From: Emma Asnicar [mailto:Emma.Asnicar@kmir.com.au]
Sent: Wednesday, 14 March 2018 2:42 PM
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Subject: AM2016/31

Dear Sir,

On behalf of Katrina Murphy, please find attached the Dental Hygienists Association of Australia Ltd's submission opposing a variation to the Health Professionals and Support Services Award sought by the Health Services Union. There are two attachments.

DHAA will be attending the conciliation tomorrow morning in Melbourne.

Regards,
Emma Asnicar
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14 March 2018

(AM2014/204)(AM2016/31) formerly (AM2014/204)

4 yearly review of Modern Awards
Health Professionals and Support Services award 2010

SUBMISSION OPPOSING VARIATION SOUGHT BY HEALTH SERVICES UNION IN SUBMISSION 12 FEBRUARY 2018

DENTAL HYGIENISTS ASSOCIATION OF AUSTRALIA LIMITED.

The Dental Hygienists Association of Australia Limited (DHAA) is the peak professional national organisation of dental hygienists and oral health therapists in Australia, with 1500 members.

The DHAA wants to retain the status quo of award-free status for Dental Hygienists and Oral Health Therapists. The DHAA has no other interest in this matter. The DHAA files this submission in reply in relation to the 4 Yearly Review of the *Health Professionals and Support Services Award 2010* ("the Award") in accordance with Directions issued on 21 December 2018, and specifically in response to the HSU's most recent proposal to vary the award dated 12 February 2018. The DHAA submission relies on:

. the DHAA's previous submissions, in particular the submission of 22 May 2017 (**attached**).
. Witness evidence and sworn statement from Dr Melanie Hayes, President (and now CEO) of DHAA (AM2016/31 on 11 December 2017 at PN 1464 -PN1563 and Exhibit #DHAA1 Statement of Melanie Jane Hayes and
. Witness evidence and sworn statement from Dr Carol Tran PN1568-PN 1646 and Exhibit #DHAA2 Statement of Dr Carol Tran.

List of Common Health Professionals – the HSU's Views

The HSU posits that the List of Common Health Professionals must be seen as indicative rather than exhaustive. The DHAA has already provided extensive submissions refuting this view, in particular our submission of 22 May 2017 (copy attached) and in witness evidence and sworn statement from Dr Melanie Hayes (AM2016/31 at PN 1464 -PN1563) and Exhibit #DHAA1 Statement of Melanie Jane Hayes and Witness evidence and sworn statement from Dr Carol Tran PN1568-PN 1646 and Exhibit #DHAA2 Statement of Dr Carol Tran.

The DHAA have no vested interest in the drafting of this Award other than ensuring that these two occupations of dental hygienist and oral health therapist remain specifically award free.

Award Free Status

If the Full Bench is of a view that the List of Common Health Professionals should be indicative rather than exhaustive, DHAA submits that the variation proposed by the HSU at clause 61 of their submission of 12 February 2018 should be altered. The HSU's proposed wording is:

A.2 Health Professional employees – definitions
An indicative list of common health professionals which are covered by the definitions is contained in Schedule B – Indicative List of Common Practice Areas and Titles.

DHAA's proposed re-wording is:

A.2 Health Professional employees – definitions
An indicative list of common health professionals which are covered by the definitions is contained in Schedule B – Indicative List of Common Practice Areas and Titles. This list does not include the award free occupations of Dental Hygienist or Oral Health Therapist.

Oral Health Therapist vs Dental Therapists

In relation to the 2009 AIRC Full Bench decision [2009] AIRFB 958, DHAA did not make application to the Full Bench of AIRC to have the occupation of oral health therapist removed from award coverage because the occupation was not in the List of Common Health Professionals, therefore there was no need to do so. Only the occupation of Dental Hygienist was on the List. Therefore, the DHAA's application to preserve traditional award free status referred only to dental hygienists. (*ref para 18 of Exhibit #DHAA1 Statement of Melanie Jane Hayes*.)

There was a new view posited at the Hearing on 11 and 12 December 2018 by the HSU in cross examination of Dr Hayes at PN 1487-1498 (but not supported by any witness evidence) that the occupation of oral health therapist did not exist at the time of the 2009 AIRC Full Bench decision.

The view was also posited (e.g. PN 1725) that the occupation of oral health therapist which emerged after 2009 has essentially replaced the occupation of dental therapist. The view of the HSU appears to be that this change since 2009 is sufficiently substantive to warrant inclusion of oral health therapist in the List of Common Health Professionals, because the occupation is an organic development of the occupation of Dental Therapist which is currently covered by the Health Professionals and Support Services Award.

DHAA submits that this view **is not correct** (PN 1498.)

Oral Health Therapist has been a registered profession with State Boards since 2006. This data is retained by the Australian Institute of Health and Welfare since 2006. (PN 1498). There were 371 oral health therapists registered in 2006. The attached statistics from the Australian Institute of Health and Welfare show that in 2006, oral health therapists were employed in New South Wales, Victoria, Queensland, Western Australia and South Australia (see attachment.) Moreover, the profession of oral health therapist is equally built on the professions of dental therapist and dental hygienist. (PN 1496)

DHAA submits that there has been no evidence submitted, to support the HSU's contention that award coverage for oral health therapists is warranted due to changes/development in that occupation since 2009, particularly given that the occupation has no history of award coverage.

Yours sincerely,

Katrina Murphy, representing DHAA Ltd
13 March 2018

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22 May 2017

(AM2014/204)(AM2016/31) formerly (AM2014/204)

4 YEARLY REVIEW OF MODERN AWARDS
HEALTH PROFESSIONALS AND SUPPORT SERVICES AWARD 2010

SUBMISSION IN REPLY

DENTAL HYGIENISTS ASSOCIATION OF AUSTRALIA LIMITED.

The Dental Hygienists Association of Australia Limited (DHAA) is the peak professional national organisation of dental hygienists and oral health therapists in Australia, with 1030 members.

The DHAA files this submission in reply in relation to the 4 Yearly Review of the *Health Professionals and Support Services Award 2010* ("the Award") in accordance with Directions issued on 23 November 2016.

This submission in reply supports the DHAA's submission and supporting Witness Statement from Dr Melanie Hayes, President of DHAA filed on 17 March 2017. That submission related solely to our view that the Award's Schedule B - List of Common Health Professionals, is exhaustive in nature as opposed to indicative, meaning that any occupation not listed in the Schedule is unambiguously and unequivocally not covered by this award. The status quo of the occupations of dental hygienist and oral health therapist is that they are not covered by this or any modern Award. The DHAA submits that this status quo should not be disturbed. Any variation to the award consequential of these proceedings must not result in any ambiguity with regard to the current award-free status of these two occupations.

The 17 March 2017 DHAA submission addressed the submissions of the Health Services Union of Australia of 28 January 2015, 4 March 2015 and 16 July 2015 at paras 10-24, notwithstanding that at paragraph 22 the HSUA acknowledges that dental hygienists were removed from award coverage by [2009] AIRCFB 948) and the Australian Workers Union (15 July 2015 at para 4) that Schedule B – List of Common Health Professionals is indicative, not exhaustive.

This DHAA submission in reply addresses paragraphs 4 to 37 inclusive of the HSUA's submission of 17 March 2017. DHAA will cross-examine the HSUA's Industrial Officer Alex Leszcynski regarding the content of his witness statement when this matter is heard before the Full Bench.

List of Common Health Professionals – the HSUA's Views

The HSUA posits that the List of Common Health Professionals must be seen as indicative rather than exhaustive because:

a) This the only logical interpretation (paragraph 4 of HSUA 17 March submission)
b) This is common sense (para 5)
c) This is consistent with the approach taken by the Commission (para 5)
d) This is consistent with the modern awards objective (para 5)
e) The classification structure in the Award is broad enough to cover all health professionals. Therefore because, the term "health professionals" is not specifically defined in the award, it follows that the default position should be that ***all*** health professionals are covered by the

award, unless expressly they are not (such as the dental hygienists, presumably as per para 33). Making the list indicative rather than exhaustive neatly accommodates this view of universal coverage as the default position.

f) Because of the use of the word "common" which according to the HSUA means that there would be other Health Professionals in the list who fall within the scope of the classifications but are not on the list, and because the HSUA believe that the classification structure covers **all** health professionals (para 7), it would be "perverse" to regard the Schedule as anything other than indicative (para 9).

g) The titles of health professionals alter from organisation to organisation, and from time to time, there are "frequent changes" (para 20) as per the once in four years change of the Play Therapist versus Child Life Therapist example elucidated in Mr Leszcynski's witness statement and referred to in para 19. Therefore the HSUA posits that making the list indicative rather than exhaustive is the logical conclusion from this state of flux, otherwise an occupation could end up denied of award coverage because the title they were using for their occupation was not the exact words used to describe that occupation in Schedule B. (paras 11, 12, 19, 20 et al). There is no mention of the option of the HSUA or other interested party seeking to vary the award under s 160 of Fair Work Act to correct the occupational name change.

h) Some occupations are not included in the list but should be. Again, the best course of action is apparently not for the HSUA to seek to vary the award to effect coverage (under s 158(1)(3)), but to assert that it makes more sense for the List to be indicative.

i) HSUA states that The Australian Dental and Oral Health Therapists Association claims that its members are confused (para 22) because their occupation is not in the Schedule. HSUA posits that it is a better option to make the list indicative to ease that confusion. It is not clear how this will ease ADOTA's confusion. Again, for reasons that are not apparent, HSUA asserts that is a better option to make things vaguer with an "indicative" list than to make things definite by accepting the list as is (viz. exhaustive) and HSUA and/or ADOHTA seeking to vary the award for the occupation of oral health therapist to be covered by the award (if that is indeed what ADOTA members want.) APESMA (Outline of Submissions 17 March 2017)has taken the usual approach of employee associations in these proceedings to seek to vary the award to include Translators and Interpreters in the List of Common Health Professionals (Schedule B.) It is not clear why ADOHTA or HSUA cannot do the same.

j) HSUA states that because the nature of health professional terminology is of an "evolving nature" the Schedule must be indicative otherwise the HPSS Award "would be stuck with the health professional nomenclature of a particular point in time, and would become quickly out of date." Given that the Four Yearly Proceedings are designed specifically for interested parties to make application to correct ambiguity and update the awards, it is part of the role and purpose of employee associations such as the HSUA to make application to vary the award if they believe that there is a cogent and supportable argument to support a change (as apparently they do with the Child Life Therapists/ Play Therapists.)

k) The HSUA posits that to make the list indicative will work to "minimise confusion about award coverage" (para 22) The HSUA references the undesirability of "lack of certainty." (23). It is illogical to suggest that an "indicative" list is "clearer" than an exhaustive list. If this was the case, the HSUA would have drafted their own Rules (R2016/196) on the same indicative lines. But they are not drafted in such a way. Their Rules, like all well drafted

industrial instruments, are very specific as to coverage and non-coverage issues. For example, clause 38(d) (refer Attachment) provides a list of health classifications which may be members of the Victoria No. 3 Branch of the HSUA. The list is exhaustive. It is clearly designed to ensure there is no confusion. As an exhaustive list, it provides clarity about who is covered and who is not. Such is the nature and purpose of an exhaustive list. The Rules contain specific provisions about how the list can be altered/updated – analogous to the provisions available to vary the Award via application to Fair Work Commission.

l) HSUA maintains that the fact that the Award has an exhaustive list of occupations is not usual with regard to modern awards. They give two examples of the 130 modern awards as evidence for this point. They state that there is “no reason” why the Award should be “an exception to other modern awards by creating an exhaustive list of health professionals.”

HSUA first makes reference to Schedule B of the Aged Care Award 2010. This schedule defines the classifications into levels. i.e. Level 1 through to Level 7. Each level has a list of ‘indicative tasks’ such as cleaner and laundry hand. The Health Professionals and Support Services Award 2010 also has a Schedule B which has classification definitions divided into levels with indicative tasks such as cleaner and laundry hand.

The Health Professionals and Support Services Award Schedule C cannot properly be compared to the Aged Care Award 2010 Schedule B, as it is entirely unrelated. The HPSS Schedule B is related, but not schedule C. The Health Professionals and Support Services Award Schedule C has a list of ‘Common Health Professionals’. Health Professionals who are in most cases degree qualified. To compare the Aged Care Award 2010 Schedule B and the Health Professionals and Support Services Award 2010 Schedule C is like comparing apples and oranges.

The HSU claims there is no reason why the HPSS Award should be an exception to other modern awards by creating an exhaustive list of health professions.

The DHAA submit that the format of the HPSS Award is not an exception. For example:

. the Aboriginal Community Controlled Health Services Award 2010 has an exhaustive list of job titles at Schedule B, B.3. Dental. B.3. includes an exhaustive list including Dental Assistants and Dental Therapists. It also has an exhaustive list of ancillary staff being cleaners, drivers and caretakers.

. the Ambulance and Patient Transport Industry Award 2010. Schedule B of this award has a very detailed exhaustive list at B1.

. the Animal Care and Veterinary Services Award 2010 has a list of Exhaustive job titles at Schedule B, and indicative tasks to classify employees within the levels under that job titles.

. the Broadcasting and Recorded Entertainment Award 2010 has an exhaustive list covered by seven separate Schedules. Only 3 of these schedules mention indicative tasks, all others are exhaustive.

If the HSUA continue to press this arm of their argument, the DHAA will submit documentary evidence of all 130 of the modern awards at arbitration to demonstrate that the HSUA’s

submission that the exhaustive list of health professions should be made indicative to be in line with other modern awards is unsubstantiated.

m) The HSUA argue that to regard the schedule as exhaustive would have "undesirable and anomalous effects including the removal from award coverage of health professionals who have hitherto been regarded as covered by the Award." (para 29) No examples are given.

n) The HSUA state "there can be no rationale for treating one type of health professional as covered by the award, and another as outside the scope of its benefits" (para 29). This is the core of the HSUA's position – that **all** health professionals should be covered by the award, as the default position. They do not offer a rationale. There is of course a rationale opposing this position. An example of that rationale was accepted by the Full Bench of the AIRC, in their decision ([2009] AIRFB 958, to accept the DHAA's application to vary the award by removing the occupation of dental hygienist from the List of Common Health Professionals to render the occupation award-free.

o) The HSUA argue that the modern award objectives are not served by an exhaustive list (paras 29-32.) In fact, the opposite is the case. Certainty and simplicity is achieved by having a list which clearly states which occupations are covered, and which are not. This assists all parties, including Fair Ombudsman telephone advisors, to easily understand and give correct advice on award coverage to health sector employers.

<u>Proposed Variation</u>

As per our previous submissions, the DHAA submits to Fair Work Commission that the exhaustive status of Schedule B is not ambiguous. However to ensure that submissions to claim that it is ambiguous are quashed permanently, DHAA proposes the following variation with numbering based on the current award, not the current Exposure Draft. The proposed change is highlighted in bold.

Clause 4.1 (b): employers engaging a health professional employee falling within the classifications described in clause 15. **Clause 15 has application only to the occupations specified in Schedule B – List of Common Health Professionals.**

Yours sincerely,

Katrina Murphy, representing DHAA Ltd
22 May 2017

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Australian Government

Australian Institute of Health and Welfare

AIHW DENTAL STATISTICS AND RESEARCH UNIT

RESEARCH REPORT 49 • JULY 2011

research report 49

Oral health practitioners in Australia, 2006

This report provides information on the oral health practitioner labour force in Australia, comprising dental therapists, dental hygienists and dual-qualified hygienists and therapists—commonly referred to as oral health therapists. Estimates in this report are derived from the 2006 national dental labour force data collection. Where appropriate, comparisons have been made with data from previous collections.

Main findings

In 2006, there were 1,171 practising dental therapists, 674 practising hygienists and 371 practising oral health therapists. Dental therapists were the oldest group among the oral health labour force, with an average age of 42.9 years. The oral health practitioner workforce was overwhelmingly female, with 98.8% of dental therapists, 96.7% of hygienists and 94.8% of oral health therapists being female in 2006.

New South Wales had the lowest rate of practising dental therapists with 3.3 per 100,000 population, and Western Australia had the highest with 13.9 per 100,000. The highest rate of practising hygienists was in the Australian Capital Territory, at 11.3 per 100,000 population, while the lowest was in Tasmania at 1.0 per 100,000 (excluding the Northern Territory who had no registered hygienists in 2006). Queensland had the highest rate of oral health therapists, with 5.6 per 100,000 population, while there were no registered oral health therapists in Tasmania, the Northern Territory or the Australian Capital Territory.

The large majority (82.0%) of dental therapists worked in the public sector while hygienists practised predominantly in the private sector (92.7%). Two-thirds of oral health therapists (62.0%) worked in private general practice. The distribution of hygienists across remoteness areas was highly skewed towards the more populous regions. Oral health therapists worked the longest week (33.4 hours).

Contents

Main findings 1
Background 2
Data collection and methods 2
Overall numbers 3
Demographic characteristics 4
Geographic distribution 5
Practice characteristics 6
Practice activity 6
References 8
Acknowledgments 8

Background

Since the late 1990s, there has been a substantial change in the structure of dental therapy and dental hygiene training programs. Historically, programs were predominantly single qualification Advanced Diplomas. In recent years, these programs have been replaced by Bachelor of Oral Health courses training dual-qualified hygienists and therapists, commonly referred to as oral health therapists. The first Bachelor of Oral Health course was an academic upgrade program offered by The University of Queensland (2002), quickly followed by the establishment of programs in other states.

Dental hygienists are trained in an accredited school and registered by the state/territory board to provide various dental services including examinations, scaling and polishing teeth, prevention, health promotion and radiography in accordance with the restrictions in place by the dental boards. Dental therapists provide various clinical and preventive services to preschool-aged and school-aged children and young adults, which include services such as examinations, fillings, extractions, health promotion and prevention. Oral health therapists are eligible to register as both a dental therapist and dental hygienist, but may not necessarily maintain dual registration or employment in a dual capacity.

Legislation in states and territories that defines the scope of practice for this labour force group has changed considerably since 2000. These changes and their timing varied by state/territory and by occupational groups, and are expected to have an impact on the practising patterns of these occupational groups. As of 2010, under national registration arrangements, scope of practice provisions have become uniform across all jurisdictions (a description of clinical services performed by hygienists and dental therapists in 2006 can be found in Balasubramanian & Teusner 2011).

Previous AIHW dental labour force reports have treated dental therapists and hygienists separately. Due to these recent legislative changes and the rapid emergence of the oral health therapist labour force, it is appropriate to compare the characteristics of the three occupational groups, and understand how they are employed in the delivery of dental services. As an oral health therapist can practise as either or both a therapist and hygienist, for the purposes of this report, the three occupational groups have been categorised according to registration type, rather than how they are principally employed.

Data collection and methods

This publication reports population estimates derived from the Dental Labour Force Data Collection 2006. The data collection was done by a questionnaire distributed in the second half of 2006 to all oral health practitioners registered with the dental boards in all states and territories. The overall response rates were high across the three occupational groups (dental therapists 81%, hygienists 76% and oral health therapists 82%). Data collection methods and response rates varied by state and territory (for full details see Balasubramanian & Teusner 2011).

To calculate population estimates, data were weighted for non-response. Not all questionnaires were completed in full, and missing data were imputed based on the assumption that non-respondents had the same characteristics as respondents.

Overall numbers

In 2006, the employed oral health labour force consisted of 1,171 dental therapists, 674 dental hygienists and 371 oral health therapists. In total, 2,216 practitioners were currently employed (Table 1). These three groups comprised 16% of the registered clinical dental labour force, which also includes dentists and dental prosthetists (dentists were the largest occupational group at 77%, and dental prosthetists comprised 7% of the dental labour force. Dental assistants are currently not registered and dental technicians are registered in most states and territories but do not provide clinical services).

Table 1: Oral health practitioner registrations, by labour force status, 2006

	Oral health practitioner type				
Labour force status	**Dental therapists**	**Hygienists**	**Oral health therapists**	**Total**	**Percentage of oral health practitioner labour force**
Employed	1,171	674	371	2,216	86
Employed in another state/territory	16	26	12	54	2
On leave (more than 3 months)	44	38	11	93	4
Overseas	5	16	1	22	1
Not in paid work	45	18	8	70	3
Working in dentistry but not as an oral health practitioner	46	10	3	59	2
Working in another industry/profession	53	2	4	59	2
Total	**1,380**	**784**	**410**	**2,574**	**100**
Percentage employed	85	86	90	86	

Note: Column/row totals may not sum to total due to rounding estimates.

Between 2000 and 2006 there was a decline in the number of registered and practising dental therapists per 100,000 population, resulting from the cessation of dental therapy courses and from an unknown number of therapists completing academic upgrades to become oral health therapists. Over the same period the practising rate of hygienists increased slightly from 2.1 in 2000 to 3.3 in 2006 (Figure 1).

In 2006, there were 1.8 oral health therapists per 100,000 population. In 2000 and 2003, there were small numbers (about 30 and 50 respectively) of employed dual-qualified oral health therapists but, due to inconsistent registration of oral health practitioners across the state/territories, numbers were difficult to estimate, and were included in the dental therapist estimates for those time points. State and territory dental boards began registration of therapists and hygienists at different times, but by 2005 these groups were registered in all states and territories, improving the capacity to calculate national estimates (Figure 1).

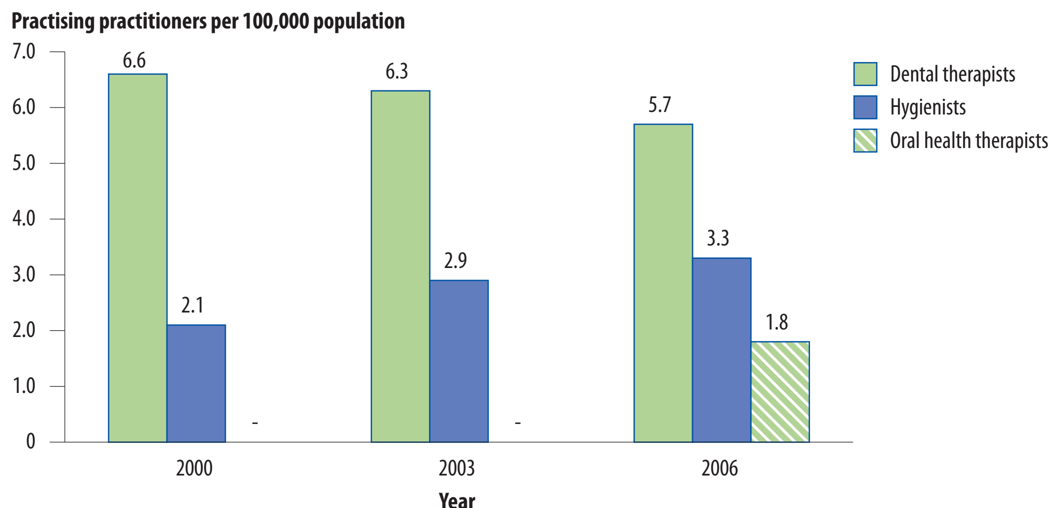


Figure 1: Practising oral health practitioners per 100,000 population, 2000, 2003 and 2006

Demographic characteristics

The oral health practitioner labour force was predominantly female. Of the dental therapist, hygienist and oral health therapist labour force, males comprised 1.2%, 3.3% and 5.2%, respectively, in 2006. Dental therapists had the highest average age (42.9 years) compared with hygienists (37.7 years) and oral health therapists (36.4 years). Nearly one-third (29.1%) of the oral health therapist labour force was in the youngest age group (20–29 years). In contrast, only 7.2% of dental therapists were in the youngest age group, and nearly one-fifth (17.7%) were 50 years or older. Hygienists were more evenly distributed across age groups (Figure 2).

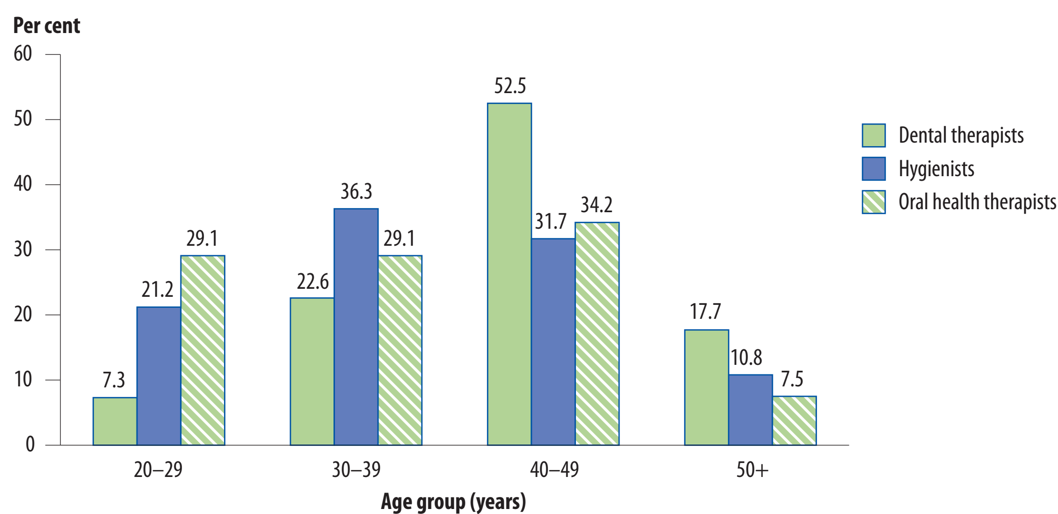


Figure 2: Proportion of practising oral health practitioners, by occupational group and age group, 2006

Geographic distribution

The numbers of oral health practitioners per 100,000 population varied by state and territory. Variations largely relate to historical differences in state oral health policy and availability of training programs. Western Australia had the highest rate of dental therapists (13.9), the Australian Capital Territory the highest rate of hygienists (11.3), and Queensland had the highest rate of oral health therapists (5.6) (Table 2).

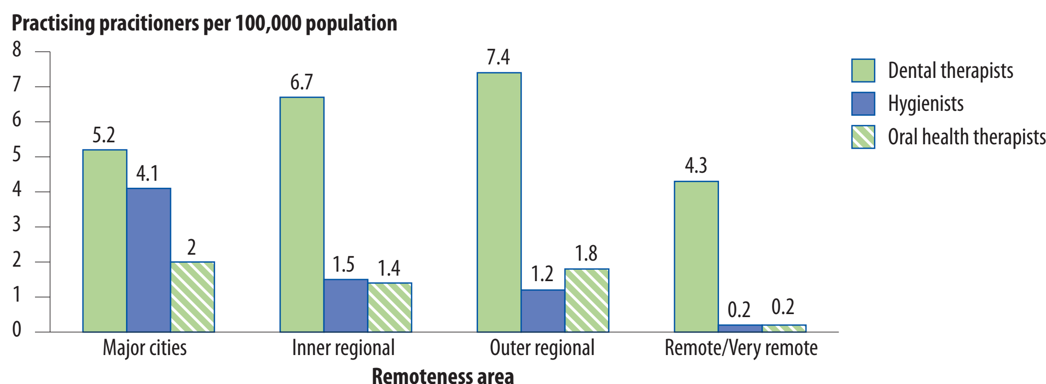
Table 2: Number of oral health practitioners and number practising per 100,000 population, by state and territory, 2006

Registration type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				Number of practitioners					
Dental therapists	225	196	245	286	121	56	19	23	**1,171**
Hygienists	149	120	74	135	154	5	38	–	**674**
Oral health therapists	39	41	228	38	26	–	–	–	**371**
Total	**413**	**356**	**546**	**458**	**300**	**61**	**57**	**23**	**2,216**
				Number practising per 100,000 population					
Dental therapists	3.3	3.8	6.0	13.9	7.7	11.4	5.7	11.0	**5.7**
Hygienists	2.2	2.3	1.8	6.6	9.8	1.0	11.3	–	**3.3**
Oral health therapists	0.6	0.8	5.6	1.8	1.7	–	–	–	**1.8**
Total	**6.1**	**6.9**	**13.4**	**22.3**	**19.2**	**12.4**	**17.0**	**11.0**	**10.7**

Note: Column/row totals may not sum to total because of rounding of estimates.

Information on geographic location is presented using remoteness areas. The remote areas are structured according to the Australian Standard Geographical Classification developed by the Australian Bureau of Statistics (for details see ABS 2006). Categories include *Major cities*, *Inner regional*, *Outer regional* and *Remote* and *Very remote* areas. These categories provide an indication of the degree of remoteness, or distance, from major cities.

The distribution of practitioners across remoteness areas differed by occupational group. The practising rate of dental therapists was highest in *Outer regional* areas. In contrast, the practising rate for hygienists was highest in *Major cities*, while the oral health therapist labour force was more evenly distributed across the three least remote areas with only a few working in *Remote* or *Very remote* areas (Figure 3).



Note: Remote and Very remote areas have been combined into the Remote category

Figure 3: Practising oral health practitioners per 100,000 population by occupational group and remoteness area, 2006

Practice characteristics

Dental therapists were predominantly employed in the public sector, with 60.4% working in school dental services and 16.2% working in community dental services (Table 3).

In contrast, hygienists were predominantly employed in the private sector, with nearly one-fifth (19.3%) working in private specialist practice.

Nearly two-thirds (62.0%) of the oral health practitioner labour force worked in the private sector (Table 3).

Table 3: Practising oral health practitioners, by occupational group and practice type, 2006

	Dental therapists		Hygienists		Oral health practitioners	
Practice type	Number	Per cent	Number	Per cent	Number	Per cent
Public						
School Dental Service	707	60.4	5	0.7	127	34.3
Community Dental Service	190	16.2	11	1.7	4	1.0
Dental hospital	26	2.2	6	0.8	5	1.4
Teaching	18	1.6	14	2.1	5	1.3
Public other	18	1.6	13	2.0	—	—
Private						
Private general practice	127	10.9	494	73.2	184	49.5
Specialist—Orthodontic	70	6.0	73	10.9	35	9.4
Specialist—Periodontic	1	0.1	44	6.6	9	2.5
Specialist—Other	10	0.8	12	1.8	2	0.6
Private other	3	0.2	1	0.2	—	—
Total	**1,171**	**100.0**	**674**	**100.0**	**371**	**100.0**

Notes
Column/row totals may not sum to total due of rounding of estimates.
— means zero or rounded to zero.

Practice activity

Oral health therapists, who worked on average 33.4 hours per week, had the longest week, compared with hygienists and dental therapists, who worked, on average, 28.2 and 28.0 hours per week, respectively. Although there was variation in hours worked per week by age group, the pattern of oral health therapists working a longer week was consistent across all age groups (Table 4). For dental therapists and oral health therapists, younger and older age groups (20–29 years and 50 years or older) worked a longer week than those in the 30–39 years and 40–49 years age groups.

Table 4: Practising oral health practitioners, average hours worked per week, by age group, 2006

Age group (years)	Dental therapists	Hygienists	Oral health therapists
20–29	35.1	34.0	38.0
30–39	23.0	27.4	30.7
40–49	28.8	28.0	31.1
50+	29.2	25.1	37.4
All	**28.0**	**28.2**	**33.4**

The majority oral health practitioners worked in one practice location: 80.5% of dental therapists, 64.9 of hygienists, and 55.3% of oral health therapists (Figure 4).

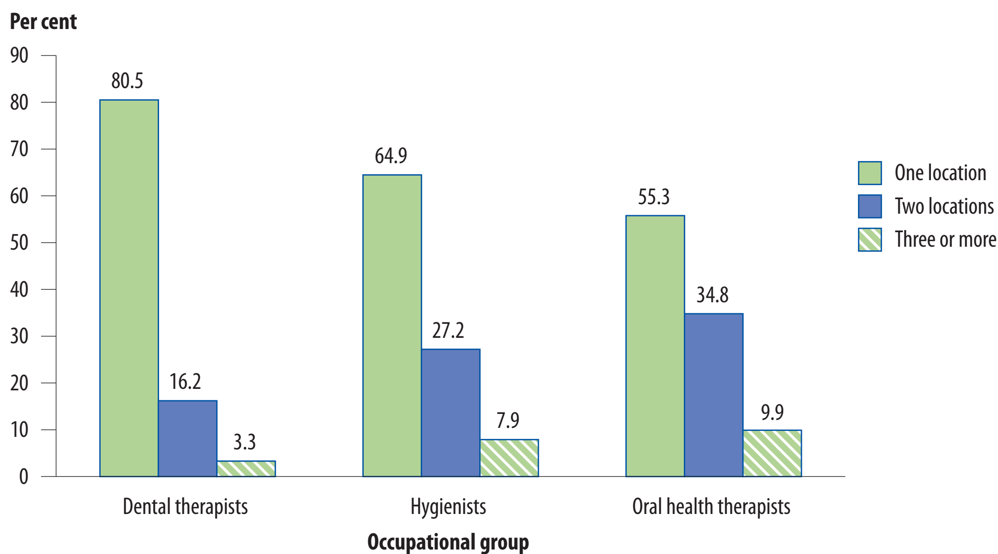
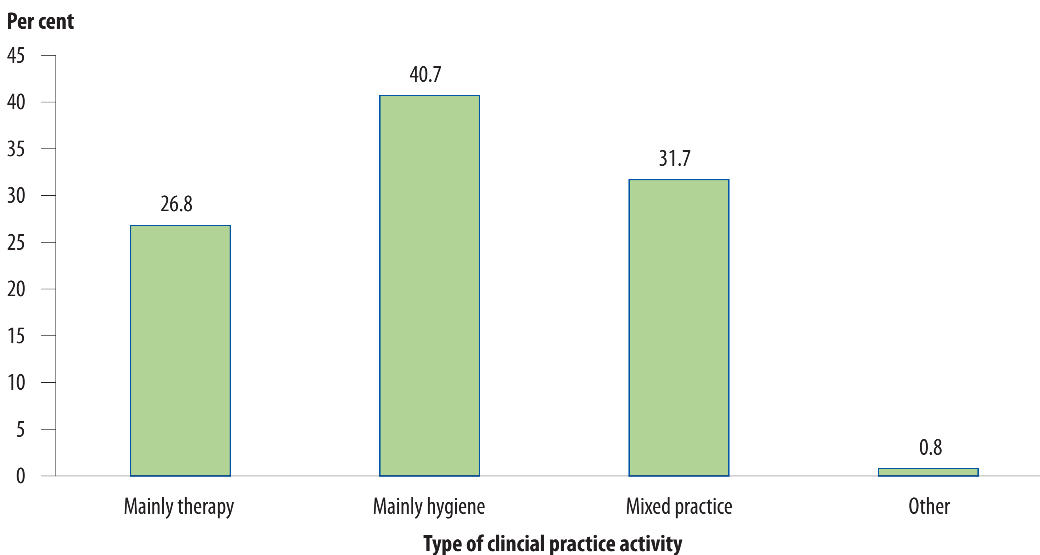


Figure 4: Practising oral health practitioners, by occupational group and number of practice locations worked, 2006

The most commonly reported type of clinical practice activity for the oral health therapist labour force was working mainly in hygiene practice. About one-quarter (26.8%) worked mainly in therapy, and nearly one-third (31.7%) worked in mixed practice (hygiene and therapy clinical activity) (Figure 5).



Note: Mainly therapy: 70% or more of hours worked were dedicated to therapy clinical practice. Mainly hygiene: 70% or more of hours worked were dedicated to hygiene clinical practice. Mixed practice: those not classified as mainly hygiene or mainly therapy were working the majority of their hours in dual hygiene and therapy clinical practice. Other: includes practitioners whose hours worked were dedicated mainly to non-clinical activities.

Figure 5: Percentage of practising oral health therapists, by type of clinical practice activity, 2006

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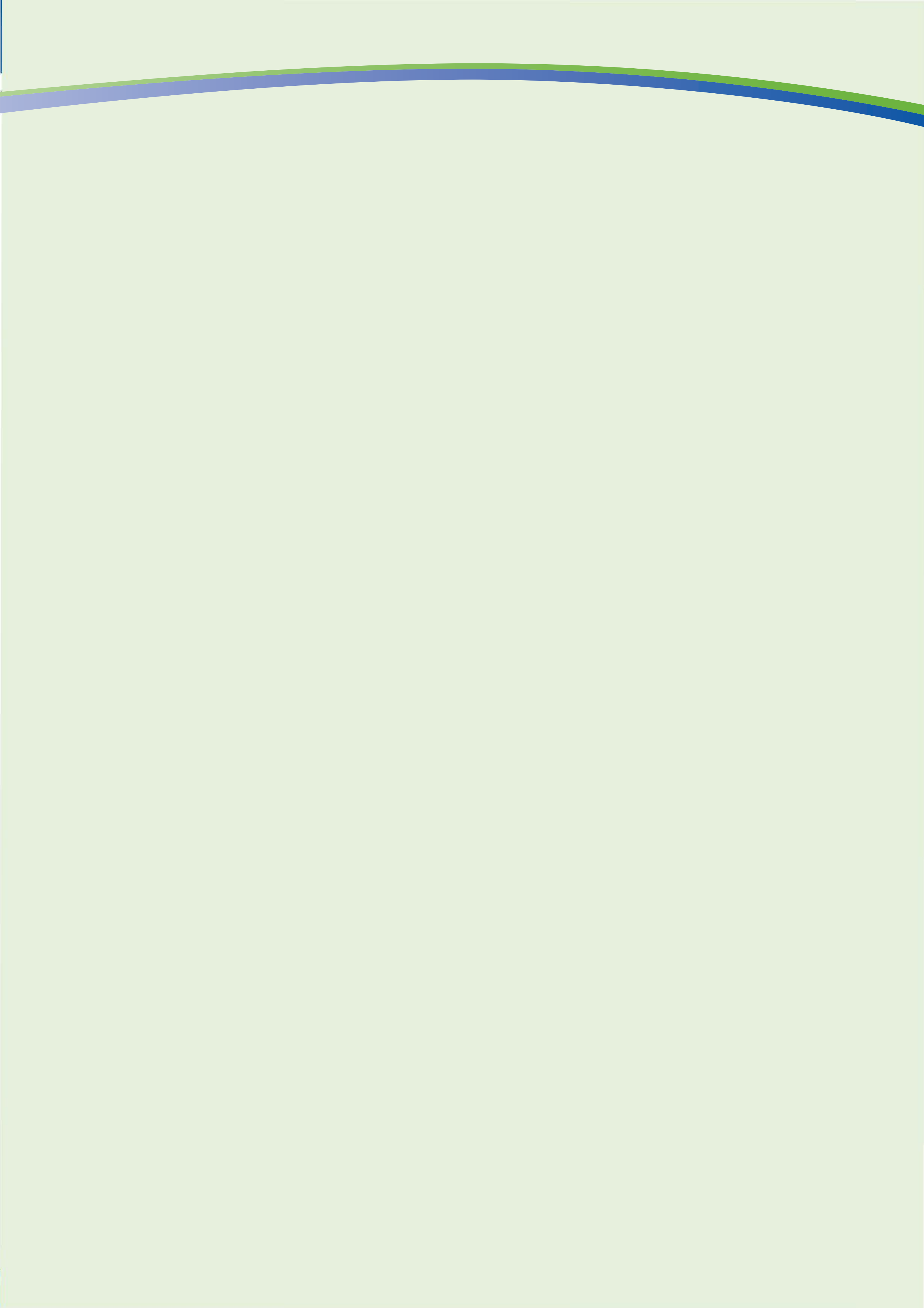

research report 49

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