
In 2017, 49.9% of dental practitioners were female, an increase from 47.6% in 2014.

Figure 2: Gender distribution, 2014-2017



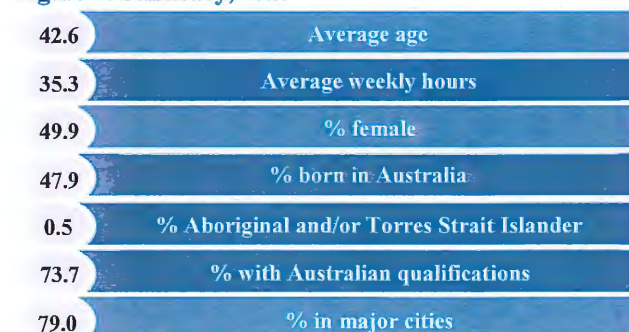
In 2017, the average age of dental practitioners was 42.6 years, remaining unchanged from 2014. Between 2014 and 2017, the proportion of male dental practitioners aged 45 years and over decreased from 27.8% to 25.7%.

Figure 3: Age and gender distribution, 2014 and 2017



## Quick Facts - 2017

Figure 4: Summary, 2017



## Replacement Rate

In 2017, there were 1.7 new registrants for every dental practitioner that did not renew their registration from 2016.

## Hours Worked

In 2017, dental practitioners worked an average of 35.3 hours per week in total, and worked an average of 3.8 hours per week in non-clinical roles.

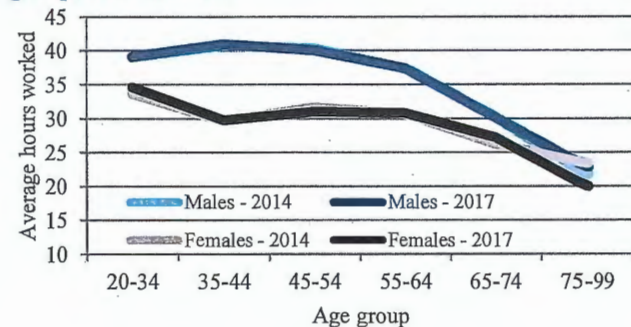


**Table 2: Average hours per week, 2014-2017**

Average hours worked	2014	2015	2016	2017
Clinical	31.3	31.2	31.4	31.4
Non-clinical	4.0	4.0	4.0	3.8
<b>Total</b>	<b>35.3</b>	<b>35.1</b>	<b>35.4</b>	<b>35.3</b>

In 2014 and 2017, male dental practitioners worked an average of 38.4 hours per week. In 2017, female dental practitioners worked an average of 32.1 hours per week, increasing from 31.9 hours in 2014. Males aged 35-44 worked the longest hours per week, at 41.0 hours on average.

**Figure 5: Average hours per week by gender and age group, 2014 and 2017**



## Job Role

### Principal role

In 2017, 96.7% of dental practitioners worked as clinicians in their principal role, an increase from 96.5% in 2014.

**Table 3: Principal role, 2014 and 2017**

Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	17,873	96.5	19,283	96.7
Administrator	213	1.1	263	1.3
Teacher or educator	281	1.5	241	1.2
Researcher	82	0.4	59	0.3
Other	81	0.4	103	0.5
<b>Total</b>	<b>18,530</b>	<b>100</b>	<b>19,949</b>	<b>100</b>

### Second job

In 2017, 18.6% of dental practitioners reported a second job role in dental practice, a decrease from 18.9% in 2014.

**Table 4: Second job role, 2014 and 2017**

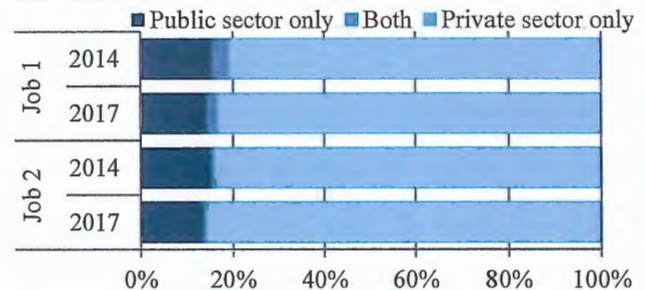
Principal role	2014		2017	
	Headcount	%	Headcount	%
Clinician	2,646	14.3	2,964	14.9
Administrator	234	1.3	194	1.0
Teacher or educator	457	2.5	436	2.2
Researcher	84	0.5	39	0.2
Other	83	0.4	72	0.4
<b>Total</b>	<b>3,504</b>	<b>18.9</b>	<b>3,705</b>	<b>18.6</b>

## Principal work sector

In 2017, 14.4% of the workforce reported that in their principal role, they worked only in the public sector, a decrease from 15.6% in 2014.

Of those dental practitioners reporting a second job role in 2017, 13.5% reported they worked only in the public sector, a decrease from 15.2% in 2014.

**Figure 6: Sector in which clinical hours were worked, 2014 and 2017**



Note: 'Not applicable' responses are excluded from the chart

## Principal Work Setting

In 2017, 81.1% of dental practitioners worked in a Group or Solo private practice setting in their principal role, an increase from 79.3% in 2014, and 8.9% worked in a Public setting, a decrease from 9.7% in 2014.

**Table 5: Principal work setting, 2014 and 2017**

Principal work setting	2014		2017	
	Principal role	Second job	Principal role	Second job
Group private practice	9,019	1,753	10,118	2,062
Solo private practice	5,676	738	6,054	1,064
Public clinic	1,803	268	1,772	258
Hospital	879	314	876	313
Tertiary education facility	293	304	257	277
Defence forces	144	26	160	29
Locum private practice	175	82	155	77
Other	175	70	151	62
Commercial/ business service	74	20	102	21
Other community health care service	87	21	101	29
Aboriginal health service	82	23	89	20
Other gov dept	56	17	37	21
Remaining work settings	67	48	77	46
<b>Total</b>	<b>18,530</b>	<b>3,684</b>	<b>19,949</b>	<b>4,279</b>

Note: In this instance the principal work setting headcount for the reported second job does not equal the principal role for the reported second job. This occurs when the survey respondent indicates a second job work setting but not a second job principal role.

In 2017, dental practitioners working in a Hospital setting reported the highest average weekly hours (37.1) and those in Residential health care facilities



(included in 'Remaining work settings') reported the lowest average hours (22.8).

## Principal Job Area

In 2017, 63.6% of dental practitioners reported general dental practice as their principal job area, up from 62.3% in 2014 and 7.6% principally worked in dental hygiene, down from 7.9% in 2014.

**Table 6: Principal job area, 2014 and 2017**

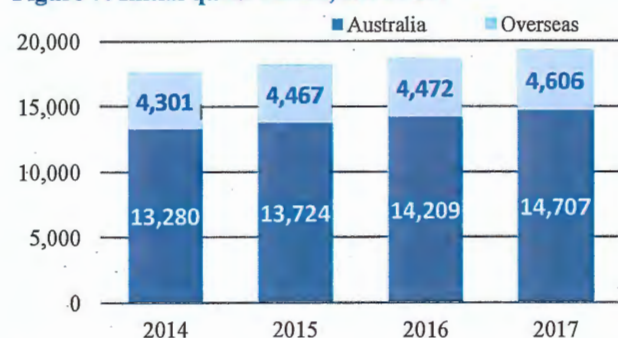
Principal job area	Headcount	
	2014	2017
General dental practice	11,551	12,679
Dental hygiene	1,455	1,516
Dental prosthetics	1,113	1,172
Dental therapy	1,033	965
Orthodontics	782	832
Oral health therapy (dental hygiene)	523	626
Oral health therapy (dental therapy)	348	414
Public health dentistry	316	305
Prosthodontics	248	262
Periodontics	230	229
Oral and maxillofacial surgery	208	221
Endodontics	180	184
Paedodontics	171	177
Other	150	139
Oral surgery	95	108
Special needs dentistry	61	50
Oral medicine	32	35
Remaining job areas	34	35
<b>Total</b>	<b>18,530</b>	<b>19,949</b>

## Primary Speciality

In 2017, 9.9% of dentists reported a primary speciality, down from 10.2% in 2014. Further detail on primary specialities is presented in the Dentist Factsheet.

## Initial Qualification

**Figure 7: Initial qualification, 2014-2017**



Note: 'Not stated/Unknown' responses are excluded from this chart

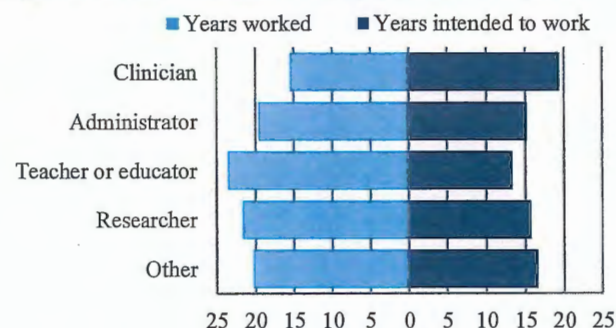
The workforce survey asks dental practitioners where they obtained their initial qualification. In 2017, 73.7% of oral health practitioners obtained

their initial qualification in Australia and 23.1% obtained their initial qualification overseas.

## Working Intentions

In 2014 and 2017, dental practitioners had, on average, worked 16 years in the profession and intended to work for another 19 years.

**Figure 8: Workforce intentions by principal role, 2017**



## Distribution

### State and Territory

In 2017, the jurisdictions with the highest rates of full-time equivalent dental practitioners per 100,000 population (FTE rate) were SA and the ACT. Between 2014 and 2017, the total FTE rate increased from 73.3 to 75.2 and the NT had the largest FTE rate increase (5.8).

In 2017, dental practitioners in the NT worked the most hours per week on average (37.5 hours) and those in SA worked the fewest (33.4 hours).

**Table 8: Distribution by state/ territory, 2017**

State / Territory	Headcount	Total FTE	Avg. total hours	<sup>2</sup> FTE rate per 100,000 population
NSW	6,172	5,840.1	36.0	74.3
VIC	4,743	4,364.9	35.0	69.0
QLD	4,125	3,902.9	36.0	79.2
SA	1,671	1,468.1	33.4	85.2
WA	2,357	2,088.8	33.7	81.1
TAS	349	338.0	36.8	64.7
ACT	374	349.4	35.5	84.9
NT	148	145.9	37.5	59.0
<b>Total</b>	<b>19,949</b>	<b>18,507.4</b>	<b>35.3</b>	<b>75.2</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

### Remoteness Area

In 2017, 93.2% of dental practitioners worked in either major cities or inner regional locations, compared with 93.0% in 2014.

Between 2014 and 2017, the largest shift in average hours worked was in very remote areas, decreasing from 41.0 to 36.4 hours per week.



However, due to the increase in the number of dental practitioners in very remote areas, the FTE rate in these areas increased by 6.7.

**Table 9: Distribution by remoteness area, 2017**

Remoteness Area	Headcount	Total FTE	Avg. total hours	FTE rate per 100,000 population
Major cities	15,755	14,536.9	35.1	82.3
Inner regional	2,830	2,686.1	36.1	61.2
Outer regional	1,172	1,099.4	35.7	53.7
Remote	130	126.3	36.9	43.2
Very remote	54	51.7	36.4	25.8
<b>Total</b>	<b>19,949</b>	<b>18,507.4</b>	<b>35.3</b>	<b>75.2</b>

Note: 'Not stated/Unknown' are excluded from this table but are included in the total

### Other Work Location Outside of Major Cities

In 2017, 4.9% of dental practitioners reported that they had worked in a regional, rural or remote location, in addition to their principal or second job location. Of these respondents, 72.2% had worked in an inner regional or outer regional location, and 12.0% had worked in either remote or very remote locations.

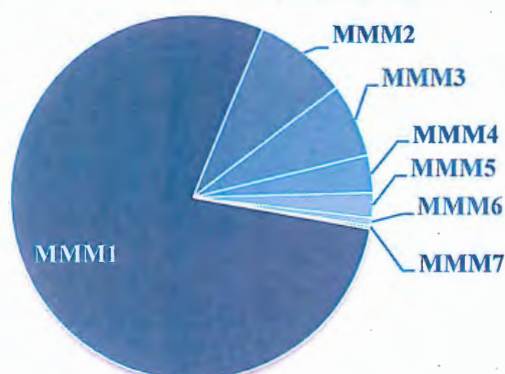
### Modified Monash Model

In 2017, the majority (78.5%) of FTE dental practitioners were located in a major city or a location considered as MMM1 under the Modified Monash Model (MMM) classification system, a small increase from 78.2% in 2014.

(See [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au) for more information on the MMM).

MMM1 locations had the highest FTE rate of dental practitioners (82.8) followed by MMM4 (69.5). The lowest FTE rate was in MMM5 locations (22.7).

**Figure 9: FTE Distribution by MMM, 2017**



### Tele-Health

The workforce survey asks dental practitioners to report their hours practiced via tele-health in dental practice in the previous year.

Note: Tele-health is the use of telecommunication techniques for the

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purpose of providing telemedicine, medical education, and health education over a distance.

A total of 1,403 dental practitioners (7.0%) provided a response to the Tele-Health question in 2017. On average, these respondents practiced via Tele-Health for 19.7 hours per week, with the majority (81.6%) of Tele-Health services provided by practitioners based in a major city.

**Table 10: Tele-health dental practitioners by remoteness location, 2017**

Major cities	Inner regional	Outer regional	Remote	Very remote
81.6%	11.8%	5.3%	0.7%	0.6%

Note: The tele-health workforce remoteness location refers to the location of the Practitioner, not the location of the person receiving the service.

### References

- 1) National Health Workforce Dataset (NHWDS): Allied Health Practitioners 2014-2017.
- 2) ABS - 3218.0 - Regional Population Growth, Australia, 2016-17, Released 31/08/18.

### Notes

- 1) 'NP' denotes figures that are not published (suppressed) for confidentiality reasons
- 2) The 2013-2016 NHWDS have been revised due to an error in recoding the missing values for job role. As such the figures may not match those that were previously published.
- 3) FTE number measures the number of standard-hour workloads worked by employed health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work. FTE number is calculated based on the total hours worked in a 'standard working week'. The standard working week is assumed to be 38 hours, equivalent to 1 FTE for all practitioners with the exception of medical practitioners where it is assumed to be 40 hours.

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# ANNEXURE 8



# Dental Board of Australia Registrant data

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Reporting period: 01 April 2019 to 30 June 2019





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## Introduction

The functions of the Dental Board of Australia (the Board) include:

- registering dentists, students, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists
- developing standards, codes and guidelines for the dental profession
- handling notifications, complaints, investigations and disciplinary hearings
- overseeing the assessment of overseas trained practitioners who wish to practise in Australia, and
- approving accreditation standards and accredited courses of study.

The Board's functions are supported by the [Australian Health Practitioner Regulation Agency](#) (AHPRA). For information about legislation governing our operations see AHPRA's Legislation & Publications at [www.ahpra.gov.au/Publications](http://www.ahpra.gov.au/Publications)

The Board has analysed its registration data and produced a number of statistical breakdowns about registrants to share with the profession and community. The Board shares these breakdowns regularly. For more information on dental registration, please see the Board's website:

[www.dentalboard.gov.au/Registration.aspx](http://www.dentalboard.gov.au/Registration.aspx)

For more information on medical registration, please see the Board's website:

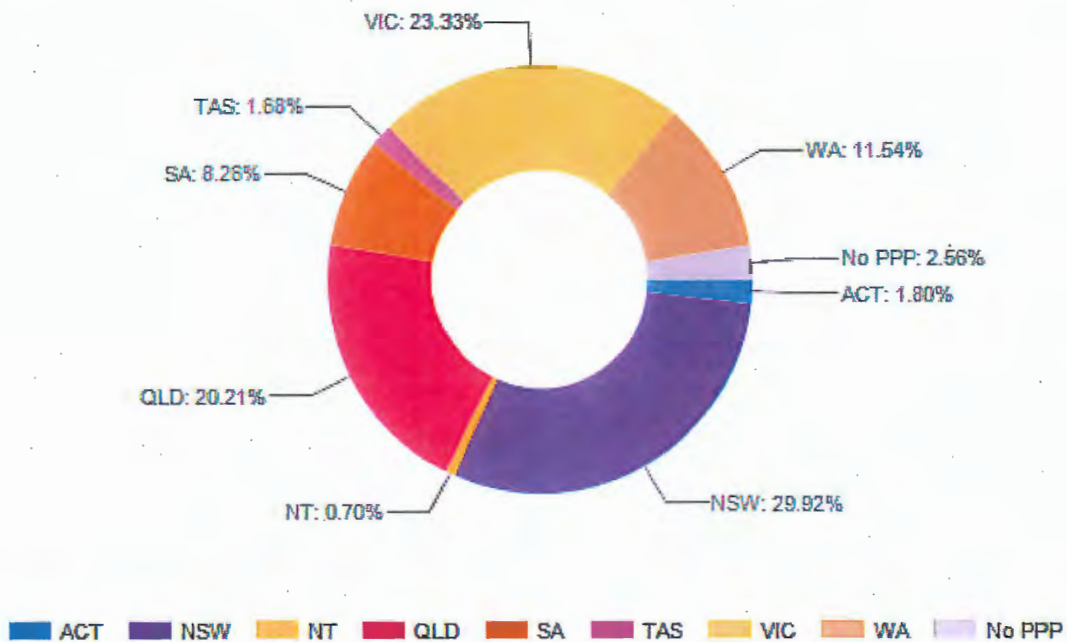
<http://www.medicalboard.gov.au/Registration.aspx>

## Registration type

**Table 1.1 Dental practitioners - registration type by state or territory**

Registration types	Registration subtypes	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
General		379	6,419	160	4,368	1,766	367	4,961	2,475	397	21,292
General and Non-practising					1						1
General and Specialist		41	501	4	334	147	30	437	186	40	1,720
Specialist		1	9		6	4		11	8	9	48
	Postgraduate training or supervised practice		6		6	2		4	5		23
Limited	Public interest										
	Teaching or research		9		17	5		3	6		40
Non-practising		7	156	2	65	35	2	120	58	161	606
<b>Total</b>		<b>428</b>	<b>7,100</b>	<b>166</b>	<b>4,797</b>	<b>1,959</b>	<b>399</b>	<b>5,536</b>	<b>2,738</b>	<b>607</b>	<b>23,730</b>

**Table 1.2 Dental practitioners - percentage by principal place of practice**





## Registration divisions

**Table 2.1 Dental practitioners - division(s) by state or territory**

Division	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Dental Hygienist	42	398	9	155	296	21	240	264	26	1,451
Dental Hygienist and Dental Prosthetist		2		1						3
Dental Hygienist and Dental Prosthetist and Dental Therapist		1					1			2
Dental Hygienist and Dental Therapist	7	65	4	131	61	3	124	57	1	453
Dental Hygienist and Dental Therapist and Dentist				1						1
Dental Hygienist and Dental Therapist and Oral Health Therapist		7		6	5		8	1		27
Dental Hygienist and Dentist		2		2			2			6
Dental Hygienist and Oral Health Therapist		15	1	4	1		1	5		27
Dental Prosthetist	14	402	7	275	68	46	361	88	3	1,264
Dental Prosthetist and Dental Therapist							1			1
Dental Prosthetist and Dentist							3			3
Dental Prosthetist and Oral Health Therapist			1							1
Dental Therapist	13	181	14	161	74	42	134	253	5	877
Dental Therapist and Dentist							1			1
Dental Therapist and Oral Health Therapist								6		6
Dentist	319	5,512	113	3,636	1,239	266	4,206	1,874	562	17,727
Dentist and Oral Health Therapist		3		1			2			6
Oral Health Therapist	33	512	17	424	215	21	452	190	10	1,874
<b>Total</b>	<b>428</b>	<b>7,100</b>	<b>166</b>	<b>4,797</b>	<b>1,959</b>	<b>399</b>	<b>5,536</b>	<b>2,738</b>	<b>607</b>	<b>23,730</b>

## Registration type and divisions

**Table 3.1 Dental practitioners - registration type and division by state or territory**

Registration Types	Division	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total	
General	Dental Hygienist	41	385	9	151	291	21	234	253	15	1,400	
	Dental Hygienist and Dental Prosthetist		2		1						3	
	Dental Hygienist and Dental Prosthetist and Dental Therapist		1					1			2	
	Dental Hygienist and Dental Therapist	7	61	4	128	61	3	120	55	1	440	
	Dental Hygienist and Dental Therapist and Dentist				1						1	
	Dental Hygienist and Dental Therapist and Oral Health Therapist		7		6	5		8	1		27	
	Dental Hygienist and Dentist		2		1			2			5	
	Dental Hygienist and Oral Health Therapist		15	1	4	1		1	5		27	
	Dental Prosthetist	13	388	7	274	68	46	351	86	1	1,234	
	Dental Prosthetist and Dental Therapist								1		1	
	Dental Prosthetist and Dentist								3		3	
	Dental Prosthetist and Oral Health Therapist			1							1	
	Dental Therapist	13	168	14	158	73	42	122	247	2	839	
	Dental Therapist and Dentist								1		1	
	Dental Therapist and Oral Health Therapist								6		6	
	Dentist	272	4,879	107	3,223	1,055	235	3,667	1,632	370	15,440	
	Dentist and Oral Health Therapist		3		1			2			6	
	Oral Health Therapist	33	508	17	420	212	20	448	190	8	1,856	
	<b>Sub Total - General</b>		<b>379</b>	<b>6,419</b>	<b>160</b>	<b>4,368</b>	<b>1,766</b>	<b>367</b>	<b>4,961</b>	<b>2,475</b>	<b>397</b>	<b>21,292</b>

Continued on next page.

Registration Types	Division	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
General and Non-practising	Dental Hygienist and Dentist				1						1
	Dental Hygienist and Oral Health Therapist										
<b>Sub Total - General and Non-practising</b>					1						1
General and Specialist	Dentist	41	501	4	334	147	30	437	186	40	1,720
Specialist	Dentist	1	9		6	4		11	8	9	48
Limited	Dental Hygienist		1								1
	Dentist		14		23	7		6	11		61
	Oral Health Therapist							1			1
<b>Sub Total - Limited</b>			15		23	7		7	11		63
Non-practising	Dental Hygienist	1	12		4	5		6	11	11	50
	Dental Hygienist and Dental Therapist		4		3			4	2		13
	Dental Prosthetist	1	14		1			10	2	2	30
	Dental Therapist		13		3	1		12	6	3	38
	Dentist	5	109	2	50	26	1	85	37	143	458
	Oral Health Therapist		4		4	3	1	3		2	17
<b>Sub Total - Non-practising</b>		7	156	2	65	35	2	120	58	161	606
<b>Total</b>		428	7,100	166	4,797	1,959	399	5,536	2,738	607	23,730



## Dental specialities

**Table 4.1 Dental practitioners - dental speciality by state or territory**

Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Dento-maxillofacial radiology		1		8			1	3		13
Endodontics	6	50		34	17	4	46	16	5	178
Forensic odontology	2	5	1	2	2	2	4	5		23
Oral and maxillofacial surgery	4	61	1	47	16	5	58	23	8	223
Oral medicine		9		7			12	8	2	38
Oral pathology		8		5	3	1	2	3	1	23
Oral surgery		36		6			7	2	1	52
Orthodontics	14	184	2	125	56	13	148	64	18	624
Paediatric dentistry	2	44		26	13	1	43	18	3	150
Periodontics	9	64	1	43	16	4	63	34	4	238
Prosthodontics	5	69		42	25		55	19	7	222
Public health dentistry (Community dentistry)		3		1	1		8	1		14
Special needs dentistry		3		4	2		8	1	1	19
Surgery				1						1
<b>Total</b>	<b>42</b>	<b>537</b>	<b>5</b>	<b>351</b>	<b>151</b>	<b>30</b>	<b>455</b>	<b>197</b>	<b>50</b>	<b>1,818</b>

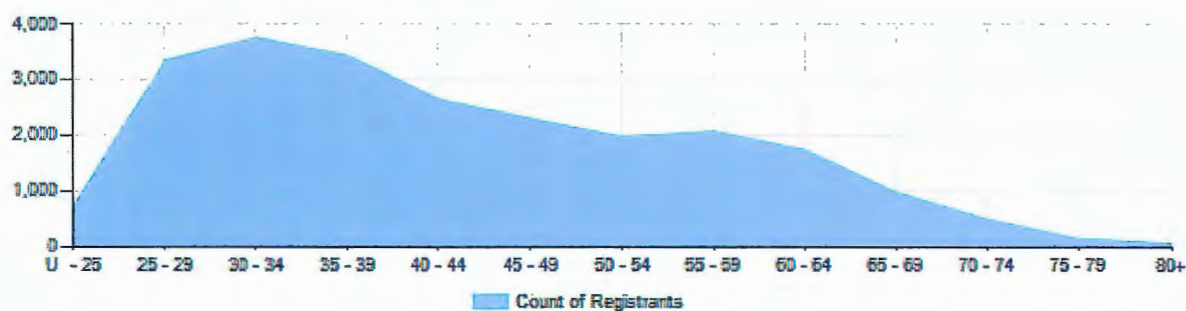
## Endorsements

**Table 5.1 Dental practitioners - endorsement by state or territory**

Endorsement	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Area of Practice - Conscious sedation	4	53	2	19	2	2	7	12	1	102

## Age group

**Table 6.1 Dental practitioners - by age group**



**Table 6.2 Dental practitioners - registration type by age group**

Age group	General	General and Non-practising	General and Specialist	Specialist	Limited			Non-practising	Total
					Postgraduate training or supervised practice	Public interest	Teaching or research		
U - 25	753								753
25 - 29	3,306		10	1	6			33	3,356
30 - 34	3,537	1	117	5	10		1	89	3,760
35 - 39	3,093		262	12	3		6	67	3,443
40 - 44	2,320		263	14	2		10	46	2,655
45 - 49	2,029		206	5	2		7	52	2,301
50 - 54	1,714		192	7			7	53	1,973
55 - 59	1,781		223	1			6	60	2,071
60 - 64	1,465		199				2	74	1,740
65 - 69	775		142	2			1	54	974
70 - 74	383		65					48	496
75 - 79	107		26	1				13	147
80+	29		15					17	61
<b>Total</b>	<b>21,292</b>	<b>1</b>	<b>1,720</b>	<b>48</b>	<b>23</b>		<b>40</b>	<b>606</b>	<b>23,730</b>

## Gender

**Table 7.1 Dental practitioners - registration type by gender**

Gender	Registration types	Registration sub types	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Female	General		250	3,224	88	2,281	1,078	179	2,695	1,493	188	11,476
	General and Non-practising					1						1
	General and Specialist		8	128	1	82	42	8	140	57	10	476
	Specialist		1	5		2	1		7	2		18
	Limited	Postgraduate training or supervised practice		4		2	1		1	4		12
	Limited	Teaching or research		3		6	3			2		14
	Limited			7		8	4		1	6		26
	Non-practising		3	77		33	16	1	67	32	78	307
	<b>Total Female</b>		<b>262</b>	<b>3,441</b>	<b>89</b>	<b>2,407</b>	<b>1,141</b>	<b>188</b>	<b>2,910</b>	<b>1,590</b>	<b>276</b>	<b>12,304</b>
	Male	General		129	3,195	72	2,087	688	188	2,266	982	209
General and Specialist			33	373	3	252	105	22	297	129	30	1,244
Specialist				4		4	3		4	6	9	30
Limited		Postgraduate training or supervised practice		2		4	1		3	1		11
Limited		Teaching or research		6		11	2		3	4		26
Limited				8		15	3		6	5		37
Non-practising			4	79	2	32	19	1	53	26	83	299
<b>Total Male</b>		<b>166</b>	<b>3,659</b>	<b>77</b>	<b>2,390</b>	<b>818</b>	<b>211</b>	<b>2,626</b>	<b>1,148</b>	<b>331</b>	<b>11,426</b>	
<b>Total</b>		<b>428</b>	<b>7,100</b>	<b>166</b>	<b>4,797</b>	<b>1,959</b>	<b>399</b>	<b>5,536</b>	<b>2,738</b>	<b>607</b>	<b>23,730</b>	

**Table 7.2 Dental practitioners - percentage by gender**

Gender	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Female	61.2%	48.5%	53.6%	50.2%	58.2%	47.1%	52.6%	58.1%	45.5%	51.8%
Male	38.8%	51.5%	46.4%	49.8%	41.8%	52.9%	47.4%	41.9%	54.5%	48.2%



# ANNEXURE 9

# GradStats

February 2018

## EMPLOYMENT AND SALARY OUTCOMES OF HIGHER EDUCATION GRADUATES FROM 2017

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Graduate Careers Australia's (GCA) annual Australian Graduate Survey (AGS) was a study of the activities of new higher education graduates around four months after the completion of their qualifications. Every year since 1976, new graduates who completed the requirements for awards in the preceding year were surveyed regarding their major activities, including labour market engagement, further full-time study, or their unavailability for work or study.

With the cessation of Federal Government funding, the AGS concluded after the 2015 survey, with the Quality Indicators for Learning and Teaching (QILT – [www.qilt.edu.au](http://www.qilt.edu.au)) suite of surveys replacing it.

Over the years, *GradStats*<sup>1</sup> has presented a summary of national AGS data concerning the destinations of Australian resident bachelor degree graduates. This edition will endeavour to provide a summary link between the last AGS figures and the first two tranches of related QILT results. Figures for 2016 and 2017 quoted in this publication largely come from the QILT Graduate Outcomes Survey (GOS) 2016 and 2017 National Reports (which can be downloaded from [www.qilt.edu.au/about-this-site/graduate-employment](http://www.qilt.edu.au/about-this-site/graduate-employment)).

It must be noted that there are a number of ways in which QILT departs from AGS methods and data analysis, and comparisons of results between the two surveys need to be read with that in mind. The 2017 GOS report notes that

*The 2017 GOS was primarily conducted as a national online survey among 97 higher education institutions [and a] ... total of 120,747 valid survey responses were collected across all study levels, representing a response rate of 39.7 per cent.*

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<sup>1</sup> Previous editions of *GradStats* can be downloaded from [www.graduatecareers.com.au/Research/ResearchReports](http://www.graduatecareers.com.au/Research/ResearchReports)

## Overview

The 2017 GOS report saw a further slight improvement in the short-term employment prospects of new graduates compared with the 2015 AGS and 2016 GOS reports.

- **71.8 per cent were in full-time employment** at the time of the 2017 GOS compared with 70.9 per cent in 2016 (see Fig. 1). This is notably up from 68.1 per cent in the 2014 AGS (see Fig. 2)
- The full-time employment figure for males (see Fig. 1) was 71.2 per cent in 2017 (70.1 per cent in 2016) while for females it was 72.1 per cent (71.5 per cent in 2016).
- **The overall employment rate for undergraduates was 86.5 per cent in 2017.** This refers to graduates who had any employment (whether full or part time – see Fig. 1).
- **Middle- to longer-term employment prospects** for undergraduates remain strong. QILT's follow-up longitudinal GOS (GOS-L) showed that three years after a full-time employment rate of 67.5 per cent in the 2014 AGS, **by 2017 this had grown to 89.3 per cent.** GCA's Beyond Graduation Survey (BGS) showed similar improvements in employment figures three years out.
- **Bachelor degree graduates in the wider Australian workforce** (aged 15-74) had (at the time of the 2017 GOS) an **unemployment rate of just 3.0 per cent** compared with an overall population rate of 5.4 per cent and 8.2 per cent for those with no post-school qualifications (see Fig. 3).
- The **median annual starting salary** for new Australian resident bachelor degree graduates in full-time employment in Australia was **\$60,000 in 2017**, up from \$57,900 in 2016 (see Table 3).
- **Just over one-fifth of respondents** (20.7 per cent, down from 21.8 per cent in 2016), were **undertaking further full-time study** (see Fig. 5).
- **Overall satisfaction with courses** as measured by the Course Experience Questionnaire (CEQ) remains at an elevated level, with **79.4 per cent of graduates** expressing satisfaction with their courses (see Fig. 6).
- Just over half of the **graduates who found full-time employment** in 2014 or 2015 learned of their job first through one of three strategies (see Table 4): **searching advertisements on the internet** (26.9 per cent), **talking to family or friends** (14.2 per cent) and **visiting university or college careers services** (11.7 per cent).
- Overall, **84 per cent of employers** were highly satisfied with the performance of their new recruits.



## Full-time employment

The results of the 2017 GOS show that 71.8 per cent of new bachelor degree graduates seeking full-time employment had found a position by the time of the survey – four months after course completion. This was up slightly from the comparable figure of 70.9 per cent in 2016 and 68.8 per cent in the 2015 AGS (see Figure 1).

The 2017 GOS report notes (p.3) that

*This continues the steady improvement in the full-time employment rate of graduates in recent years from the low point of 68.1 per cent in 2014. This is consistent with a modest improvement in the overall labour market over the period.*

Of those graduates available for full-time employment, similar percentages of males and females (71.2 per cent and 72.1 per cent respectively - see Figures 2 and 3) had found a full-time position by the time of the 2017 survey. The comparative figures from the 2016 GOS were 70.1 and 71.5 per cent.

The GOS reports also calculate an overall employment rate. This refers to the percentage of all employed graduates (full-time plus part-time or casual employment), as a proportion of those available for any employment. In 2017, the overall employment rate for all graduates was 86.5 per cent (84.2 per cent for males and 87.7 per cent for females – see Figure 1).

AGS figures for 2015 are also presented in Figures 1 and 2, but the 2017 GOS report notes that “caution should be used when directly comparing the different series due to changes in survey methodology”.

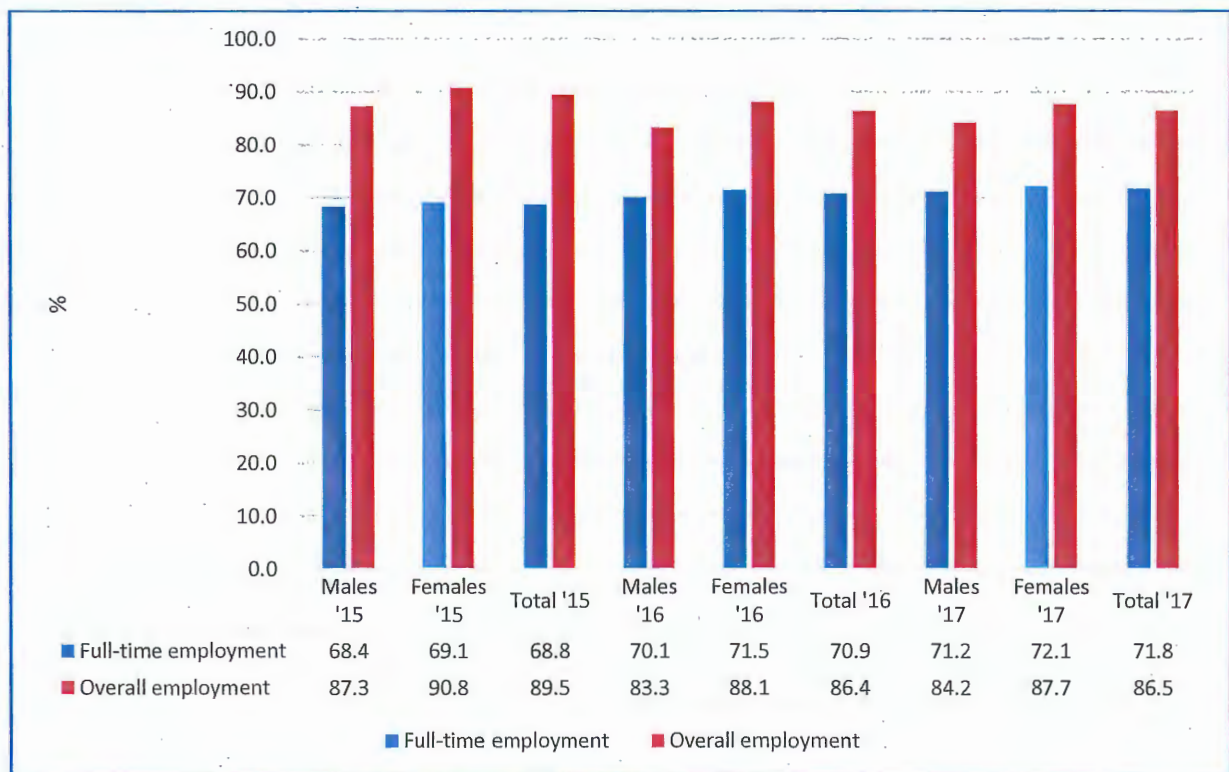


Figure 1: Undergraduates in employment, by sex, 2015-7 (%)

Sources: 2015 Australian Graduate Survey and 2016-17 Graduate Outcomes Survey

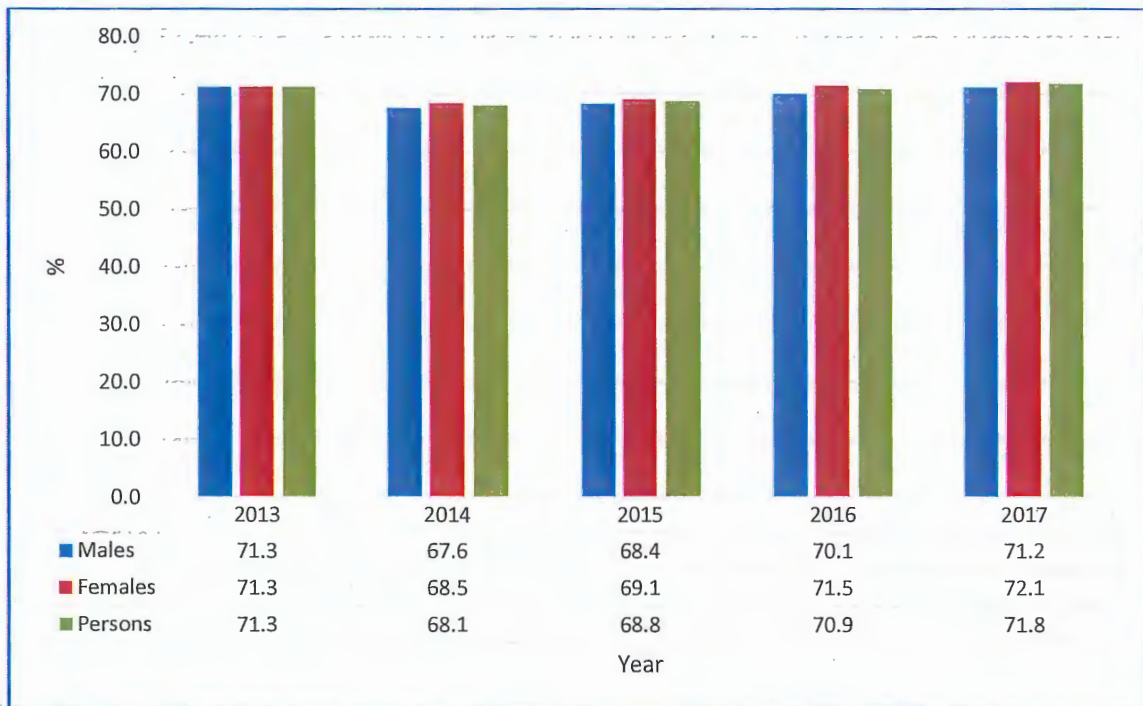


Figure 2: Undergraduates in full-time employment, by sex, 2013-17 (%)

Sources: 2013-15 Australian Graduate Survey and 2016-7 Graduate Outcomes Survey

## Long-term full-time employment prospects

Of additional note regarding the employment prospects of new graduates are longer-term figures, which remain strong.

QILT's 2017 follow-up longitudinal GOS (GOS-L) showed that after a full-time employment rate of 67.5 per cent<sup>2</sup> was found in the 2014 AGS, three years later in 2017 this had grown to 89.3 per cent. GCA's Beyond Graduation Survey (BGS<sup>3</sup>) showed similar improvements in employment figures three years out.

And looking at the wider population, Australian Bureau of Statistics (ABS) figures for May 2017<sup>4</sup> show that, in the general labour force (aged 15-74), just 3.0 per cent of bachelor degree graduates were unemployed (see Figure 3). The comparative figure for those with a postgraduate degree was 3.6 per cent, and for those with a graduate or postgraduate diploma it was 3.1 per cent.

For the total population (with or without non-school qualifications), the unemployment rate was 5.4 per cent and 8.2 per cent for persons with no post-secondary qualifications. Longer-term prospects for those with higher education qualifications remain very positive.

<sup>2</sup> This was re-calculated by QILT for the GOS-L report. The 2014 AGS reported 68.1 per cent, as shown in Figure 2 in this document.

<sup>3</sup> Download the BGS report from: <http://www.graduatecareers.com.au/research/surveys/beyondgraduationsurvey/>

<sup>4</sup> ABS, 2017, *Education and Work, Australia, May 2017*, 6227.0 (Table 10), Canberra.

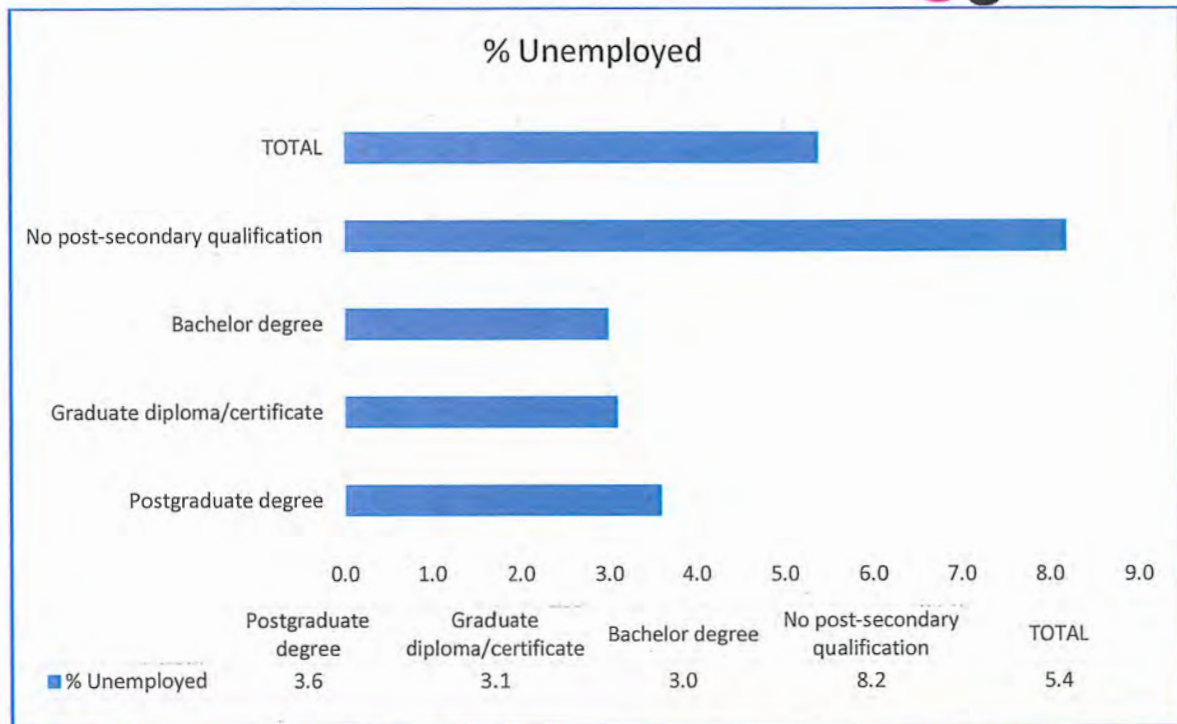


Figure 3: Unemployment rates by level of educational attainment, May 2017, Australian labour force aged 15-74

Source: *Education and Work, Australia, May 2017*, Australian Bureau of Statistics, publication 6227.0, released 6 November 2017 (Table 10)

## Part-time employment

As in the general population, part-time employment is an important option for some new graduates, with females more likely to be in such. The 2017 GOS report notes that 37.9 per cent of all employed new graduates were working on a part-time basis (41.1 per cent for females and 32.2 per cent for males – see Figure 4).

Of those in any employment at the time of the 2017 GOS, 19.7 per cent were working part time and seeking more hours. Females (20.5 per cent) were also more likely than males (18.2 per cent) to be seeking more hours (defined as ‘involuntary’ part-timers in the 2016 GOS report).

A further 14.2 per cent were in part-time work and not seeking additional hours (described as ‘voluntary’ part-timers in the 2016 GOS report). As with ‘involuntary’ part-time work, females were more likely than males to be in ‘voluntary’ part-time employment (16.3 per cent and 10.1 per cent respectively).

While reliable comparisons with the old AGS categories are not possible based on the published data, this ‘voluntary’ category would broadly coincide with the ‘working part-time, not seeking full-time’ AGS category while the ‘involuntary’ group would seem to coincide with those ‘working part-time, and seeking full-time’.



In the 2017 GOS (Table 5 in that report), graduates from the fields of

- creative arts
- communications
- psychology
- tourism, hospitality, personal services,
- humanities, culture and social sciences
- science and mathematics
- health services and support

were more than five percentage points above the overall average of 19.7 per cent of employed graduates in ‘involuntary’ part-time positions and thus seeking more hours.

Table 6 in that report reveals that slightly more than half of ‘involuntary’ part-time employment (52.3 per cent) was based on labour market factors, and this figure was made up largely of 19.6 per cent who had not been able to find a suitable job in their area of expertise and 16.8 per cent who were unable to find a job with a suitable number of hours. The report notes that “recent trends towards increasing rates of part-time work ... reflect at least, in part, the relatively weak state of the labour market over the past decade”.

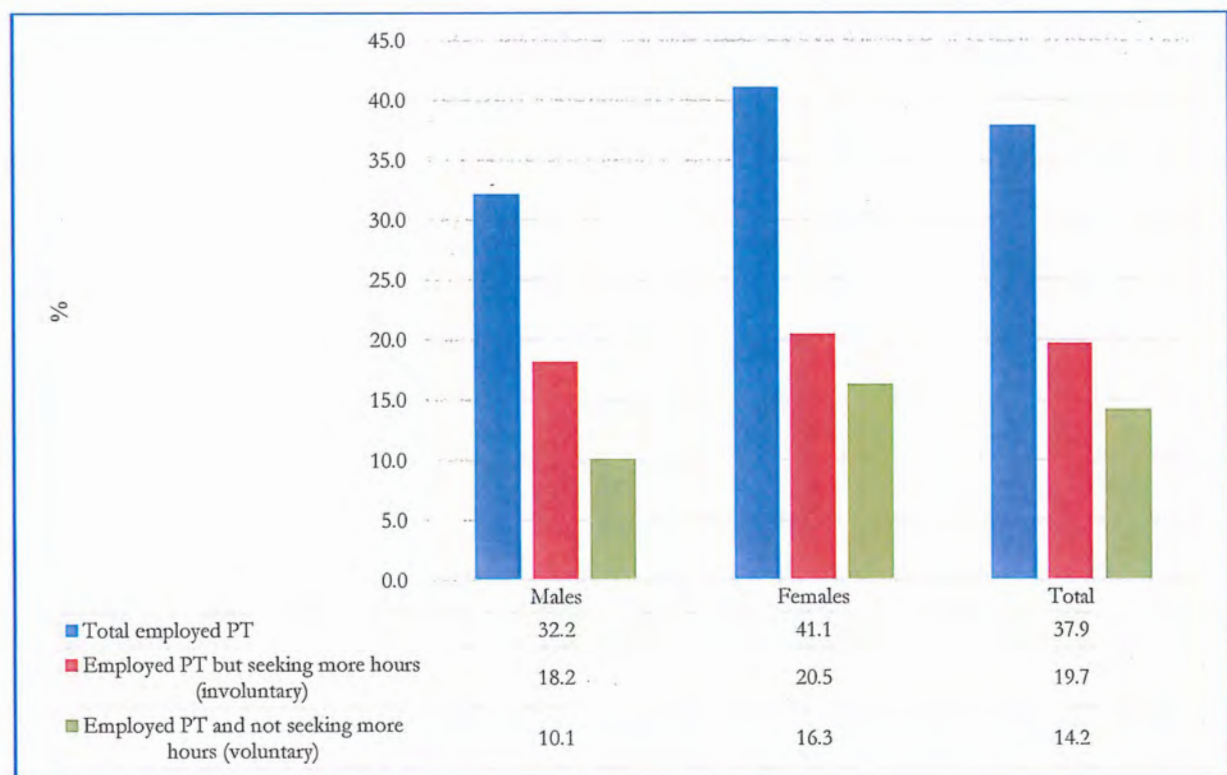


Figure 4: Undergraduates in part-time employment, by sex, 2017 (%)

Source: 2017 Graduate Outcomes Survey

## Further full-time study

The proportion of graduates continuing in further full-time study in 2017 was 20.7 per cent, down slightly from 21.8 per cent in 2016 (see Figure 5). Historically, between one-fifth and one-quarter of respondents elect to continue in further full-time study<sup>5</sup> with the figures generally falling when labour market prospects are stronger. This relationship between further full-time study and full-time employment figures will be of interest.

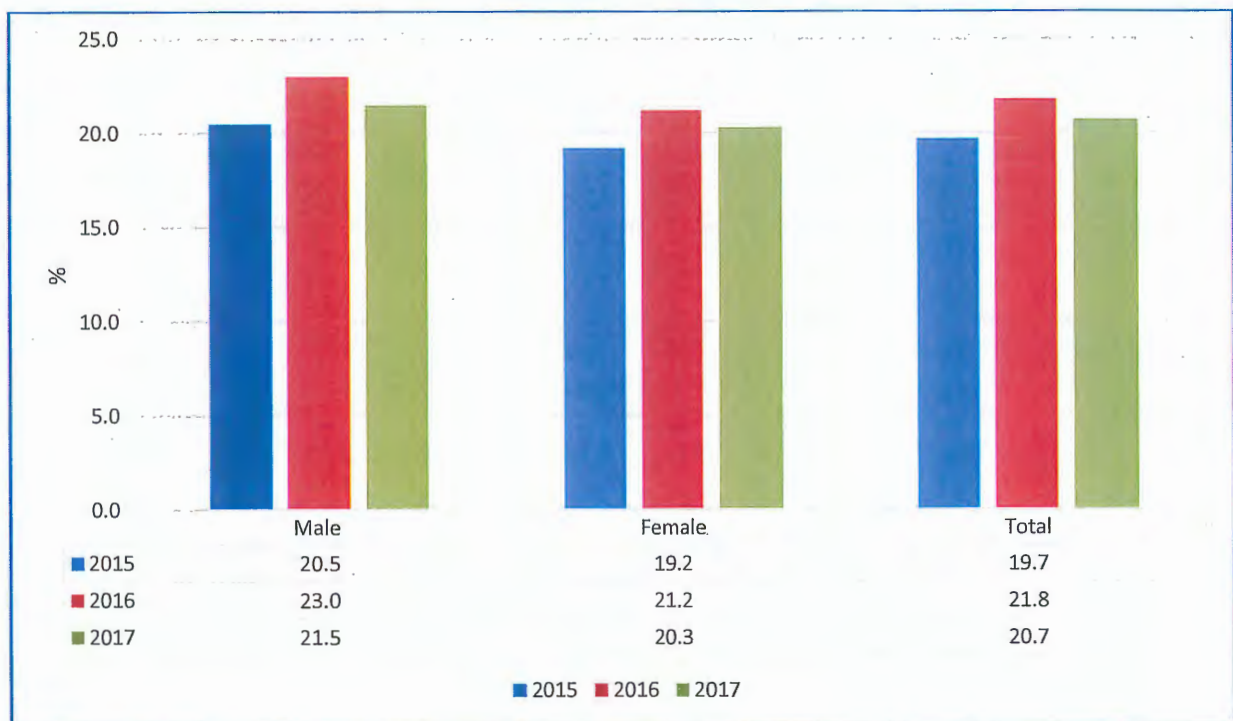


Figure 5: Undergraduates going into further full-time study, by sex, 2015-16 (%)  
Sources: 2015 Australian Graduate Survey and 2016-17 Graduate Outcomes Survey

<sup>5</sup> See related discussion in *Graduate Destinations* reports available from [www.graduatecareers.com.au/Research/ResearchReports/GraduateDestinations](http://www.graduatecareers.com.au/Research/ResearchReports/GraduateDestinations)

## Employment and equity groups

As with the AGS, the GOS examines employment outcomes for graduates from various sub-groups and equity groups (see Table 1).

As a general rule, some caution is required when comparing results for such groups as they can be affected by other variables not taken into account here. For example, the 2017 GOS report shows that those who had studied externally were notably more likely to have been in full-time employment at the time of the survey (80.3 per cent) than those who had studied mainly internally (70.5 per cent). However, external students are often also studying part-time and can have full-time employment while enrolled and this gives them an artificial ‘advantage’ in terms of such unadjusted employment figures.

The relatively positive employment figures for indigenous graduates (77.5 per cent) compared with 71.7 per cent for non-indigenous graduates should be interpreted with a little caution because a rather small number of respondents (980) are involved; however, the response numbers were representative of the survey sample and it is worth noting that most editions of *GradStats* have observed similar figures over the years.

The figures in Table 1 indicate that graduates from a non-English speaking background (53.9 per cent) were taking longer to find full-time employment compared with graduates from an English-speaking background (72.3 per cent), as were those who identified as having a disability (61.5 per cent cf. 72.4 per cent).

Older graduates (over 30) were also more likely to be in full-time employment (74.0 per cent) than their younger colleagues (71.3 per cent).

Table 1: Undergraduate employment outcomes for various sub-groups and equity groups, 2015-2017 (%)

	Full-time employment (%)			Overall employment (%)		
	2015	2016	2017	2015	2016	2017
<b>Age</b>						
30 years or under	68.1	70.5	71.3	89.8	86.4	86.5
Over 30 years	72.6	73.2	74.0	88.1	86.1	86.3
<b>Indigenous status</b>						
Indigenous	80.6	74.5	77.5	90.6	86.0	88.8
Non-Indigenous	68.8	70.9	71.7	89.5	86.4	86.4
<b>Home language</b>						
English	70.3	71.5	72.3	90.7	86.8	86.9
Language other than English	60.6	55.0	53.9	83.0	73.6	71.6
<b>Disability</b>						
Reported disability	56.2	60.9	61.5	77.5	79.5	78.7
No disability	69.2	71.5	72.4	89.9	86.8	86.9
<b>Mode of study</b>						
Internal and mixed mode	67.5	69.7	70.5	89.2	85.8	86.0
External	81.9	81.0	80.3	92.2	91.0	90.2
<b>Socio-economic status</b>						
High	NA	72.2	73.6	NA	87.3	87.3
Medium	NA	70.1	71.1	NA	86.6	86.7
Low	NA	69.4	70.3	NA	84.7	85.0
<b>Location</b>						
Metro	67.8	69.3	70.6	NA	86.0	86.0
Regional/Remote	72.0	75.2	75.5	NA	88.3	88.6
<b>Total</b>	<b>68.8</b>	<b>70.9</b>	<b>71.8</b>	<b>89.5</b>	<b>86.4</b>	<b>86.5</b>

Sources: 2015 Australian Graduate Survey and 2016-17 Graduate Outcomes Survey



## Employment by study area

The 2017 GOS report (Table 3 in that report, Table 2 in this document) shows the full-time and overall employment figures for each of 21 QILT-based fields of study with 2015 AGS figures adapted into the QILT fields. Fields which achieved a full-time employment rate of 80 per cent or better in 2017 included

- medicine
- pharmacy
- dentistry
- rehabilitation
- teacher education, and
- veterinary science

Most of these fields were also strong in the 2015 and 2016 figures. However, teacher education showed a notable improvement, moving from 71.7 per cent full-time employment in 2015 to 81.7 per cent in 2017. The fields of creative arts and science and mathematics returned full-time employment figures lower than 60 per cent in 2017.

There are important factors to note regarding these figures. Creative arts graduates often find themselves in unrelated part-time employment while practising their art or craft on a part-time basis. Simply put, there are few available full-time positions for new creative arts graduates in their fields and sometimes a degree of entrepreneurship and what some might define as self-employment, is required in terms of establishing their own careers.

Moreover, it is worth noting that the graduates of some fields of study can often take longer to find full-time employment than those from other fields, and this slower labour market uptake of such graduates reflects more the state of the labour market, and not necessarily the quality of the graduates or their study choices. Further, not all employment reported by graduates will necessarily be in the area in which the graduate trained, as opportunities in relevant occupations can be limited and it might be the case that some prefer to work on a part-time basis, or not at all, while seeking relevant employment.

Additionally, within the field of study aggregations used in Table 2, there can be notable variation in terms of the proportions in and seeking full-time employment at the more detailed field of education level. For example, while the proportion of agriculture and environmental studies graduates in full-time work was relatively low in 2017, closer examination of the detailed fields that make up the overall group can show marked differences in outcomes. In previous AGS reports, it was shown that while employment figures for the aggregated field were low, the figures for some component fields such as agricultural science and agribusiness were very strong.

In terms of overall employment (full-time and part-time figures combined), all fields achieved 80 per cent or higher. The fields of

- medicine
- pharmacy
- rehabilitation
- dentistry
- teacher education, and
- nursing

all demonstrated strong employment prospects with over 90 per cent overall employment.

Table 2: Undergraduate employment outcomes by field of study, 2015-2017 (%) \*\*

Study area	Full-time employment			Total employment		
	2015	2016	2017	2015	2016	2017
Agriculture and environmental studies	58.1	59.8	66.3	84.0	84.2	84.2
Architecture and built environment	75.4	75.2	75.2	89.3	85.8	87.2
Business and management	72.7	75.5	76.5	90.1	87.1	87.2
Communications	53.1	60.7	60.6	85.4	83.0	84.6
Computing and information systems	67.0	72.5	73.3	83.2	82.5	82.1
Creative arts	47.0	55.0	53.2	85.4	81.4	80.0
Dentistry	86.9	82.3	86.8	95.6	94.1	95.7
Engineering	73.9	76.4	79.4	85.7	83.9	86.5
Health services and support	67.9	70.9	72.7	91.9	90.1	89.9
Humanities, culture and social sciences	59.3	61.8	62.2	86.6	83.5	83.6
Law and paralegal studies	73.0	72.6	74.8	89.8	84.3	85.3
Medicine	96.3	98.2	95.9	98.7	97.4	95.9
Nursing	78.7	82.5	79.3	95.1	93.3	91.7
Pharmacy	95.6	96.3	95.2	97.6	96.0	95.8
Psychology	55.4	60.8	60.3	86.4	85.0	84.8
Rehabilitation	87.4	84.0	85.7	96.1	95.2	95.8
Science and mathematics	49.5	61.0	59.0	82.1	81.5	80.6
Social work	71.2	66.7	70.9	87.7	85.5	86.1
Teacher education	71.7	80.3	81.7	94.4	94.3	93.0
Tourism, hospitality, personal services, sport and recreation	57.8	68.1	62.9	92.4	92.5	86.8
Veterinary science	84.9	89.8	81.4	93.0	89.4	87.5
<b>All study areas*</b>	<b>68.8</b>	<b>70.9</b>	<b>71.8</b>	<b>89.5</b>	<b>86.4</b>	<b>86.5</b>

\*For 2016, where a graduate completes combined degrees across two study areas, their outcomes are included in both study areas. 'All study areas' figures count each graduate once only.

\*\* 2015 figures from the 2015 Australian Graduate Survey, 2016-17 figures from the 2016-17 Graduate Outcomes Survey

## Graduate earnings

The advent of the QILT suite of surveys saw a change to the way in which graduate earnings are reported. The AGS used, as a basic measure, 'graduate starting salaries', which represented the median annual earnings of domestic graduates aged less than 25 and in their first full-time employment in Australia.

Thus, GCA's overall graduate starting salary figure in 2015 was \$54,000, and the re-defined 2016 and 2017 QILT starting salary figures used in GOS were \$57,900 and \$60,000 respectively (see Table 3). To avoid confusion, further discussion in this document will focus on the QILT definition.

Table 3: Median full-time salaries by study area and sex, 2015-17 ~

Study area	Males (\$,000)			Females (\$,000)			Total (\$,000)		
	2015*	2016	2017	2015*	2016	2017	2015*	2016	2017
Agriculture and environmental studies	50.0	57.0	57.4	48.0	53.5	55.0	49.0	55.0	55.8
Architecture and built environment	50.0	59.0	60.0	45.0	50.0	52.2	45.0	55.0	56.4
Business and management	50.0	57.0	58.0	49.5	53.0	55.0	50.0	55.0	55.2
Communications	47.0	48.0	50.0	45.0	48.0	50.0	45.0	48.0	50.0
Computing and Information Systems	53.0	59.5	60.0	57.0	60.0	58.0	55.0	60.0	59.9
Creative arts	42.0	50.0	49.6	40.0	47.0	47.2	40.0	48.0	48.0
Dentistry		84.0	94.6	76.5	82.8	75.1	80.0	83.5	78.3
Engineering	60.0	62.6	63.5	63.0	62.3	65.0	60.0	62.6	64.0
Health services and support	55.0	64.0	62.6	56.0	58.2	60.5	56.0	59.5	61.3
Humanities, culture and social sciences	52.0	57.4	59.6	50.0	54.8	55.1	50.0	55.0	47.0
Law and paralegal studies	55.5	63.0	63.0	55.0	57.4	58.0	55.0	60.0	60.0
Medicine	65.0	70.0	70.0	64.0	68.2	70.0	65.0	69.2	70.3
Nursing	55.5	60.5	62.0	53.0	58.4	60.0	53.0	58.4	60.0
Pharmacy	40.5	43.8	45.9	42.0	43.6	43.8	42.0	43.8	44.2
Psychology	51.5	54.0	60.0	50.0	54.8	56.6	50.0	54.8	57.6
Rehabilitation	59.0	60.7	62.6	58.0	59.0	60.5	59.0	60.0	61.5
Science and mathematics	54.0	60.0	59.2	51.0	54.0	56.9	52.0	55.2	57.5
Social work		60.5	63.2	55.5	60.0	62.5	55.5	60.0	62.6
Teacher education	61.0	63.6	65.0	60.3	62.6	63.4	61.0	62.9	63.5
Tourism, hospitality, personal services, sport and recreation			55.0		51.4	51.8	40.0	52.2	52.2
Veterinary science				49.5	50.0	50.6	50.0	50.0	51.6
<b>All study areas**</b>	<b>55.0</b>	<b>60.0</b>	<b>60.1</b>	<b>53.0</b>	<b>56.4</b>	<b>59.0</b>	<b>54.0</b>	<b>57.9</b>	<b>60.0</b>
GCA 2015 figures reflecting QILT definition^	58.0			54.0			55.0		

\*Graduates aged less than 25 and in first full-time employment.

\*\*For 2016 and 2017, where a graduate completes combined degrees across two study areas, their outcomes are included in both study areas. 'All study areas' figures count each graduate once only

~2015 figures from the 2015 Australian Graduate Survey, 2016-17 figures from the 2016-17 Graduate Outcomes Survey. Blank cells indicate no or insufficient data for use.

^Taken from GCA spreadsheets (Tables J1, J3 and J4) distributed to Australian university careers services.



In 2017, new male graduates earned a median salary of \$60,100, while new female graduates earned \$59,000. So, in dollar terms, the overall 2017 median graduate salary rose by \$2,100 (or 3.6 per cent) from \$57,900. The change for males was just \$100 (0.2 per cent) and \$2,600 for females (4.6 per cent). In 2017 the median female salary was 98.2 per cent of the male salary (94.0 per cent in 2016).

Over the years, GCA research has suggested that overall differences in median salaries earned by males and females can be partly explained in terms of the differing enrolment profiles of male and female students. An analysis undertaken by GCA in 2014<sup>6</sup> suggested that much of the earnings gap between new male and female graduates was determined by field of education choices often made prior to university enrolment.

The analysis suggested that when the field of education, personal, enrolment and occupational characteristics of male and female graduates were taken into account, males' overall starting salaries were 4.4 per cent higher than those for females. It highlighted the overall wage gap favouring males as being due, in part, to an over-representation of males in fields of education that typically had higher starting salaries, such as engineering. Alternatively, females outnumbered males when it came to humanities, which was ranked at the lower end of the salary distribution.

While the analysis recognised that some of the wage gap might be explained by 'like for like' inequalities in some workplaces (that is, females doing identical work to males but being paid less), it might also be further explained if additional or more detailed information not captured within the GDS had been available.

The 2017 GOS report (Table 28 in that report, Table 3 in this document) shows median full-time salary figures for each of 21 QILT-based fields of study with 2015 AGS figures adapted into the QILT fields.

At \$78,300, the median salary for dentistry was the highest for this group of aggregated study areas. Following well behind (in the \$60,000-\$70,300 band) were medicine, engineering, teacher education, social work, rehabilitation, health services and support, law and paralegal studies, and nursing.

Study areas with lower levels of earnings (under \$50,000) were creative arts and pharmacy.

It should be noted that graduates in a number of fields must meet additional training requirements in order to gain professional registration, and this period can sometimes result in relatively low starting salaries. As an example, some pharmacy graduates in this survey are 'pre-registration' and hence earn relatively low salaries (\$44,200 in 2017) due to the further on-the-job training requirements they must meet for professional registration.

The longitudinal (2014-2017) GOS report (GOS-L) shows that by 2017, earnings for the cohort that responded to the 2014 AGS grew from \$56,000 to \$68,700, or by 22.7 per cent.

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<sup>6</sup> See Lindsay, E., *An analysis of the gender wage gap in the Australian graduate labour market, 2013*, which can be downloaded from <http://www.graduatecareers.com.au/wp-content/uploads/2014/06/GCA%20Gender%20Wage%20Gap%20Paper%20-%202013%20GDS%20-%2017%20June%202014%20FINAL.pdf>

Usefully, the GOS reports break salaries down by various groups (Table 27 in the 2017 report). In sum,

- graduates aged over 30 earned more than their younger colleagues (\$66,800 cf. \$58,200). It should be remembered that the older group would benefit from greater work experience and being better established in the work force, so a difference is to be expected.
- indigenous graduates (\$62,600) earned more than non-indigenous graduates (\$60,000).
- graduates who spoke a language other than English at home (\$56,400) earned less than their English-speaking colleagues (\$60,000).
- a disability or lack of a disability made no difference in earnings (both \$60,000).
- graduates who studied externally (\$66,000) earned more than those who studied internally or via mixed mode (\$58,700). Again, it should be remembered that external studiers have more opportunity to be employed while studying and developing careers and work experience, giving them an earnings advantage.
- Based on socio-economic status (SES), there were no notable differences in salaries between those ranked low, medium or high<sup>7</sup>.
- Location (metro or regional/remote) made only a minor difference in earnings (\$59,600 cf. \$60,000 respectively).

---

<sup>7</sup> The 2017 GOS report notes that SES was (p. 13) “derived from geocoded measures based on the location of where students are ‘from’, that is, their permanent home address at the commencement of study”.

## Graduate course satisfaction

The Course Experience Questionnaire (CEQ) has been in use since 1993 and is an instrument developed to measure graduates' satisfaction with aspects of their study experiences. In the CEQ, which is administered approximately four months after course completion, respondents are asked to rate the extent to which they agree or disagree with 13 core items constituting two rating scales (good teaching and generic skills development) and a single-item overall satisfaction indicator.

The changes in survey and analysis methods in the move from the AGS to QILT might have brought about a change in CEQ responses (which can often be the case in such psychometric instruments). As a result, comparisons between 2015 AGS-CEQ and 2016 QILT-CEQ results will be of somewhat limited value.

The satisfaction figures represent the percentage of respondents answering '4' or '5' on a five-point scale (with the fifth point indicating highest satisfaction). In 2017, 63.0 percent expressed satisfaction with the standard of teaching in their course (unchanged from 2016), 81.5 per cent were satisfied with the development of their generic skills (down slightly from 82.1 per cent in 2016) and 79.4 per cent were, overall, satisfied with their course (down slightly from 80.6 per cent in 2016, see Figure 6).

While slight drops were recorded for the latter two measures, it is unlikely that they represent a real statistical fall in graduates' views.

However, a figure of 63.0 per cent satisfaction with teaching, while appearing anomalous compared with the overall satisfaction indicator, must be of concern. While the equivalent figure from the 2015 AGS-CEQ was 68.0 per cent, and the difference of five percentage points could be an indication of the change in method and analysis, having fewer than two-thirds of 2017 respondents expressing satisfaction with what is obviously a core aspect of graduates' university experience might be seen as needing further exploration, even if it just to understand the relationship between views on good teaching and overall satisfaction.

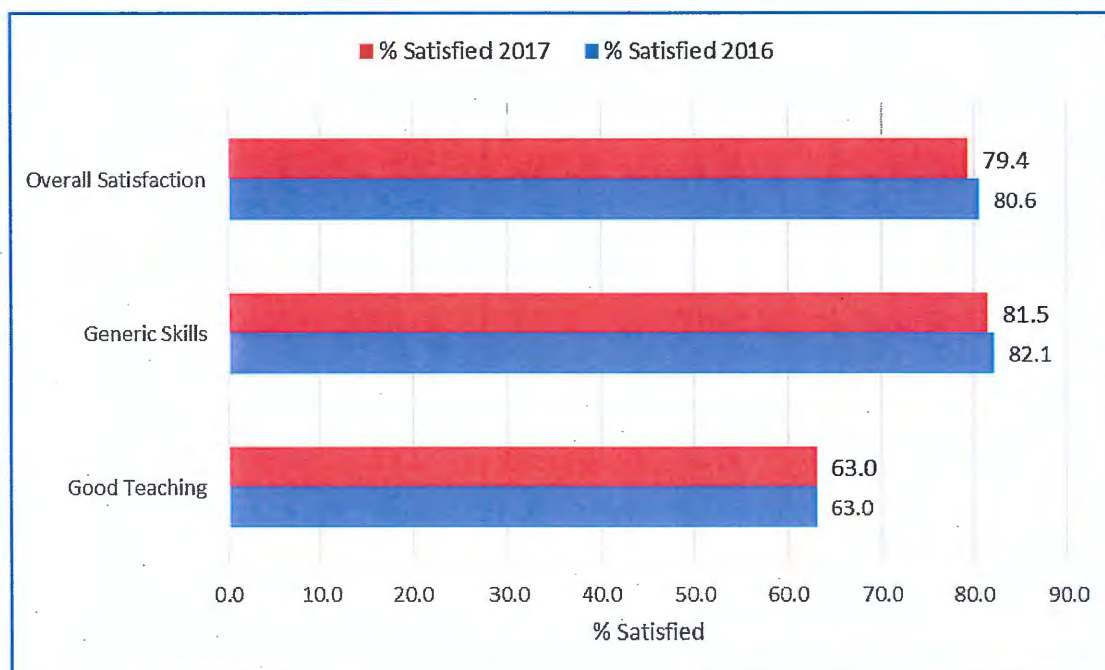


Figure 6: Undergraduates' satisfaction with aspects of their study, 2016-17 (%)

Source: 2016-17 Graduate Outcomes Survey



## Job search strategies

The 2016 and 2017 GOS reports gathered, but did not report on, data regarding how employed graduates conducted their job search strategy or how they first found the job they reported in the survey. As such, related figures from the 2015 AGS can be usefully discussed here, as the results don't change markedly from one year to the next.

The 2015 AGS<sup>8</sup> report noted that of those full-time employed graduates who had commenced their job in 2014 or 2015, over a quarter (26.9 per cent) first found their position via an advertisement on the internet (see Table 4). While this figure reflects the importance of scouring online vacancies in today's job market, it is notable that around three-quarters of graduates in full-time employment did not first find their employment via this method.

Demonstrating the diversity in how graduates found their full-time jobs, Table 4 suggests employment seekers need to cast their nets widely, as these results clearly indicate that there are many effective ways to find a full-time position.

However, of the 12 job search methods identified in Table 4, just over half of the graduates in full-time work learned of their current employment first through one of three strategies: searching advertisements on the internet (26.9 per cent), talking to family or friends (14.2 per cent) and visiting university or college careers services (11.7 per cent). This suggests these are key strategies around which graduates should base their overall job search, while not ignoring other strategies.

Table 4: How graduates who started in full-time employment in 2014 or 2015 first found out about their employment, AGS, 2015 (%)

	Total Cases	%
Advertisement on the internet	5,513	26.9
Family or friends	2,915	14.2
University or college careers service	2,393	11.7
Other	1,895	9.3
Approached employer directly	1,742	8.5
Approached by an employer	1,483	7.2
Work contacts or networks	1,459	7.1
Other university or college source (such as faculties or lecturers)	1,010	4.9
Careers fair or information session	826	4.0
Employment agency	531	2.6
Advertisement in a newspaper or other print media	378	1.8
Via résumé posted on the internet	313	1.5
<b>Total</b>	<b>20,458</b>	<b>100.0</b>

<sup>8</sup> Previous AGS reports can be downloaded from: [www.graduatecareers.com.au/Research/ResearchReports](http://www.graduatecareers.com.au/Research/ResearchReports)

## Employer satisfaction

Part of the QILT suite of surveys is an Employer Satisfaction Survey (ESS). It is positive for Australian higher education that the ESS results indicate that 84 per cent of employers are highly satisfied with their new graduate recruits.

Overall, employers reported

- 93 per cent satisfaction with foundation skills – general literacy, numeracy and communication skills and the ability to investigate and integrate knowledge.
- 90 per cent satisfaction with adaptive skills – the ability to adapt and apply skills/knowledge and work independently.
- 86 per cent satisfaction with collaborative skills – teamwork and interpersonal skills.
- 93 per cent satisfaction with technical skills – application of professional and technical knowledge and standards.
- 85 per cent satisfaction with employability skills – the ability to perform and innovate in the workplace.

As in 2016, employers seemed to be more satisfied with graduates with vocational degrees (Engineering, Health, Architecture and Building, and Education graduates, all between 85 and 90 per cent rounded) than they were with graduates with generalist degrees (the report cites the highly aggregated fields of Agriculture, Environmental and related studies, Management and Commerce (both with 80 per cent satisfaction) and Creative Arts, Natural and Physical Sciences, and Society and Culture (all with 81 per cent)). It's worth noting that these generalist aggregations could be hiding a great deal of diverse detail, as suggested previously regarding employment figures.

Further, these generalist graduates were not rated markedly lower by their supervisors than were vocationally qualified graduates, and it could be argued that the skill sets expected of the vocational graduates are more easily identified and assessed than those of the generalists.

Of additional note, 85 per cent of supervisors expressed satisfaction with their female graduate recruits compared with 82 per cent satisfaction with males.

On a methodological note, critics of the ESS have pointed to low response rates and the potential for bias in graduates' decisions to give QILT their supervisors' contact details to allow them to be included in the survey. These issues are addressed in the 2017 report (p. 5) and regarding the latter issue, the report notes

*Graduates who did not provide supervisor contact details rated their foundation skills at 82 per cent. While still high, this was lower than for graduates who supplied their supervisor contact details, 88 per cent, and the supervisor satisfaction rating of foundation skills of 93 per cent. It would appear graduates who were more positive about the skills they had acquired would be more comfortable having their supervisor participate in the ESS. This is expected to lead to upward bias in reported levels of employer satisfaction in the 2017 ESS.*

In the absence of more robust measures of employer satisfaction with new graduates, users of the ESS data need to keep these issues in mind.

## For further information on ...

Beyond Graduation reports:

<http://www.graduatecareers.com.au/research/surveys/beyondgraduationsurvey/>

GCA: [www.graduatecareers.com.au](http://www.graduatecareers.com.au)

GradStats and AGS reports: [www.graduatecareers.com.au/Research/ResearchReports](http://www.graduatecareers.com.au/Research/ResearchReports)

Graduate Opportunities: [www.graduateopportunities.com/](http://www.graduateopportunities.com/)

QILT: [www.qilt.edu.au](http://www.qilt.edu.au)

QILT reports: [www.qilt.edu.au/about-this-site/graduate-employment](http://www.qilt.edu.au/about-this-site/graduate-employment)



# ANNEXURE 10



## Dental surgeons – general

Businesses in this industry provide general dental health services.

These benchmarks do not apply to dental specialists, hygienists, assistants or technicians.

### Performance benchmarks

These benchmarks use information reported on tax returns and activity statements for the 2016–17 financial year, and are updated each year. This is the most current data.

The benchmarks show ranges of business income to business expenses that you can use to compare your performance against similar businesses in your industry.

### Key benchmark range

Labour to turnover is the key benchmark range for this industry – it is likely to be the most accurate when predicting business turnover. If you don't report labour, or only report a small amount, use total expenses to turnover instead.

Generally, you should fall within the key benchmark range for your particular annual turnover.

Falling outside the key benchmarks for your industry may indicate your business has room for improvement.

It may also be worthwhile checking you reported all income and accounted for any trading stock you may have used for private purposes, as these can affect your results. Certain businesses can use amounts we accept as estimates, check if they are available for you.

#### See also:

- [Compare your business now \(/business/small-business-benchmarks/compare-your-business-now/\)](#)
- [Using stock for private purposes \(/Business/Income-and-deductions-for-business/Accounting-for-trading-stock/Using-stock-for-private-purposes/\)](#)

### 2016–17 financial year

#### Tax return – key benchmarks for 2016–17

Key benchmark range	Annual turnover range		
	\$50,000 – \$435,000	\$435,001 – \$815,000	More than \$815,000
Labour/turnover	21% – 37%	20% – 34%	22% – 35%
Average labour	29%	27%	29%
Total expenses/turnover	52% – 68%	66% – 77%	67% – 81%

<b>Average total expenses</b>	60%	71%	74%
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### Activity statement – key benchmarks for 2016–17

Key benchmark range	Annual turnover range		
	\$50,000 – \$435,000	\$435,001 – \$815,000	More than \$815,000
<b>Non-capital purchases/ total sales</b>	30% – 58%	42% – 65%	40% – 60%

### Other benchmark information that may assist your business

Not all expenses, such as those below, are reported by every business.

Because there are fewer businesses in your industry that report this information, only use this information as a guide if it applies to your business.

### Tax return – other benchmarks for 2016–17

Benchmark range	Annual turnover range		
	\$50,000 – \$435,000	\$435,001 – \$815,000	More than \$815,000
<b>Rent/turnover</b>	8% – 13%	6% – 9%	4% – 7%
<b>Motor vehicle expenses/turnover</b>	1% – 3%	1%	0% – 1%

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# ANNEXURE 11

# ORAL HEALTH THERAPY PROGRAMS IN AUSTRALIA AND NEW ZEALAND

EMERGENCE AND DEVELOPMENT

Edited by  
**AKL Tsang**  
The University of Queensland School of Dentistry

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## **ABOUT THE BOOK COVER**

### **"Mitre Peak"**

**(Photographed by Chris Piper)**

Mitre Peak is one of New Zealand's earliest tourist destinations in the Milford Sound, described by Rudyard Kipling as the "eighth wonder of the world". Mitre Peak rises 1700m out of the water and has another 270m underwater.

### **"Jacaranda mimosifolia in Late October"**

**(Photographed by Patrick Tsang)**

The photo was taken at The University of Queensland. The Jacaranda is locally known as the "exam tree" because of its full bloom coinciding with final exams at the end of each year. The species is a native of South America but is also regarded as a "signature tree" in Australia where it is most widespread in South East Queensland and Northern New South Wales.

### **"Oral Health in a Tea Cup" (back cover)**

**(Photographed by Gigi Au Yeung)**

Other photographs taken by Annetta Tsang at The University of Queensland. Photographs of oral health learning activities, taken during clinical and preclinical sessions.

### A New Oral Health Professional – The Oral Health Therapist

**Julie Satur**

**L**ike many other types of health care, dentistry has several occupational streams that have developed in response to changing technologies and demands for care. In Australia and New Zealand, dental therapists, dental hygienists and dental prosthetists deliver care in combination with dentists and dental specialists in a team environment. Dental technicians are responsible for the manufacture of dental prostheses, e.g. dentures, mouthguards, crowns, bridges and orthodontic appliances, under prescription of a dentist. Dental prosthetists are dental technicians with advanced training who may prescribe, manufacture and insert dentures and mouthguards independently. Dental therapists and hygienists provide primary preventive and clinical care of dental caries and periodontal diseases respectively, as well as oral health promotion.

Advanced dental nurses and expanded function dental auxiliaries were developed to complement the work of dentists by providing, under delegation, various clinical tasks. Most common were oral hygiene instructions and other preventive advice, radiography, cleaning and polishing of teeth (dental prophylaxis). These functions were soon extended into areas such as periodontology, orthodontics or surgical assistance and restorations depending on the practices in which they worked. Today their most common characterisations are as dental hygienists and dental therapists, with both occupations having existed for around 90 years.

#### **DENTAL THERAPISTS**

Dental therapists operate in a primary care role, carrying out routine dental care and health promotion, referring patients to a dentist for services which are beyond their scope of practice. Up until July 2000, dental therapists in most states of Australia and in New Zealand were limited to public sector employment with School Dental Services providing care to children and



## Oral Health Therapy Programs in Australia and New Zealand

adolescents<sup>3</sup> in collaborative and referral relationships with dentists and with the chairside assistance of a dental nurse. Their skills include examination, diagnosis and treatment planning, radiography/radiology, preparation of cavities and their restoration with amalgam and plastic filling materials, pulp therapies and extractions of deciduous teeth, clinical preventive services such as prophylaxis and scaling, fissure sealants and fluoride therapies, diet counselling and oral health education and promotion. Scope of practice differs slightly between countries and jurisdictions but may also include fabrication of mouthguards, orthodontic procedures on the advice of a dentist or orthodontist, extraoral radiography, placement of stainless steel crowns, incisal edge restorations, pulp therapies in permanent teeth and permanent tooth extractions. Since 2000, employment limits on dental therapists practice have been progressively relaxed in Australia and New Zealand (Satur, 2003; Nash et al., 2008).

In practice, a dentist will be available by telephone for consultation and, in Australia, generally attend a dental therapist's clinic weekly or fortnightly for half a day to attend to referred patients, mostly comprising orthodontic referrals, complex restorations, endodontics and permanent extractions. In New Zealand, patients with additional needs have been referred to private dentists, hospital departments or the Dental School. In both countries there is now a trend toward providing School Dental Services from larger community clinics in a more family-focused approach. The overwhelming majority of dental care for children in New Zealand and Australia since the 1920s and 1970s respectively has been provided by dental therapists (Coates et al., 2009; Dooland, 1992).

In 2005, an Australian national data collection found that there were 1760 registered dental therapists in Australia of which 1521 or 86.4% were practising. Their average age was 40.7 years, only 2.5% were male and they worked on average, 25 hours per week, with 56% working part-time. This study also showed that in 2005, around 79% of therapists worked in the School Dental Service and 21% in private practice employment. Ratios of therapists to population were low with a national average of 7.5 therapists /100,000 population. Rural and urban distri-

<sup>3</sup> The ages of people treated by dental therapists have traditionally been limited to 0-18 years although in Victoria the upper limit is now accepted as 25 years (and without limits in orthodontic practices) and in Western Australia dental therapists in private settings have provided care for all ages under prescription from a dentist for many years. Today in New Zealand, Victoria and Northern Territory, dental therapists with appropriate training may also provide care for adults.

butions differed with 6.6 therapists/100,000 people in urban areas, 8.8 in inner regional areas, 10.9 in outer regional areas and 8.1/100,000 people in remote areas (Tuesner and Spencer 2008a). Workforce misdistributions are a significant issue for the dental workforce in Australia; however the distribution of dental therapists in rural and remote areas is reportedly more balanced than any other dental practitioner groups.

In 2008, of the 682 dental therapists registered with the Dental Council of New Zealand (DCNZ), 648 were practising in New Zealand. The average age was 48.9 years and only 15 were male (1.4%). The majority of therapists worked in the public sector (with District Health Boards (DHB)), while approximately 6% worked in private practice. 69% of therapists worked full-time and, on average, therapists worked a total of 33.9 hours per week. Data on the distribution of dental therapists in New Zealand is collated by DHB but includes all therapists working in those areas, whether in the public or private sector. There is a variation in the therapist to population by area. The Bay of Plenty had the highest therapist to population ratio at 132 therapists / 100,000 population, and the greater Wellington area had the lowest at 36 therapists / 100,000 population. The New Zealand average was 55 therapists / 100,000 population. Of concern is the fact that the New Zealand dental therapy workforce is ageing, with over half of dental therapists aged 50 years or more. Therapists are predominantly older, female and Pakeha (NZ European); however, numbers of therapists representing other ethnicities and numbers of younger therapists are increasing (Broadbent, 2009).

## DENTAL HYGIENISTS

Dental hygienists have also worked as part of the dental team providing preventive and periodontal treatment interventions, in a team setting with a dentist. Their scope of practice varies across Australia and New Zealand. For example, dental hygienists in most regions are registered to take radiographs, perform risk assessments, polish and remove deposits from teeth, take impressions and carry out periodontal debridement and dressings for periodontal surgeries. However, not all areas allow their dental hygienists to administer local anaesthesia and apply fissure sealants, examine, diagnose and plan care for their patients. Dental hygienists also work in orthodontic practices providing clinical services, checking, maintaining and removing orthodontic appliances and maintaining oral hygiene. Their role is also preventive and includes dietary counselling, oral

## Oral Health Therapy Programs in Australia and New Zealand

health education and promotion and the provision of fluoride therapies. There are no limits on the age range or employment settings of dental hygienists but they predominantly work in private practices and may require the on-site presence of a dentist.

In Australia in 2005, there were on average 4.3 hygienists per 100,000 population and practice ratios ranged from 1.9/100,000 in Tasmania to 8.8/ 100,000 in South Australia. The 2005 national data collection found that the average age of hygienists was 36.8 years and they worked an average of 31.6 hours per week. Around 95% worked in private practices and only 2.5% were male (Tuesner & Spencer, 2008b). Of interest is the rise in numbers of hygienists across Australia over the past few years. The survey carried out in 1996 (Szuster & Spencer, 1997) found a total of 227 practising hygienists, whereas data collected in 2005 showed that the number had more than tripled to 1046, with an increase of 66% since 2003 alone (Tuesner & Spencer, 2008b). Western Australia and South Australia have the highest ratios of dental hygienists, reflecting a longer history of practice and training.

Analysis of the dental workforce data for New Zealand is more complicated. Three types of worker exist: these are dental hygienists, dental auxiliary and orthodontic auxiliary<sup>4</sup>. In total, 371 were registered and practising within the above categories in 2008; with dental hygienists comprising the largest group at 250 in number. The average age of the dental hygienist group was 39.8 years and only 6 were male. The majority of dental hygienists worked in private practice, with approximately 53% working full-time. Approximately a quarter of the group worked in more than one practice. On average, New Zealand dental hygienists work less hours per week (23.8) than their Australian counterparts (Broadbent, 2009). In 2007, the average dental hygienist / 100,000 population ratio for New Zealand was 5.2 / 100,000 with higher ratios reported in the main metropolitan areas of New Zealand (Broadbent, 2009).

### EMERGENCE OF A NEW ORAL HEALTH PROFESSIONAL

It is clear that there is significant overlap in the range of skills and approaches to care by dental therapists and dental hygienists. There have been proposals for the development of a 'hybrid' dental auxiliary combining the skills of a dental therapist and dental hygienist for some time (Barmes, 1983; Wright,

<sup>4</sup> For a more detailed description of these categories and their scopes of practice, see [http://www.dnz.org.nz/Documents/Scopes/ScopesofPractice\\_Hygienists.pdf](http://www.dnz.org.nz/Documents/Scopes/ScopesofPractice_Hygienists.pdf)

1991; Nuffield Foundation, 1993; DH&CS, 1995; Wright, 1995). A formal recommendation that the skills of dental therapists and hygienists be combined to develop the generalist “oral health therapist” arose from the 1993 Nuffield Inquiry conducted in the United Kingdom. This inquiry defined and described the oral health therapist as one who could adapt their generalist oral health training and education (a combination of hygiene and therapy) to provide services in areas of greatest need where access to care is limited and levels of disease highest. This inquiry also proposed that these practitioners be able to add skills in a modular way to meet particular specialised needs and to work in all types of practice settings – including both public and private sectors (Nuffield, 1993). Several Australian educators and policy makers attended the presentation of the findings and they were subsequently influential in dental policy development decisions in Australia around that time (DH&CS, 1995; Wright, 1995).

However, in Western Australia, there have been dental therapists working in the private sector providing both dental therapist and dental hygienist services under the prescription of a dentist since 1971: the year that the training of dental therapist began (Gussy, 2001; DTHAWA, 2007). Western Australia was unique in graduating dental therapists who could provide services for children and who had also completed a component dealing with the management of gingival health in adults. As mentioned earlier, WA dental therapists could work in both the private sector under prescription and autonomously in the School Dental Services. These distinctions in title have remained in place in Western Australia with School Dental Therapists able to examine, diagnose and treatment plan and provide services to school children under employment in the School Dental Service and Dental Therapists providing treatment services under the prescription of a dentist to all age groups in private practices. Some dental therapists have also undertaken additional training in periodontal procedures to enable them to provide dental hygienist services in private practices (DTHWA, 2003 & 2007; Prichard, 1994).

Moreover, the Gillies Plains College of TAFE in South Australia has been offering a program since around 1980, enabling dental therapists to acquire dental hygiene skills. The Universities of Melbourne and Queensland both commenced add-on programs in 1999 for 8 and 26 students respectively, both of which ceased in 2004 (H. Calache, personal communication, 2002; L. Short, personal communication, 1999). The University of Melbourne at the time also offered the only bridging program



to enable dental hygienists to acquire dental therapy skills.

### CONTEMPORARY ORAL HEALTH THERAPISTS

In 1996, the University of Melbourne became the first University Dental School in Australia to offer dental therapy and dental hygiene education at the Diploma level, and appointing the first dental therapists and dental hygienists as academic staff. The Diploma in Oral Health Therapy was unique at the time in that it had a core first year in which dental therapists and hygienists studied the same units in shared classes, with separate streams in the second year to develop their profession specific skills. This program was designed to establish the first steps towards developing the Oral Health Therapist in Australia.

In 1998, breaking new ground, the University of Queensland in combination with Queensland University of Technology, offered the first Bachelor of Oral Health degree program in Australia which qualified graduates for registration as both dental therapist and hygienist i.e. oral health therapists. In 2002, the University of Adelaide followed and in 2005 the University of Melbourne's Bachelor of Oral Health program began. This was followed by the University of Sydney in 2006. In parallel was the establishment of three new dental schools in Australia; the first at Griffith University on the Gold Coast in Queensland in 2004, at La Trobe University in Bendigo, rural Victoria in 2006 and Charles Sturt University at their Wagga Wagga campus in rural NSW in 2008, all of whom offer undergraduate programs in both Oral Health (program for oral health therapists) and Dentistry (program for dentists). In 2005 the University of Newcastle began a Bachelor of Oral Health in Dental Hygiene, which is the only single outcome Bachelor program in Australia. In 2010, the University of Newcastle commenced the first post-graduate program in dental therapy for dental hygienists. Western Australia's Curtin University continues to offer Associate Degrees in Dental Therapy and in Dental Hygiene, whilst Torrens Valley TAFE in South Australia, now the oldest training setting, continues to offer an Advanced Diploma in Oral Health (Dental Hygiene).

In New Zealand, formal training in dental hygiene commenced in 1994 when Otago Polytechnic offered a 15-month Certificate in Dental Hygiene which developed into a two-year Diploma program in 1998 (Hannah, 1998; NZDHA, 2001). Dental hygiene education moved to the University of Otago in 2001, with the School of Dentistry offering a two-year Diploma pro-

gram. The oldest and last remaining (Department of Health administered) dental therapy school in Wellington closed in 1991 and training was transferred to the Wellington Polytechnic. In 1999, the University of Otago introduced dental therapy education, offering a Diploma in Dental Therapy from its School of Dentistry (TAGDT, 2001). 2002 saw the introduction of a three-year Bachelor of Health Sciences in Oral Health (Dental Therapy) program (University of Otago, 2002). The Diploma and Degree programs in therapy and hygiene ran concurrently, with the final students graduating from these courses in 2007. In 2002, the Auckland University of Technology (AUT) also established a Bachelor of Health Science in Oral Health (Dental Therapy) program. Both the Otago and AUT programs have since evolved into Oral Health degree programs with graduates qualified for registration as both dental therapists and dental hygienists.

These developments are in keeping with international developments in dental hygiene education where many countries offer three and four year programs awarding bachelor degrees (Hovius & Blitz, 2001). The United Kingdom, as a result of the Nuffield Inquiry recommendations, has shifted the emphasis in training to a Bachelors degree in Oral Health Therapy although many institutions continue to offer single outcome programs. In the Netherlands a similar development has also occurred and in the US states of Alaska and Minnesota, dental therapy practice has been legalised as both an addition to dental hygiene and as a stand-alone qualification (McKinnon et al., 2007; Nash et al., 2008; IOM, 2009; MDH & MBD, 2009).

In 2009, ten out of thirteen Australian and New Zealand programs are educating oral health therapists with only the University of Newcastle, Torrens Valley TAFE and Curtin University in WA offering single skill outcome programs. Curtin University has indicated its intention to offer a combined Bachelor of Oral Health program in 2012.

In line with developments in dentistry, contemporary oral health therapists (including dental therapists and dental hygienists) are more broadly educated professionals than their tightly regulated predecessors. Courses today require students to study across a wider range of areas, often integrated with dental students for various course components. They are educated to synthesise and apply knowledge to complex problems, understand and apply technology in more complex ways and to have well-developed research, communication and cultural sensitivity skills in keeping with the contemporary health professional role. Courses encompass clinical practice, biological,

## Oral Health Therapy Programs in Australia and New Zealand

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health and social sciences, ethics and evidence-based practice essential to contemporary health practice and are accredited by the Australian and New Zealand Dental Councils. Today, qualification for practice in oral health therapy requires a bachelor-level tertiary course of education and training over three years, with applicants to most courses requiring university level entrance and pre-requisite studies in English and Biology.

The oral health therapist's key role is as a primary oral health care provider who has a capacity to promote oral health for individuals and the community, diagnose and recognise oral conditions, plan and deliver clinical and preventive treatment, evaluate care and collaborate with other dental and general health practitioners to improve the oral health status of the community.

The following chapters will describe in more detail, the education of oral health therapists for the Australian and New Zealand environment.

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# ANNEXURE 12



## Public consultation document

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22 March 2018

### Consultation on a proposed revised *Scope of practice registration standard* and *Guidelines for scope of practice*

#### Public consultation

This public consultation paper released by the Dental Board of Australia (the Board) seeks feedback from stakeholders on:

- a proposed revised *Scope of practice registration standard* (the registration standard)
- a proposed revised *Guidelines for scope of practice* (the guidelines), and
- a new *Reflective practice tool for scope of practice* (the tool).

This consultation paper will be published on the Board's website, see the *Current Consultations* section of [www.dentalboard.gov.au](http://www.dentalboard.gov.au).

#### Feedback

You are invited to provide feedback by email to [dentalboardconsultation@ahpra.gov.au](mailto:dentalboardconsultation@ahpra.gov.au) by close of business on 14 May 2018.

You are welcome to supply a PDF file of your feedback in addition to the Word (or equivalent) file; however we request that you do supply a text or Word file. As part of an effort to meet international website accessibility guidelines, the Australian Health Practitioner Regulation Agency (AHPRA) and the Board are striving to publish documents in accessible formats (such as Word), in addition to PDFs. More information about this is available at [www.ahpra.gov.au/About-AHPRA/Accessibility](http://www.ahpra.gov.au/About-AHPRA/Accessibility).

#### How your submission will be treated

Submissions will generally be published unless you request otherwise. The Board publishes submissions on its websites to encourage discussion and inform the community and stakeholders. However, the Board keeps the right not to publish submissions at their discretion, and will not place on their website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the consultation.

Before publication, the Board will remove personal or identifying information from submissions, including contact details.

The views expressed in the submissions are those of the individuals or organisations who submit them and their publication does not imply any acceptance of, or agreement with, these views by the Board.

The Board will accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cwlth), which has provisions designed to protect personal information and information given in confidence.

**Please let the Board know if you do not want your submission published, or want all or part of it treated as confidential.**

## Purpose

1. The role of the Board is to work with the AHPRA and other National Boards to achieve the objectives of the National Registration and Accreditation Scheme (the National Scheme) in accordance with the guiding principles of the National Scheme.
2. To ensure continued relevance in a dynamic regulatory environment, the Board carries out regular reviews of all its registration standards, guidelines and policies.
3. The registration standard and the guidelines are due for review and the Board has developed a revised proposal for consultation.

## Scope of practice

4. The **dental profession's** scope of practice covers the full range of activities and responsibilities which individuals within the profession are educated, trained and competent to perform within the relevant division.
5. While **scope of practice of an individual dental practitioner** is that which the individual is educated, trained and competent to perform. The individual's scope of practice will vary from practitioner to practitioner and may be more limited than the scope of the dental profession.
6. An individual's scope of practice is influenced by a number of factors including the Board's registration standard and guidelines.

## Scope of practice registration standard

7. The Health Practitioner Regulation National Law, as in force in each state and territory (the National Law) protects the titles of dentist (including specialist titles), dental therapist, dental hygienist, dental prosthetist and oral health therapist.
8. The National Law does not however define the scope of practice for each of these titles/divisions that form part of the dental profession. It does not define what each of the five divisions and the 13 dental specialties (which are part of the dentist division<sup>1</sup>) can and cannot do; it only protects specific dental practice, named 'restricted dental acts' (section. 121 of the National Law).
9. Section 38 of the National Law gives the Board the discretion to develop registration standards about the scope of practice of health practitioners registered in the profession. Under this section, the Board developed the first version of the registration standard which was approved by the Ministerial Council on 22 April 2010. The registration standard came into effect from 1 July 2010 and established the requirements for the scope of practice for all registered dental practitioners.
10. This registration standard was drafted to cover the range of arrangements in place in states and territories before the start of the National Scheme and to allow an individual's scope of practice before the National Scheme to continue under the National Law.
11. Notwithstanding the variations, the main requirement of the registration standard, at the start of the National Scheme, and which continues to be the salient feature, is that all dental practitioners must only perform dental treatment for which they have been educated and trained, and in which they are competent.
12. The Ministerial Council requested that the registration standard should be reviewed by the Board. The Board was specifically requested to assess whether the approved standard had any unintended and negative effects on the scope of practice of dental hygienists, dental therapists and oral health therapists.

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<sup>1</sup> Under section 115, the title 'dental specialist' is protected and falls under the dentist division of the dental profession. Specialist titles and their definition have been developed by the Board and approved by the Australian Health Workforce Ministerial Council now known as the COAG Health Council (Ministerial Council) on 31 March 2010 (see *List of Specialties*).



13. In addition, Health Workforce Australia (HWA) was tasked to complete a review of the registration standard before the Board's review and that their report be publicly released. They released their report in August 2012. On 23 May 2012 the Ministerial Council released the *Scope of practice review oral health practitioners report* (the HWA report) to the Board. The HWA report made five recommendations on the registration standard:
- adjust the standard to reflect team-based practice with autonomous decision-making and without supervision requirements for review within five years, with a view to remove the bar on independent practice
  - clarify the age restriction for dental therapists and oral health therapists when practicing dental therapy on people of all ages
  - develop a general description of all dental practitioners which is understandable by the public
  - help dental professionals to simply describe their scope of practice and update it regularly, and
  - develop and implement a national communication strategy to explain and describe the current registration standard and any changes.
14. In light of the HWA's recommendations and the subsequent stakeholder feedback, the Board completed its review of the registration standard in 2013.
15. At the conclusion of that review, the registration standard, along with the addition of a new guidelines, was revised to be clearer and provide certainty to dental practitioners on the scope of practice for the profession. This included the different dental divisions and level of education and training expected for each division. This was reflected in the inclusion of a definition of dentistry and descriptions for each division. As part of the changes, the Board also included the expectation of a team approach to dental care and removed the supervision requirements for dental hygienists, dental therapists and oral health therapists.
16. The Ministerial Council approved the revised registration standard on 11 April 2014 with the revised registration standard and associated guidelines effective from 30 June 2014. The [current registration standard and guidelines have a review date of 30 June 2017](#).

#### Broader regulatory framework of the dental profession

17. Under the National Law, the Board approves [accreditation standards](#) developed by the Australian Dental Council (ADC) which are used to assess whether programs of study leading to registration in the five divisions provides individuals with the knowledge, skills and professional attributes necessary to practise the profession in Australia<sup>2</sup>. The ADC has been appointed as the accreditation authority for the dental profession. The ADC has developed [professional competencies](#) for each of the five divisions and accredits all programs in accordance with these competencies and the approved accreditation standard. Once assessed as meeting the accreditation standards, and accredited by the ADC, these programs of study are then considered by the Board for approval. An individual who successfully graduates from an accredited and Board-approved program of study is deemed qualified for registration and to have the required professional competencies to practise.
18. Competencies of overseas-trained dental practitioners are assessed through the examination process set up by the ADC. This examination process (with written and practical components) is based on the same professional competencies used in the accreditation process of Australian programs of study.
19. The Board has also developed other registration standards which are relevant to certain aspects of scope of practice such as the:
- a. [Professional indemnity insurance registration standard](#) which requires dental practitioners to have the necessary level of insurance cover for all areas of their practice
  - b. [Recency of practice registration standard](#) which requires dental practitioners to maintain an adequate connection with, and recent practice in the profession, and
  - c. [Registration standard: continuing professional development \(CPD\)](#) and the associated guidelines which require dental practitioners to complete a specific amount of CPD activities within the definition of dentistry.

<sup>2</sup> Section 5, National Law

20. The Board's [Code of conduct](#)<sup>3</sup> describes professional standards for dental practitioners' behaviour, including the importance of maintaining a high level of professional competence in order to provide the best dental care to patients. Dental practitioners have a responsibility to recognise and work within the limits of their competence and scope of practice and arrange delegation, referral or handover of care in accordance with the principles of the Code of conduct.
21. In addition to complying with the Board's regulatory framework, dental practitioners should comply with state and territory legislative requirements including (but not limited to) authorities that regulate possessing, prescribing/supplying and administering medications and the use of radiation apparatus or any other relevant legislation and/or regulatory requirements.
22. Employers (e.g. health services and/or individuals) may have in place workplace requirements to define dental practitioners' scope within the parameters of their employment.

### Proposed changes to the current registration standard and guidelines

23. Since the start of the National Scheme, the Board has adopted an incremental approach to the scope of practice requirements of dental practitioners in meeting the objectives and guiding principles of the National Scheme (see [Regulatory Principles for the National Scheme](#)).
24. These include:
  - Provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
  - Facilitate access to health services in the public interest by encouraging a team approach between dental practitioners so that patients are assured of receiving the most appropriate treatment from the dental practitioner who is most appropriate to provide it.
  - Enable a flexible, responsive and sustainable workforce by enabling dental practitioners to practice to the full scope of their education, training and competence.
25. The proposed revised registration standard and guidelines outlined in this document are consistent with the incremental approach adopted by the Board. The changes continue to encourage a responsive, risk-based approach to scope of practice that aligns with the Board's broad regulatory framework, have the objectives and guiding principles of the National Scheme as its goal and is effective for all dental practitioners providing clarity and certainty on the main requirements.
26. The following are the changes proposed.

#### Remove reference to programs to extend scope

27. Before the National Scheme, dental hygienists, dental therapists and dental prosthetists could extend their scope of practice in some jurisdictions by completing an 'add-on' program. The add-on programs, now known as *Programs to extend scope* transitioned to the National Scheme as [programs](#) reviewed and approved by the Board.
28. Recently, the Board reviewed the approval process for *Programs to extend scope* and agreed to phase out approval of these programs with a transition period lasting until 31 December 2018. The Board made this decision considering a number of factors, including:
  - The National Law<sup>4</sup> only provides a statutory framework to regulate programs of study that lead to registration or endorsement. *Programs to extend scope* do not lead to registration or endorsement and are offered to dental practitioners already registered, with general or limited registration.

<sup>3</sup> The Code of conduct for the dental profession is also used by ten other National Boards (Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Chiropractic, Medical Radiation Practice, Occupational Therapy, Optometry, Osteopathy, Pharmacy, Physiotherapy and Podiatry) with some minor profession-specific changes for some Boards.

<sup>4</sup> Part 6.

- The demand for these programs has decreased over time with the content of these programs largely incorporated in the approved programs of study leading to registration.
  - The objectives, the guiding principles and the Regulatory principles of the National Scheme.
29. For these reasons, the Board proposes to remove reference to Programs to extend scope from the registration standard and guidelines giving effect to the Board's decision to phase out the approval process of these programs, and for these programs to be continued to be delivered as continuing professional development. The Board proposed that moving forward, dental practitioners wishing to "broaden their knowledge, expertise and competence" may do so by completing CPD. All dental practitioners are required to undertake CPD activities and/or to attend CPD courses that comply with the Board's *CPD registration standard* and guidelines. Dental practitioners are expected to self-assess whether their selected CPD activities/courses provide them with the sufficient clinical experience to incorporate a new procedure/technique/treatment into their clinical practice.
30. All dental practitioners must only perform those dental procedures for which they have been educated and trained and in which they are competent, as per the *registration standard* and the guideline. Dental practitioners who are not educated and trained to perform a certain treatment cannot undertake that type of treatment. However, they can obtain the required skills and knowledge through CPD programs, relevant to core knowledge and skills based on the initial qualification(s) leading to registration and the division in which they are registered.
31. The Board will monitor compliance with this requirement at registration or renewal. Dental practitioners are required to make an annual declaration to undertake to comply with all relevant legislation, Board registration standards, codes and guidelines. The notification management processes also allows the Board to investigate the practice of a practitioner when a peer or member of the public make a complaint and this can include practicing outside of their scope of practice.
32. Education providers wishing to deliver programs to extend scope of practice may consider delivering these courses as continuing professional development. The Board strongly encourages education providers to develop and deliver CPD programs in line with the Board's registration standard and guidelines on CPD, the Board's scope of practice registration standard and guidelines and the Code of Conduct.

#### **Clarify expectations around education, training and competence**

33. The guidelines have been restructured and re-worded to improve readability and clarify current requirements around education, training and competence.
34. The Board proposes to remove terminology relating to 'education requirements' within each division description. As accreditation standards, competencies and processes for approving programs of study are now well established under the National Scheme, the Board proposes to remove this prescriptive terminology from each division description. This will enable flexibility with the accreditation standards and approved programs of study within an established accreditation framework and will address inconsistencies in terminology within the registration standard.
35. The other proposed amendment to the division descriptions relates to dental therapists and oral health therapists and adult scope. The current *guidelines* include the following in the descriptions of dental therapist and oral health therapist:
- Dental therapists** provide oral health assessment, diagnosis, treatment, management and preventive services for children, adolescents and young adults and, if educated and trained in a program of study approved by the National Board, for adults of all ages.
- Oral health therapists** provide oral health assessment, diagnosis, treatment, management and preventive services for children and adolescents and, if educated and trained in a program of study approved by the National Board, for adults of all ages.
36. The above descriptions imply that dental therapists and oral health therapists may provide dental therapy treatment (e.g. simple restorative treatment) to patients of all ages (as opposed to only patients under 18 or 26 years), provided that they complete an education program approved by the Board. Stakeholders have highlighted that this approach remains confusing for practitioners, employers and the public.



37. The modalities to provide dental therapy treatment on patients of all ages are being taught in at least three out of the eight Bachelor of Health (BOH) Board approved programs of study ( La Trobe University, Newcastle University and Central Queensland University) and through Programs to extend scope (University of Adelaide and University of Melbourne's Graduate Certificate related to adult scope. Other education providers have indicated that this content may be included in courses in the future.
38. The Board proposes to amend both descriptions to make its expectations clear in regard to adult scope. Dental therapists and oral health therapists need to self assess their individual scope of practice in respect of their individual education and training. Dental therapists and oral health therapists, who are currently not educated and trained to provide dental therapy treatment to adult patients, cannot undertake this type of treatment. However, they can obtain the required skills and knowledge through CPD programs, by building upon their core knowledge and skills that they have developed through their initial qualification(s) leading to registration.
39. The primary purpose of the dental practitioner divisions section is for practitioners and employers to understand the scope of practice of each division. Further, information about the dental team to help consumers understand the different roles and responsibilities will be published at the implementation stage.
40. The link between an approved program of study and the relevant professional competencies described by the ADC has been strengthened in the guidelines. The Board is of the view that the relevant professional competencies support scope of practice and act as a reference point for practitioners in understanding the minimum competencies expected at the point of graduation from an accredited program, and should be read in conjunction with the registration standard and guidelines.

#### **Remove the requirements of 'independent practitioner'**

41. There are two main requirements that relate to 'independent practitioner' in the current registration standard.
42. First, the term independent practitioner is defined in the registration standard and has been since it came to effect in 2010. The current registration standard reflects an amended definition of 'independent practitioner' replacing supervision with structured professional relationship.
 

*Independent practitioner means a practitioner who may practise without a structured professional relationship.*
43. Second, is the requirement within the standard that *dental therapists, dental hygienists and oral health therapists must not practise as independent practitioners*. This requirement has been in place since 2010.
44. At the time of the last review the Board agreed that it should move incrementally towards removing the bar on independent practice from the registration standard. This approach was adopted to effectively recognise the professional roles, responsibilities and regulation of all dental practitioners.
45. Over the past few years the Board has seen important changes to the education programs for dental therapists, dental hygienists and oral health therapists as accreditation functions have continued strengthen and mature under the National Scheme. Through compliance with accreditation standards and professional competencies, current training is sufficient to support these practitioners in working in team-based settings without supervision.
46. The practice requirements related to 'independent practitioner' have been a source of significant confusion and subjective interpretation. The term is often misconstrued as a requirement of solo practice, requirement to deal directly with the public, or as a basis for issuing provider numbers.' Stakeholder feedback suggests that the requirement has little meaning in contemporary dental practice and restricts the flexibility of e-healthcare models which are reflective of the needs of the population.
47. Another consideration for the Board is to respond proportionately to risks in order to protect the public. Notifications related to practitioners working beyond their scope of practice are exceedingly few. The Board's recent *Dental notifications classification of issues project* found that only two percent of dental



practitioners were found to be practising in areas beyond their scope.<sup>5</sup> Dentists, including specialists, account for about 90 percent of dental practitioner notifications annually<sup>6</sup>.

48. These changes provide the Board with the basis to remove the requirements for dental hygienists, dental therapists and oral health therapists 'not to practice as independent practitioners' and consequently remove the definition of independent practitioner. This position is consistent with the HWA's recommendation:

*Within five years the Dental Scope of Practice Registration Standard be reviewed to remove the bar on "independent practice" from the Standard and retain only the paragraph that relates to formal education and competency requirements that applies to all dental practitioners.*

#### **Remove the requirement of a structured professional relationship**

49. At the last review, the requirement of a structured professional relationship was included in the registration standard to provide a framework to support the team approach for dental care. The Board subsequently provided clarity about the expectations for practitioners working within a structured professional relationship and its connection with the Code of conduct, which reiterates many of the elements included in the definition of a structured professional relationship.
50. The Board proposes to remove the requirement of a structured professional relationship from the registration standard. In the proposed revised registration standard, the Board has strengthened its expectations for working through a team approach for dental practitioners, and also included reference to the Code of conduct.
51. The Board considers that the Code of conduct more aptly details important standards for dental practitioners in understanding the expected ways of working. Specifically the Code of conduct provides that:
- dental practitioners have a responsibility to recognise and work within the limits of their competence and scope of practice, which may vary over time
  - scope of practice will vary according to different roles
  - dental practice is fundamentally team-based and requires practitioners to work with other practitioners to provide patient care, which includes the appropriate delegation, referral and handover of patient care.
  - good practice involves keeping knowledge and skills up to date to ensure that practitioners continue to work within their competence and scope of practice, and
  - dental practitioners ensure that they have sufficient training and/or qualifications when moving into a new area of practice, in order to achieve competency in that area.
52. The Code of conduct helps the Board in protecting the public by setting and maintaining standards of good practice. The Board will use this code when evaluating the professional conduct of dental practitioners. If professional conduct varies significantly from the code, dental practitioners should be prepared to explain and justify their decisions and actions. Serious or repeated failure to meet the Code may have consequences for registration.
53. It should be noted that the Board has started a scheduled review of the Code of conduct, and is working with other National Boards on the review. The Board will highlight opportunities for practitioners and the public to be involved in the review in its communiqué and newsletter.

#### **Develop a new reflective tool for scope of practice**

54. As an outcome from the last review, the Board published [FAQ](#) to help practitioners assess their own individual scope of practice.

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<sup>5</sup> Dental Notifications: classification of issues project (final report), 2016.

<sup>6</sup>AHPRA and National Boards Annual report 2016/17; [www.ahpra.gov.au/Publications/Corporate-publications/Annual-reports](http://www.ahpra.gov.au/Publications/Corporate-publications/Annual-reports).

55. To support the changes proposed as part of this review and aid the continuous learning of practitioners through reflective practice, the Board has developed a new reflective tool to help practitioners to assess their individual scope of practice. This tool is designed to support dental practitioners in reflecting on their knowledge, skills and abilities and consider how their overall competence relates to their areas of practice

56. Implementation of this tool would be supported by a broad communications strategy.

### Options statement

57. The Board has considered the following options in developing this proposal.

#### Option one – maintain the status quo

58. Option one is to continue with the current registration standard and guidelines which details the Board's requirements for scope of practice under the National Law. The Board has, however identified ways to improve the standard and guidelines, including the opportunity to clarify the language and structure to make it easier to understand and ensure currency of scope of practice requirements.

59. Importantly, the Board has also identified opportunities to improve the current requirements to meet the objectives and guiding principles of the National Scheme.

#### Option two – proposed revised registration standard and guidelines

60. Option two is to consult on a number of proposed changes to the current registration standard and guidelines. Under this option, the proposed revised registration standard and guidelines would continue to set out the Board's requirements for scope of practice however it would:

- remove reference to Programs to extend scope from the registration standard and guidelines giving effect to the Board's decision to phase out the approval process of these programs with a transition period until 31 December 2018
- clarify expectations around education, training and competence including revisions to the practitioner dental divisions and strengthening the link between an approved program of study and the relevant professional competencies
- reduce unnecessary regulation in light of well-established accreditation functions which have shaped practitioner training and competencies
- remove the requirements for dental hygienists, dental therapists and oral health therapists not to practise as independent practitioners
- further clarify the Board's expectations around the team-based approach and remove the requirement for a structured professional relationship, and
- improve readability and clarify current requirements by restructuring and re-wording the standard and guidelines.

61. As part of this option the Board has developed a new reflective tool for scope of practice to help practitioners assess their individual scope and support continuous learning through reflective practice. Implementation of this tool would be supported by a broad communications strategy to deliver effective engagement and uptake.

#### Preferred option

62. The Board prefers option two.

### Issues for consultation

#### Potential benefits and costs of the proposal

63. The benefits of the preferred option are that the proposed revised registration standard and guidelines are:

- use of plain, non-ambiguous English to ensure the registration standard and guidelines are easily understood by dental practitioners, employers and consumers of dental services
- regulation which is proportional to the level of risk to public safety

- maintain the balance between protecting the public, while facilitating access to services in accordance with the public interest, and
  - closer alignment with the requirements for approved programs of study under the National Law.
64. The costs of the preferred option are likely to be minimal. Dental practitioners, other stakeholders, AHPRA and National Boards will need to become familiar with the proposed revised registration standard and guidelines.

### **Estimated effects of the proposed revised registration standard**

65. The changes proposed in the proposed revised standard and guidelines do not substantially change current requirements, although more significant changes may emerge through consultation. There is a minor effect anticipated on practitioners, business and other stakeholders arising from the changes proposed.
66. There would be no financial impact for dental practitioners as any changes will not affect application or registration fees.

### **Relevant sections of the National Law**

The relevant sections of the National Law are:

- section 12, the Ministerial Council may approve a registration standard recommended by a National Board
  - section 38(2)(b) allows a National Board to develop and recommend to the Ministerial Council a registration standard about the scope of practice of health practitioners registered in the profession, and
  - section 39 states that a National Board may develop and approve codes and guidelines to provide guidance to the health practitioners it registers and about other matters relevant to the exercise of its functions.
67. The current registration standard and guidelines are published on the Board's website, accessible from [www.dentalboard.gov.au](http://www.dentalboard.gov.au).

### **Questions for consideration**

In addition to your general feedback, the Board is seeking your views about the preferred proposal outlined above

Please consider the following questions:

1. From your perspective, how is the current registration standard and guidelines working?
2. Are there any issues that have arisen from applying the existing registration standard and guidelines?
3. Is the content and structure of the proposed revised registration standard and guidelines helpful, clear, relevant and more workable than the current registration standard and guidelines?
4. Is there any content that could be changed or deleted in the proposed revised registration standard and guidelines?
5. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?
6. Do you have any other comments on the proposed revised registration standard and guidelines?
7. Is the content and structure of the new reflective tool helpful, clear and relevant?
8. Is there anything missing that needs to be added to the new reflective tool?





## PROPOSED Revised Scope of practice registration standard

**Effective from:** <<date>>

**Review date:** <<date>>

This registration standard sets out the Dental Board of Australia's (the Board) requirements for the scope of practice for dental practitioners.

### Does this standard apply to me?

This registration standard applies to all registered dental practitioners except those with student or non-practising registration.

### What must I do?

1. All dental practitioners are members of the healthcare team. They are expected to work with other members of the healthcare team to provide the best possible care and outcome for their patients.
2. Dental practitioners must only perform dental treatment:
  - a. for which they have been educated and trained<sup>7</sup>, and
  - b. in which they are competent.
3. A dental practitioner must not direct any person whether a registered dental practitioner or not to undertake dental treatment or give advice outside that person's education or competence.
4. All dental practitioners are expected to practice within the definition of dentistry and their dental practitioner division.<sup>8</sup>

### Guidelines for scope of practice

The [Guidelines for scope of practice](#) provide guidance about the expectations of the registration standard and how to meet its requirements. Dental practitioners are expected to understand how to apply these guidelines together with this registration standard.

### Code of conduct

The [Code of conduct](#) outlines how dental practitioners work with a wide range of other health practitioners. This includes delegation, referral and handover of patient care. The Code of conduct should be read in conjunction with the Scope of practice registration standard.

### What happens if I don't meet this standard?

The National Law establishes possible consequences if you don't meet this registration standard, including that registration standards, codes or guidelines may be used in disciplinary proceedings against health practitioners as evidence of what constitutes appropriate practice or conduct for the health profession (see section 41 of the National Law).

<sup>7</sup> As defined in National Law.

<sup>8</sup> Refer to the *Definitions* section of this registration standard.

Dental Board of Australia Public consultation – *Scope of practice registration standard and Guidelines on scope of practice*



## Authority

This registration standard was approved by the COAG Health Council on XX XXXX XXXX.

Registration standards are developed under section 38 of the National Law and are subject to wide-ranging consultation.

## Definitions

**Definition of dentistry** and practitioner descriptions are included in the [Guidelines for scope of practice](#). Restricted dental acts (section 121 of the National Law) also apply to this definition.

**National Law** means the Health Practitioner Regulation National Law, as in force in each state and territory.

### Programs of study approved by the National Board:

- **approved programs of study** are programs accredited by the accreditation authority for the profession and approved by the National Board under the National Law. Approved programs are those which, on successful completion, lead to registration or endorsement as a dental practitioner in the division or specialty in which study was completed, or
- **other assessment, examination or qualification** that qualifies a practitioner for general registration (section 53 of the National Law), specialist registration (section 57) limited registration with the Board (section 65) or endorsement (section 99).

## References

Dental Board of Australia, [Specialist Registration Standard](#).

Dental Board of Australia, [Guidelines for scope of practice](#).

Dental Board of Australia, [Code of conduct](#).

## Review

This registration standard will be revised at least every three/five years.

Last reviewed: XXXX XXXX

This registration standard replaces the previously published registration standard from 30 June 2014.



## PROPOSED Revised Guidelines for scope of practice

<<date>>

The Dental Board of Australia (the Board) develops registration standards which are approved by the COAG Health Council and which define the requirements that applicants, registrants and/or students need to be registered and/or maintain registration.

Guidelines are developed by the Board to provide guidance to the profession and to help clarify the Board's expectations on a range of issues including requirements of registration standards.

These guidelines provide further detail on the Board's [Scope of practice registration standard](#) (the registration standard) and related matters. These guidelines should be read in conjunction with the registration standard, which establishes the scope of practice for all registered dental practitioners.

The [Code of conduct](#) should also be read in conjunction with the Scope of practice registration standard and these guidelines. The code outlines how dental practitioners work with a wide range of other health practitioners. This includes delegation, referral and handover of patient care.

### The dental profession<sup>1</sup>

#### Team approach

The delivery of dental healthcare involves a team approach where dental team members work collaboratively to provide the highest standard of patient care.

A team approach between dental practitioners is encouraged, so that patients are assured of receiving the most appropriate treatment from the dental practitioner who is most appropriate to provide it.

The Board expects that the level and specific nature of the dental care provided will depend on:

- what is needed for the safety and wellbeing of the patient
- the treatment being provided, and
- the type of practice and the education, experience and competence of team members.

All dental practitioners are members of the dental team. Each division of registered dental practitioner provides dental healthcare that is based on their education, training and competence.

The divisions are:

- dentists<sup>2</sup>
- dental hygienists
- dental prosthetists
- dental therapists, and
- oral health therapists.

A dentist with specialised training may be registered as a dental specialist.

Dental assistants and dental technicians are non-registered members of the dental team who support dental practitioners in the delivery of dental services<sup>3</sup>.

Consistent with the team approach, all dental practitioners are expected to work in a relationship with members of the dental team and other health practitioners to provide the best possible care for their patients.

The Board expects all dental practitioners to know when and how to refer, delegate or handover patient care for an appropriate opinion and/or treatment, when the diagnosis and/or treatments are beyond his or her skills or individual scope of practice, or to confirm treatment.

### **Profession and individual scope of practice**

The dental **profession's** scope of practice covers the range of activities and responsibilities which individuals in the profession are educated, trained and competent to perform, within the relevant division.

While the scope of practice of an **individual** dental practitioner is that which the individual is educated, trained and competent to perform. The individual's scope of practice in the division in which they are registered will vary from practitioner to practitioner and may be more limited than the scope of their dental division.

Influences on an individual's scope of practice which may enable or limit practice include:

- level of education and training
- competence and experience
- registration requirements
- legislation and regulations
- clinical need
- recency of practice
- professional indemnity, and
- workplace environment, requirements and capacity.

Dental practitioners must use sound professional judgment to assess their own (and other colleagues) scope of practice and they must only work within their area of education, training and competence.

Each individual dental practitioner is responsible for the decisions, treatment and advice that they provide.

### **Reflective tool for scope of practice**

The Board has developed a reflective tool. This tool is designed to support dental practitioners to reflect on their knowledge, skills and abilities and consider how their overall competence relates to their areas of practice.

### **Practising within the definition of dentistry**

**Dentistry** involves the assessment, prevention, diagnosis, advice, and treatment of any injuries, diseases, deficiencies, deformities or lesions on or of the human teeth, mouth or jaws or associated structures. Restricted dental acts (section 121 of the National Law) also apply to this definition.

The range of activities are considered to be the practice of dentistry and cover the widest range of any procedures that a person educated in dentistry can carry out.

**All dental practitioners are expected to practise within the definition of dentistry and their dental practitioner division.**

### **Dental practitioner divisions**

**Dentists** may practise all parts of dentistry within their competency and training. They provide assessment, diagnosis, treatment, management and preventive services to patients of all ages.

**Dental specialists** are dentists who have undertaken additional specialised training and education and are required to have completed a minimum of two years' general dental practice to be eligible for registration as a dental specialist.

The 13 dental specialist types are:

- dento-maxillofacial radiology
- endodontics
- forensic odontology
- oral and maxillofacial surgery
- oral medicine
- oral and maxillofacial pathology
- oral surgery
- orthodontics
- paediatric dentistry
- periodontics
- prosthodontics
- public health dentistry (community dentistry), and
- special needs dentistry

The Board's *List of specialties* provides further detail of each specialty. The Board's [Specialist registration standard](#) further outlines the requirements for registration as a dental specialist.

**Dental hygienists** provide oral health assessment, diagnosis, treatment, management, and education for the prevention of oral disease to promote healthy oral behaviours to patients of all ages. Their scope may include periodontal/gum treatment, preventive services and other oral care.

**Dental prosthetists** provide assessment, diagnosis, treatment, and management of patients requiring patient removable prostheses including implant retained overdentures, and flexible mouthguards used for sporting activities. Their scope may also include the taking of impressions and records for the manufacture of splints, stents, sleep apnoea/anti-snoring devices and immediate dentures.

**Dental therapists** provide oral health assessment, diagnosis, treatment, management and preventive services for children, adolescents and in some cases for adults of all ages. Their scope may include restorative/fillings treatment, tooth removal, additional oral care and oral health promotion.

**Oral health therapists** are qualified in dental therapy and dental hygiene. They provide oral health assessment, diagnosis, treatment, management and preventive services for children, adolescents and, for adults of all ages. Their scope may include restorative/fillings treatment, tooth removal, oral health promotion, periodontal treatment, and other oral care to promote healthy oral behaviours.

The primary purpose of this section is for practitioners and employers to understand the scope of practice of each division. Further information about the dental team for consumers is published on the Board's website.

### **Practicing within your education, training and competence**

#### **Approved programs of study**

In each division, registered dental practitioners must only perform those dental treatments for which they have been educated and trained in an approved program of study by the Board and in which they are competent.

Approved programs of study are programs accredited by the accreditation authority for the profession and approved by the Board under the National Law. The approved programs are those which, when successfully completed lead to registration as a dental practitioner in the division, specialty or endorsement in which the study was completed.

The alternative pathway is through another assessment, examination or qualification that qualifies a practitioner for general registration (section 53 of the National Law), specialist registration (section 57 of



the National Law) limited registration with the Board (section 65 of the National Law) or endorsement (section 99 of the National Law).

### Professional competencies

A dental practitioner's individual scope of practice can evolve from the time they obtained the qualification leading to registration and can vary from another dental registered in the same division.

As a reference point, dental practitioners can refer to:

- a. The Australian Dental Council's (ADC) professional competencies for newly qualified dental practitioners. These describe the professional competencies for dental practitioners at the point of graduation from an ADC accredited program. These include:
  - o [Professional Competencies of the Newly Qualified Dentist.](#)
  - o [Professional Competencies of the Newly Qualified Dental Hygienist, Dental Therapist and Oral Health Therapist.](#)
  - o [Professional Competencies of the Newly Qualified Dental Prosthetist.](#)
- b. The Board in conjunction with the Dental Council (New Zealand) [entry-level competencies for dental specialists](#). These competencies describe the level of competence expected of applicants for registration with the Board and the Council.

### Competent

Competent as defined in the ADC's [Attributes and competencies of a newly qualified practitioner](#) in each dental division means:

*The behaviour expected of the beginning practitioner. This behaviour incorporates understanding, skill and values in an integrated response to the full range of requirements presented in practice.*

It is not just about being able to carry out a procedure but having the understanding, skills and values to consider whether the treatment is justified under the individual circumstances, the risk of harm from performing the procedure.

### Maintaining and broadening knowledge, skills, expertise and competence

Good practice involves keeping knowledge, skills, expertise up to date to ensure that a dental practitioner continues to work within their competence and scope of practice.

Continuing Professional Development (CPD) activities maintain, improve and broaden knowledge, skills, expertise and competence, and develop the personal and professional qualities required throughout a dental practitioner's professional life.

Dental practitioners wishing to broaden their knowledge, expertise and competence may do so by completing CPD.

All dental practitioners are responsible to select their CPD as described under **Practising within the definition of dentistry**.

If a dental practitioner decides to complete CPD that broadens their knowledge, expertise and competence (e.g. a CPD course to learn a new technique) they need to self-assess whether they have been provided with sufficient clinical experience to incorporate this new technique into their clinical practice.

Also, if a dental practitioner decides to broaden their knowledge, expertise and competence, they need to be mindful of other legislative and/or regulatory requirements as detailed below.

All dental practitioners are expected to comply with the Board's [Registration standard and Guidelines on CPD](#). Information on the CPD requirements and guidance on how to choose a CPD activity is available on the [Board's website](#).

### How might the Board use the guidelines?

Registration standards, codes or guidelines may be used in disciplinary proceedings against health practitioners as evidence of what constitutes appropriate practice or conduct for the health profession under section 41 of the National Law.

### Other legislative and/or regulatory frameworks

In addition to complying with the scope of practice requirements set by the Board, dental practitioners may also work in accordance with workplace agreements which cover clinical scope of practice.

Dental practitioners should be mindful of other regulatory requirements including a dental practitioner's capacity to possess, prescribe/supply and administer medications, complete radiographic procedures, treatment planning and referral, whether professional indemnity insurance covers any additional procedures or techniques, and practice in accordance with the Board's Code of conduct.

### Authority

These guidelines have been developed by the Dental Board of Australia (the Board) under section 39 of the National Law.

### Definitions

**National Law** means the Health Practitioner Regulation National Law, as in force in each state and territory.

**Dentistry** involves the assessment, prevention, diagnosis, advice, and treatment of any injuries, diseases, deficiencies, deformities or lesions on or of the human teeth, mouth or jaws or associated structures. Restricted dental acts (section 121 of the National Law) also apply to this definition.

### References

Dental Board of Australia, [Scope of practice registration standard](#).  
Dental Board of Australia, [Specialist registration standard](#).  
Dental Board of Australia, [Continuing professional development standard](#).  
Dental Board of Australia, [Guidelines – Continuing professional development registration standard](#).  
Dental Board of Australia, [Code of Conduct](#).

All documents referred to in the guidelines are published on this website, see [www.dentalboard.gov.au](http://www.dentalboard.gov.au).

### Review

Date of issue: XX XXXX XXXX

Date of review: The Board will review these guidelines at least every three/five years.

<sup>1</sup> Sections 113 - 119 describe the title and practice protections under the National Law including the penalties for offences by individuals and bodies corporate; and section 121 of the [National Law](#) states that it is an offence to carry out a restricted dental act if you are not a registered dental or medical practitioner

<sup>2</sup> The term dentist refers to dentists, dental specialists and / or a group of dentists unless otherwise indicated.

<sup>3</sup> In some states, dental assistants have state radiography registration enabling them to take dental radiographs.



## Reflective tool for scope of practice

<<date>>

### Scope of practice for dental practitioners

Dental practitioners should be *aware of their scope of practice obligations* as described in the Dental Board of Australia's (the Board) [Scope of practice registration standard](#) and [Guidelines for scope of practice](#).

All dental practitioners must only perform dental treatment, for which they have been educated and trained and are competent, and are expected to practice within the definition of dentistry and their dental practitioner division<sup>9</sup>.

As members of the healthcare team, dental practitioners should refer, delegate or handover patient care to an appropriate practitioner when the requirements of patient care are outside their scope of practice.

### Why has the Board published the reflective tool?

The Board has developed a reflective tool. This tool is designed to support dental practitioners to reflect on their individual knowledge, skills and abilities and consider how their overall competence relates to their areas of practice as well as aid the continuous learning of practitioners through reflective practice.

As a registered dental practitioner it is your responsibility to ensure that you comply with the requirements of the Board's registration standard and guideline. You need to read the Board's registration and guidelines before using the document.

### How should you use the reflective tool?

Regular reflective practice is part of a dental practitioner's responsibility in understanding and adhering to their scope of practice. It also helps teams and organisations understand how they are expected to work. As dental care is delivered using a team-based approach, this reflective tool can be used to support professional relationships between dental team members and ensure collective commitment to patient safety.

The dental profession's scope of practice covers the range of activities and responsibilities which individuals in the profession are educated, trained and competent to perform, within the relevant division.

The scope of practice of an individual dental practitioner is that in which the individual is educated, trained and competent to perform.

The individual's scope of practice will vary from practitioner to practitioner and may be more specifically defined than the scope of the division in which the individual is registered.

The scope of practice of an individual practitioner may also vary according to the clinical setting and situation.

You should self-review your individual scope of practice regularly especially when considering:

- updating or refreshing your knowledge and skills changes in your workplace setting or requirements
- before the introduction of new technologies, equipment and /or treatments into your practice

In addition to using the reflective tool, dental practitioners are encouraged to engage in reflective discussions about scope of practice with their teams, peers, mentors and other colleagues and to use

<sup>9</sup> Refer to the *Definitions* section of this registration standard.

processes in their organisations or teams to verify practitioner qualifications, experience, training and competency.

This tool is not a substitute for the requirements described in the registration standard and guideline nor is it a comprehensive or definitive tool. You may find that you wish to add, modify or delete items as appropriate to your circumstances.

**When reflecting on your own individual scope of practice, you should ask yourself:**

Influences on scope of practice	Question	My response
Education and training	Have I completed the necessary education and training to carry out all of the components of my clinical practice?	
	Is my knowledge consistent with current evidence?	
	Have I identified any gaps in my current knowledge or training?	
Competence and experience	Can I articulate the range and types of treatments I provide?	
	Do I have the competence to safely carry out these treatments?	
	Can I manage any patient complications which may arise from these treatments?	
	Have I considered any previous adverse patient outcomes which may be relevant to my competence or experience?	
Registration requirements	Am I practising within the requirements of the Board's Scope of practice registration standard and guideline?	
	Is my conduct in accordance with the Board's Code of conduct including delegation, referral and handover of patient care?	
	Have I considered all of the aspects of my registration which are relevant to my practice, such as the type of registration which I hold and any conditions or undertakings on my registration?	
Legislation and regulations	Have I considered any additional legislative and regulatory requirements such as specific state and territory legislation?	
	If I intend to prescribe, supply or administer certain medicines, or perform certain radiographic procedures, have I met the requirements of my state or territory legislation and regulations?	
Clinical need	Do I understand all the factors relevant to my patients' clinical outlook, which may include health, social and cultural factors which are likely to impact treatment?	
	Can I communicate with patients about all of the expected risks and benefits of procedures in a way which is tailored to their specific needs and situation?	
Recency of practice	Do I practise across the range of my clinical scope at a suitable frequency to remain competent?	
	Have I considered the areas of my practice which I may need to refresh?	



Professional indemnity	Does my professional indemnity insurance provide cover for the clinical procedure(s) which I carry out?	
Workplace requirements and capacity	Have I considered any limitations which my workplace has on the range of procedures which I may provide?	
	Have I considered any additional requirements of my employer to carry out my practice, such as the need to be credentialed??	
	Do I have adequate materials, equipment, facilities and support to maintain patient safety during and after providing patient treatment?	

### What if you identify gaps?

You should take whatever action is needed to meet your obligations.

If you answered no to, or are unclear on, any of these above questions, you should recognise your own limitations to your scope of practice and refer, delegate or handover patient care to another practitioner who is educated, trained and competent to undertake the practice or procedure. Most practitioners will encounter a threshold at which the nature or complexity of certain patient treatments will require referral, delegation or handover to a practitioner with the appropriate scope of practice, such as a dentist, specialist or medical practitioner.

Dental practitioners wishing to broaden their knowledge, expertise and competence may do so by completing Continuing Professional Development (CPD).

If you decide to complete CPD that broadens your knowledge, expertise and competence (e.g. a CPD course to learn a new technique) which is relevant to your profession's scope, you need to self-assess whether you have been provided with sufficient clinical experience to incorporate this new technique into your clinical practice.

All dental practitioners are expected to comply with the Board's registration standard and guidelines on CPD. Information on the CPD requirements and guidance on how to choose a CPD activity is available on the [Board's website](#).



Board's statement of assessment against AHPRA's *Procedures for the development of registration standards, codes and guidelines* and COAG *Principles for best-practice regulation*

*Scope of practice registration standard and Guidelines for scope of practice*

The Australian Health Practitioner Regulation Agency (AHPRA) has *procedures for the development of registration standards, codes and guidelines* which are available at: [www.ahpra.gov.au](http://www.ahpra.gov.au).

These procedures have been developed by AHPRA in accordance with section 25 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law) which requires AHPRA to establish procedures for the purpose of ensuring that the National Registration and Accreditation Scheme (the National Scheme) operates in accordance with good regulatory practice.

Below is the Dental Board of Australia's (the Board) assessment of its proposal for its **proposed revised** registration standard and guidelines against the three elements outlined in the AHPRA procedures.

### **1. The proposal takes into account the National Scheme's objectives and guiding principles set out in section 3 of the National Law**

#### **Board assessment**

The Board considers that the proposed revised registration standard and guidelines meets the objectives and guiding principles of the National Law.

The proposal takes into account the National Scheme's main objective of protecting the public by ensuring only people who are suitably trained and qualified in a competent and ethical manner are granted and maintain general registration.

### **2. The consultation requirements of the National Law are met**

#### **Board assessment**

The National Law requires wide-ranging consultation on proposed registration standards and guidelines. The National Law also requires the Board to consult the other National Boards on matters of shared interest.

The Board is ensuring there is public exposure of its proposals and the opportunity for public comment by carrying out an eight week public consultation process. This process will include the publication of the consultation paper (attachments) on its website and informing dental practitioners through the Board's electronic newsletter sent to more than 95 per cent of registered dental practitioners.

The Board has drawn this paper to the attention of main stakeholders including the other National Boards.

The Board will take into account the feedback it receives when finalising its proposed revised registration standard and guidelines for submission to the Ministerial Council for approval.

### **3. The proposal takes into account the COAG Principles for best practice regulation**

#### **Board assessment**

In developing the proposed revised registration standard and guidelines for consultation, the Board has taken into account the Council of Australian Governments (COAG) *Principles for best practice regulation*.

As an overall statement, the Board has taken care not to propose unnecessary regulatory burdens that would create unjustified costs for the profession or the community.

The Board makes the following assessment specific to each of the COAG principles expressed in the AHPRA procedures.

**A. Whether the proposal is the best option for achieving the proposal's stated purpose and protection of the public**

**Board assessment**

The Board proposes minor changes to an existing registration standard. The proposed changes reflect the current practice of dental practitioners within their education, training and competence and provide greater clarity through the refinement of the guidelines. The proposal establishes the necessary balance by ensuring that dental practitioners only practise within their education, training and competence which provides for public safety.

**B. Whether the proposal results in an unnecessary restriction of competition among health practitioners**

**Board assessment**

The Board considered whether its proposal could result in an unnecessary restriction of competition among health practitioners. The proposal does not substantially change current requirements for registration and removes some requirements that are no longer necessary. It is not expected to impact the current levels of competition among health practitioners.

**C. Whether the proposal results in an unnecessary restriction of consumer choice**

**Board assessment**

The Board considers that the proposed revised registration standard and guidelines will support consumer choice by continuing to facilitate access to health services provided by dental practitioners in a framework that ensures public protection.

**D. Whether the overall costs of the proposal to members of the public and/or registrants and/or governments are reasonable in relation to the benefits to be achieved**

**Board assessment**

The Board considered the overall costs of the proposed revised registration standard and guidelines to members of the public, dental practitioners and governments. It concluded that the likely costs are minimal when offset against the benefits that the proposed revised standard and guidelines contributes to the National Scheme.

Subject to stakeholder feedback on the proposed revision and if approved by the Ministerial Council, the proposed revised registration standard and guidelines should have very minimal effects on the costs to dental practitioners as the proposals do not substantially change current requirements for registration and removes some requirements that are no longer considered to be necessary.

**E. Whether the requirements are clearly stated using 'plain language' to reduce uncertainty, enable the public to understand the requirements, and enable understanding and compliance by registrants**

**Board assessment**

The Board considers the proposed revised registration standard and guidelines has been written in plain English and that it will help practitioners to understand the requirements of the standard. The structure of the registration standard and guidelines and some wording has been reviewed to make the registration standard and guidelines easier to understand.

**F. Whether the Board has procedures in place to ensure that the proposed registration standard, code or guideline remains relevant and effective over time**

**Board assessment**

If approved, the Board will review the revised registration standard and guidelines at least every three/five years.

The Board may choose to review the standard earlier, in response to any issues which arise or new evidence which emerges to ensure the standard's continued relevance and workability.