Sociodemographic Profile and Career Decisions of Australian Oral Health Profession Students


Abstract: This study collected and analyzed recent information regarding the sociodemographic profile and career decisions of Australian oral health profession students (earning B.D.Sc. and B.O.H. degrees) and the reasons for their career choice. Data were collected during the 2009–10 academic year via a web-based survey. A total of 829 students participated; the response rates for each oral health course at the seven participating universities ranged from 15.0 percent to 88.7 percent. The respondents had an average age of 21.4 years, ranging from eighteen to fifty-one. The majority of the respondents were female (61.4 percent), single (91.0 percent), and of Asian ethnicity (65.0 percent), and almost half had attended a public secondary school (49.7 percent). Most of the responding students either lived in rented accommodation (44.0 percent) or with their parents (28.6 percent), and 41.5 percent reported having an urban address. Most respondents’ fathers (67.2 percent) and mothers (54.8 percent) had completed undergraduate or postgraduate education and were employed in managerial or professional occupations (68.5 percent and 54.9 percent, respectively). Most of the students said they had selected their course in high school (66.8 percent) and were most influenced in their career choice by self-motivation (85.3 percent) and caring for and helping other people (86.6 percent). The majority of the respondents reported wishing to work in a city (51.5 percent), practicing general dentistry (31.8 percent) in either the public or private sector (40.2 percent each). This article provides a preliminary look at the future dental workforce of Australia, identifying issues for further analysis and assisting each university to address current inequalities and challenges.

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Several studies on Australian dental students are available in the literature. Common to these studies is a report on the ethnic composition of participating cohorts, with Asian students forming a high proportion of the dental student population, a percentage that has increased in the last few years. Additionally, a previous study by Mariño et al. found a very small number of dental students coming from rural areas and an increasing proportion of female students.

Dental students’ motivation for choosing their career has also been studied extensively. However, with the exception of the Mariño et al. study, none of the studies have explored career choice in Australia. Furthermore, previous studies researched dental students with a terminal degree of Bachelor of Dental Science, without attempting to fully describe the sociodemographic profile of all oral health profession students—that is, including those earning a Bachelor of Oral Health, a three-year course offered in Australia since 2005 with a combined professional outcome of dental hygienist and dental therapist. Information on career choice by both groups of oral health profession students would increase current understanding of how the decision process develops over time and how it differs between these two oral health professions. This is important information as the government has provided resources for training, mentoring, and supervision to ensure that minorities and rural students are attracted to careers in oral health and are provided with an adequate level of support. Evidence indicates that rural background and under- and postgraduate medical education undertaken in rural areas increase the probability that medical doctors will work in rural practices. Information on the sociodemographic profile of oral health profession students would also provide valuable guidance for policymakers in developing strategies to attract, recruit, and retain students consistent with the notion of equality of access to higher education.

To address the gap in current knowledge about oral health profession students, this study aimed to
describe the sociodemographic profile of Australian oral health profession students. Additionally, this study explored the motivations and reasons behind these students’ career decisions and future career choices. As such, this analysis will provide a preliminary look at the future dental workforce in Australia. This information is important for guiding planners in the design of dental education programs, particularly in the area of cultural diversity awareness. In addition, it will provide a better understanding of career choice issues, which could inform policies in both Australia and other countries where oral health profession students come from ethnically and racially diverse backgrounds. This information can be used to inform such crucial areas as student selection and recruitment and retention from rural and other underrepresented populations. Additionally, this information will contribute to policy development aimed at addressing oral health workforce shortages in underserved areas.10

Methodology

With the approval of the Human Research Ethics Committee of the University of Melbourne, data were collected in mid-June 2009 and mid-March 2010 for students from the Bachelor of Dental Science or equivalent (B.D.Sc.) and Bachelor of Oral Health (B.O.H.) courses at Griffith University (GU), James Cook University (JCU), the University of Adelaide (UA), the University of Melbourne (MU), the University of Newcastle (NU), the University of Western Australia (WA), and La Trobe University (LTU).

The study was coordinated by researchers at the University of Melbourne, who approached the heads of the schools to obtain their approval to approach students. At each school, a faculty member was identified to coordinate local data collection. Students were briefed on the aims of the study and invited to participate in the self-completed online survey consisting of two parts: sociodemographic (twenty-seven items) and career choice (eleven items). The questions addressed a variety of topics regarding students’ personal characteristics, ethnic background, and motivating factors for selecting the oral health profession as a career.5

The sociodemographic information collected included age, gender, marital status, and living arrangements. Students were classified according to their last high school attended using the following categories: Australian public high school, Australian private high school, overseas public high school, overseas private high school, and other high schools. Participants were asked to indicate the postcode of their parents’ home or usual place of residence. Using the 2008 Australia Post local delivery service guidelines,11 home addresses were classified as urban, rural, interstate, or international.

Students’ socioeconomic status was determined by asking them to identify their parents’ level of education (primary, secondary, technical and trade, undergraduate, or postgraduate) and occupation. Parental occupations were reclassified into five groups, based on the Australian Standard Classification of Occupations: managers and professionals, para-professionals, trades clerks and personal services, laborers and related workers, and not in paid jobs.12

Ethnicity was classified into Anglo-Australian, Asian, and other. Anglo-Australian students are those born in Australia, the United Kingdom, New Zealand, or Ireland, with parents and grandparents also born in those countries. Asian students include those who are Australian-born whose ancestral origins were in east Asia, China (Hong Kong, People’s Republic of China, and Taiwan), southern Asia (India, Sri Lanka, Mauritius, and Burma), or southeast Asia (Vietnam, Malaysia, and Indonesia).13,14 Ethnicities designated “other” include a range of European backgrounds other than the United Kingdom or Ireland or as being from the Americas, Africa, or the Middle East. Students’ language proficiency was assessed by asking for the language first learned, proficiency in written and spoken English, and understanding spoken English. Answers were in a multiple-choice format, with options from 1 (very well) to 4 (not well).

Career choice variables included career preferences and time of choosing the oral health profession as a career, with the options of early in high school, late in high school, and after leaving high school. Those who reported a time lapse between high school and commencing the oral health profession course were asked whether they worked or pursued other degrees before entering their courses. Students were also asked to indicate their level of agreement with sixteen statements about their reasons for choosing an oral health profession as a career and with eight options about who influenced their career selection; these questions utilized a five-point scale, from 1=little influence to 5=strong influence.

The first part of the analysis provided a comprehensive profile of oral health profession students in Australia, based on the distribution of selected sociodemographic, immigration, and study variables.
The data were analyzed using SPSS v17.0 to statistically compare results between schools and among sociodemographic variables.

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**Results**

A total of 848 students participated in the survey. Three respondents were omitted from the analysis due to noncompliance with the study’s inclusion criteria (age eighteen years and above); sixteen respondents from NU and B.O.H. students from GU were omitted due to insufficient response. Of the responses included in the analysis (n=829), 164 (110 B.D.Sc.; fifty-four B.O.H.) were from LTU (19.8 percent); 245 (221 B.D.Sc.; twenty-four B.O.H.) were from UA (29.6 percent); 331 (278 B.D.Sc.; fifty-three B.O.H.) were from MU (39.9 percent); and twenty-six (all B.D.Sc.) were from WA (3.1 percent). Due to lower numbers, responses from GU (n=54) and JCU (n=9) were merged into one group (Queensland, QLD). The response rates from each course at the respective schools ranged from 15.0 percent to 88.7 percent. Table 1 shows the demographic distribution of students and characteristics by school and course.

**Sociodemographic Profile**

The responding students’ ages ranged from eighteen to fifty-one years, with an overall mean of 21.4 (SD 3.3) years. The majority of the B.O.H. students (61.8 percent) were aged twenty and below compared to 45.1 percent of the B.D.Sc. students (χ²[8]=134.8, p<0.001). There were consistently more females than males among both the B.D.Sc. and B.O.H. respondents: 57.7 percent and 80.9 percent, respectively (χ²[7]=29.9, p<0.001). As for marital status, the majority (91.0 percent) were single.

About half of the responding students (48.5 percent) were born in Australia. Those born overseas named fifty-six countries of birth for themselves and seventy-seven countries of birth for their parents. A high proportion of the respondents (65.0 percent) reported their race/ethnicity as Asian, while 16.3 percent were Anglo-Australian/New Zealand and 18.7 percent were other. A high proportion of B.D.Sc. respondents (70.6 percent) reported themselves as Asian, compared to 35.1 percent of B.O.H. respondents (χ²[2]=61.4, p<0.001). In particular, this was the case of MU B.D.Sc. students at 84.9 percent (χ²[14]=133.3, p<0.001).

A large proportion of the respondents reported being bilingual (45.0 percent); they specified knowing a total of fifty-three languages. The most common languages other than English were Chinese or a Chinese dialect (47.9 percent), followed by Vietnamese (8.3 percent) and Korean (7.4 percent). The proportion of students with foreign language abilities differed significantly among courses and institutions, from about two-thirds of MU B.O.H. respondents to about one-third of UA B.O.H. respondents (χ²[7]=38.4, p<0.001). The vast majority of respondents reported their proficiency as “reasonably well” or “very well” in understanding English (99.8 percent), reading English (100.0 percent), and English expression (98.9 percent). Nine respondents did not consider their proficiency in English speaking and comprehension to be adequate (“not well”).

The largest proportion of the respondents’ parents lived in urban Australia (41.5 percent), with 9.8 percent in rural Australia, 26.1 percent interstate, and 22.6 percent overseas. The place of residence differed significantly by courses in each university (χ²[21]=347.7, p<0.001): MU B.D.Sc. students had the largest proportion indicating an overseas address (41.4 percent) compared to other courses (24.0 percent or less). Students reporting an interstate address were more likely to be enrolled at QLD or UA (55.6 and 44.9 percent, respectively) (χ²[12]=280.1, p<0.001), and students indicating a rural address were more likely to be enrolled at QLD or LTU (27.0 and 25.0 percent respectively) (χ²[12]=277.5, p<0.0001). Living arrangement also differed significantly among students from different institutions (χ²[12]=162.3, p<0.001).

Overall, about half of the respondents (49.7 percent) had attended a public secondary school, whether in Australia or overseas. When overseas education was not considered, students from UA and WA (60.5 and 69.6 percent, respectively) were more likely to have private education (χ²[4]=10.31, p<0.05) than those at other dental schools in Australia. With respect to ethnicity, Asian students (56.2 percent) were more likely to have attended a public high school (χ²[4]=33.2, p<0.01).

The respondents reported that most of their fathers (67.2 percent) and mothers (54.8 percent) had completed either undergraduate or postgraduate education. Fathers (73.6 percent; χ²[2]=101.1, p<0.001) and mothers (57.6 percent; χ²[2]=27.9, p<0.001) of B.D.Sc. students were more likely to have received tertiary education than parents of B.O.H. students. In reporting their parents’ occupations, there were also significant differences by course, with B.D.Sc. students more likely to have parents employed in managerial or professional occupations compared
Table 1. Demographic characteristics of Australian oral health professions students, by number and percentage of respondents to each item by school/area and total

<table>
<thead>
<tr>
<th></th>
<th>UA</th>
<th>LTU</th>
<th>MU</th>
<th>QLD</th>
<th>WA</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>(n=221)</td>
<td>(n=24)</td>
<td>(n=110)</td>
<td>(n=54)</td>
<td>(n=278)</td>
<td>(n=63)</td>
</tr>
<tr>
<td>Mean age (SD)</td>
<td>21.9 (2.6)</td>
<td>20.7 (2.7)</td>
<td>20.3 (4.1)</td>
<td>22.0 (3.8)</td>
<td>21.4 (2.9)</td>
<td>20.9 (3.3)</td>
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<tr>
<td>Age group (years)</td>
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<tr>
<td>Younger than 21</td>
<td>68 (30.7%)</td>
<td>15 (62.5%)</td>
<td>88 (80.0%)</td>
<td>28 (51.9%)</td>
<td>119 (42.8%)</td>
<td>38 (71.7%)</td>
</tr>
<tr>
<td>21 to 24</td>
<td>129 (58.4%)</td>
<td>8 (33.3%)</td>
<td>14 (12.7%)</td>
<td>15 (27.8%)</td>
<td>142 (51.1%)</td>
<td>10 (18.9%)</td>
</tr>
<tr>
<td>Older than 24</td>
<td>24 (10.9%)</td>
<td>1 (4.2%)</td>
<td>8 (7.3%)</td>
<td>11 (20.3%)</td>
<td>17 (6.1%)</td>
<td>3 (9.4%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>134 (60.6%)</td>
<td>16 (66.7%)</td>
<td>60 (54.5%)</td>
<td>43 (79.6%)</td>
<td>159 (57.2%)</td>
<td>47 (88.7%)</td>
</tr>
<tr>
<td>Male</td>
<td>87 (39.4%)</td>
<td>8 (33.3%)</td>
<td>50 (45.5%)</td>
<td>11 (20.4%)</td>
<td>119 (42.8%)</td>
<td>6 (11.3%)</td>
</tr>
<tr>
<td>Ethnic group</td>
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</tr>
<tr>
<td>Anglo-Australian</td>
<td>38 (17.2%)</td>
<td>9 (37.5%)</td>
<td>24 (21.8%)</td>
<td>22 (40.7%)</td>
<td>13 (4.7%)</td>
<td>7 (13.2%)</td>
</tr>
<tr>
<td>Asian</td>
<td>141 (63.8%)</td>
<td>7 (29.2%)</td>
<td>69 (62.7%)</td>
<td>10 (18.6%)</td>
<td>236 (84.9%)</td>
<td>29 (54.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>42 (19.0%)</td>
<td>8 (33.3%)</td>
<td>17 (15.5%)</td>
<td>22 (40.7%)</td>
<td>29 (10.4%)</td>
<td>17 (32.1%)</td>
</tr>
<tr>
<td>Place of residence</td>
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<tr>
<td>Urban</td>
<td>55 (24.8%)</td>
<td>19 (79.2%)</td>
<td>54 (49.1%)</td>
<td>31 (57.4%)</td>
<td>124 (44.6%)</td>
<td>36 (67.9%)</td>
</tr>
<tr>
<td>Rural</td>
<td>5 (2.3%)</td>
<td>3 (12.5%)</td>
<td>25 (22.7%)</td>
<td>16 (29.6%)</td>
<td>8 (2.9%)</td>
<td>7 (13.2%)</td>
</tr>
<tr>
<td>Interstate</td>
<td>108 (48.9%)</td>
<td>2 (8.3%)</td>
<td>29 (26.4%)</td>
<td>6 (11.1%)</td>
<td>31 (11.2%)</td>
<td>2 (3.8%)</td>
</tr>
<tr>
<td>Overseas</td>
<td>53 (24.0%)</td>
<td>0</td>
<td>2 (1.8%)</td>
<td>1 (1.9%)</td>
<td>115 (41.3%)</td>
<td>8 (15.1%)</td>
</tr>
<tr>
<td>Secondary education</td>
<td></td>
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<tr>
<td>Public school</td>
<td>93 (42.1%)</td>
<td>11 (45.8%)</td>
<td>57 (51.8%)</td>
<td>25 (46.3%)</td>
<td>150 (54.0%)</td>
<td>33 (62.3%)</td>
</tr>
<tr>
<td>Private school</td>
<td>122 (55.2%)</td>
<td>13 (54.2%)</td>
<td>53 (48.2%)</td>
<td>27 (50.0%)</td>
<td>118 (42.4%)</td>
<td>19 (35.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (2.7%)</td>
<td>0</td>
<td>2 (3.7%)</td>
<td>10 (3.6%)</td>
<td>1 (1.9%)</td>
<td>0</td>
</tr>
<tr>
<td>Living arrangement</td>
<td></td>
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<tr>
<td>With parents</td>
<td>46 (20.8%)</td>
<td>12 (49.9%)</td>
<td>8 (7.3%)</td>
<td>1 (1.9%)</td>
<td>112 (40.3%)</td>
<td>33 (62.2%)</td>
</tr>
<tr>
<td>Renting</td>
<td>115 (52.0%)</td>
<td>4 (16.7%)</td>
<td>48 (43.6%)</td>
<td>28 (51.8%)</td>
<td>111 (39.9%)</td>
<td>14 (26.4%)</td>
</tr>
<tr>
<td>Colleges</td>
<td>40 (18.1%)</td>
<td>4 (16.7%)</td>
<td>51 (46.4%)</td>
<td>20 (37.0%)</td>
<td>31 (11.2%)</td>
<td>3 (5.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>20 (9.1%)</td>
<td>4 (16.7%)</td>
<td>3 (2.7%)</td>
<td>5 (9.3%)</td>
<td>24 (8.6%)</td>
<td>3 (5.7%)</td>
</tr>
</tbody>
</table>

B.D.Sc.=Bachelor of Dental Science or equivalent; B.O.H.=Bachelor of Oral Health; SD=standard deviation

Note: Queensland category includes both Griffith University and James Cook University.
to B.O.H. students (fathers: 74.1 percent vs. 38.9 percent, $\chi^2[2]=63.1, p<0.001$; mothers: 57.6 percent vs. 40.5 percent, $\chi^2[2]=27.9, p<0.001$).

**Choosing Oral Health as a Career**

When these students were asked about their first three course preferences, the largest proportion named dentistry or oral health (41.0 percent), followed by medicine (18.9 percent). Other courses named were from a range of health-related professions (e.g., optometry, pharmacy), natural and physical sciences (e.g., biology), engineering and related technologies, law, management, and commerce. The majority of the responding students (66.8 percent) said they had made their career choice in high school, including 44.5 percent who made their choice in late high school. The majority (57.1 percent) said they began undergraduate study immediately after completing high school. Overall, QLD and LTU B.O.H. students were least likely to have begun their course immediately after high school (33.3 percent) compared to other institutions ($\chi^2[7]=49.8, p<0.001$). Of those who did not start immediately, 33.6 percent commenced their oral health course within one year of completing high school, and 59.5 percent began within three years. Of those who did not start immediately, the majority (60.1 percent) were studying within three years. Of those who did not start immediately, the majority (60.1 percent) were studying another course, 34.9 percent were working, and the remaining 5.0 percent were involved in other activities or unemployed. Of those who were working, 18.5 percent were working as dental assistants, and another 1.7 percent worked as dental hygienists. The majority (81.8 percent) of those who worked as dental assistants enrolled in B.O.H. programs.

For the majority of the respondents (85.3 percent), self-motivation was the most important influence for the selection of an oral health profession (Table 2), followed by parental influence, with mother and father named as equally influential (36.4 and 36.1 percent, respectively). Other persons in the dental profession, relatives or family friends, and family dentists were somewhat influential (24.8, 23.4, and 23.4 percent, respectively). Few students indicated that vocational counselors (2.6 percent) or teachers (2.2 percent) influenced their decision.

Among the reasons for choosing an oral health profession, caring for and helping others was the most important reason among these students (86.6 percent). Furthermore, with two exceptions (“better chance of entering and completing dental course than other courses” [15.4 percent] and “there is not much on-call work” [43.5 percent]), the majority of the items in this assessment were reported as important or highly important reasons by more than 50 percent of the respondents. B.D.Sc. students were significantly influenced by the following reasons compared to B.O.H. students: job security (79.3 vs. 68.0 percent; $\chi^2[2]=14.2, p<0.001$); expected lifestyle (78.5 vs. 60.2 percent; $\chi^2[2]=32.1, p<0.001$); flexible hours (76.6 vs. 55.5 percent; $\chi^2[2]=27.4, p<0.001$); easy to find employment (72.4 vs. 60.2 percent; $\chi^2[2]=11.8, p<0.001$); monetary advantages (70.3 vs. 57.0 percent; $\chi^2[2]=16.2, p<0.001$); desire to work independently (68.1 vs. 57.9 percent; $\chi^2[2]=7.0, p<0.05$); time to be with my family (67.8 vs. 50.8 percent; $\chi^2[2]=17.2, p<0.001$); more regular hours than other careers (60.7 vs. 46.1 percent; $\chi^2[2]=14.0, p<0.001$); being your own boss (57.5 vs. 32.8 percent; $\chi^2[2]=33.9, p<0.001$); and not much on-call work (46.6 vs. 27.3 percent; $\chi^2[2]=24.6, p<0.001$). Males were more significantly influenced than females by the following reasons: expected lifestyle (80.8 vs. 72.3 percent; $\chi^2[2]=13.0, p<0.05$); monetary advantages (75.9 vs. 63.3 percent; $\chi^2[2]=18.9, p<0.001$); desire to work independently (72.6 vs. 62.5 percent; $\chi^2[2]=9.5, p<0.01$); and being your own boss (63.5 vs. 47.3 percent; $\chi^2[2]=22.1, p<0.001$).

With respect to future career aspirations, the largest proportion of these B.D.Sc. students (33.6 percent) were undecided at the time of the survey. Another 31.8 percent selected general dentistry as their future career, followed by specialist (22.4 percent) and other (10.0 percent). For those who indicated a desire to become specialists (n=164), the most frequently named specialties were oral surgery (25.8 percent) and orthodontics (23.9 percent). The least frequently named (<2.5 percent) were oral medicine, maxillofacial radiology, and special needs dentistry. Another 20.2 percent said they were undecided. No significant difference was found between the institutions by gender. Careers as educators or researchers were the least frequently named: n=1 (0.1 percent), respectively. No significant differences were found among the courses, year levels, and ethnicity. However, those who indicated plans for careers in education were mostly from the MU B.O.H. program (31.3 percent). By gender, males were more likely to report specialist as their future career aspirations than females (29.6 vs. 17.9 percent; $\chi^2[5]=26.9, p<0.001$). Additionally, most (87.5 percent) of those who indicated career aspirations as educators were female.
The largest proportion of the respondents (40.2 percent) said they wished to work in either the public or private sector, while 26.3 percent preferred private practice only and 9.2 percent selected public sector only. Another 15.7 percent were undecided, and few (7.8 percent) selected further studies or university involvement. No significance differences were found among course, institution, place of residence, or ethnicity. However, females were more likely to report a mix of private and public involvement than males (44.8 vs. 34.4 percent), while males were more likely to report the private sector only than females (30.1 vs. 23.9 percent; \( \chi^2[7]=21.8, p<0.01 \)).

When asked about their preferred practice location two years after graduation, the majority of the respondents (51.5 percent) said they wished to work in a city, with 31.4 percent preferring a large city, while 19.0 percent preferred to work in the country and 1.4 percent overseas or other locations. Another 28.1 percent were undecided. When only domestic students were considered, Anglo-Australian students (34.3 percent; \( \chi^2[6]=29.8, p<0.001 \)) were more likely to select country as their location of practice. By institution, significantly fewer students from MU (14.0 percent) and UA (16.8 percent) reported rural areas as their preferred location for future practice compared to the other schools, ranging from 30.4 percent in WA to 25.0 percent in QLD (\( \chi^2[12]=31.9, p<0.001 \)).

### Discussion

Course structures, entry requirements, and selection procedures varied among the programs included in this study, and that variation affected the sociodemographic profile of the students. Despite this, the profile of these oral health profession students was consistent with previous findings regarding B.D.Sc. students in Australia.\(^{1,4} \) It is evident that, in
the future, the oral health professions will continue to be dominated by females, especially among professionals holding the B.O.H. degree. However, despite this dominance, trends suggest that male participation in B.O.H. programs will increase. In 2003, only 1.4 percent of practicing dental therapists in Australia were male, but the percentage increased to 2.5 percent in 2005. In 2005, 3.5 percent of practicing hygienists were male. Our study found that 19.1 percent of B.O.H. students were males.

Similar to other studies, the majority of students in our study were single and began their course immediately after high school. Other characteristics consistent with previous studies included dental students’ backgrounds from high socioeconomic groups or highly educated families. However, in contrast with previous studies, we found a slightly higher proportion of public school graduates among our respondents. Regarding racial and ethnic groups, the largest proportion of students in our study were Asian, with Anglo-Australian students in the minority among those earning the B.D.Sc. This finding emphasizes the need for educators to gain a better understanding of the different learning approaches of culturally and linguistically diverse Australian and international students in order to assist these students with their learning. Additionally, within the present sample, despite English-language entry prerequisites, there were some students who rated their English capabilities as poor. Academic dental institutions should make special efforts to identify these students and support them in their studies. On the other hand, the varied language skills of the future oral health workforce will be a significant resource, with major implications for practice. However, the possession of culturally competent skills should not be taken for granted.

A high proportion of the students in our study said they had selected their oral health profession in their first three course preferences. Although some caution is required when interpreting these results, it appears that dentistry was not an alternative or less preferred course than medicine as found in other studies, nor does it seem dentistry was selected because of the nature of dental practice (e.g., not much on-call work). Of those who did not start their oral health studies immediately after high school and had worked as dental assistants, the majority were enrolled in a B.O.H. program.

Motivation factors for career choice were generally similar among both oral health professions in the study. Self-motivation or parental influence and the desire for a career caring for and helping other people were the dominant influences in our respondents’ decision. Consistent with other studies, gender differences in career choice motivation were present. Male students were more attracted to the monetary advantages and autonomy associated with the profession than were females. In terms of plan of work, these students said they were more likely to practice general dentistry, within metropolitan regions, and with a mixture of public and private practice experience after graduation.

Our results suggest a possible need to promote the full range of dental specialties to undergraduate students to prevent future shortages. There are many specialty pathways oral health professionals can pursue other than oral surgery and orthodontics, the most frequently mentioned in our study. However, there are also additional roles and career paths to which students should be exposed. Oral health professionals’ skills are needed in areas as diverse as forensic dentistry, special needs, public policy, oral health science, and education. Our findings highlight the need to promote the full range of career pathways available for oral health professionals as multiple ways of practicing dentistry. Such information can help students match their interests and skills to the various career paths. Additionally, it is important to have role models for future oral health professionals.

A slightly higher proportion of students in our study reported a rural address compared to a previous study. However, our higher proportion was largely influenced by students from schools not located in metropolitan centers (LTU and the two schools in Queensland), which appear to be attracting more students from rural regions. Furthermore, the proportion at MU decreased, which may be the result of the opening of a rural school in the state of Victoria. Our results support the view that students from rural backgrounds are more likely to express a desire to practice in a rural location (48.1 percent of rural respondents) and are consistent with the evidence that rural background and rural location of under- and postgraduate education increase the probability that doctors will work in rural practices. The alignment found in our study may support the need for programs that attract rural students and promote working in areas with shortages of oral health professionals. However, longitudinal studies of students’ practice location after graduation should be conducted. Future studies using qualitative methods should also explore the differences in commencement of studies, future career paths, and aspirations related to gender.
and profession that emerged in our analysis. Such a methodology would also provide a better understanding of what “self-motivation” really means and how it relates to career paths and aspirations (perceived lifestyles, desire to work independently, etc.).

Our findings indicated an increase in the proportion of students from more privileged backgrounds, particularly those in the B.D.Sc. programs. Attention to the admissions process may be warranted to achieve better representation from various socioeconomic groups in the oral health professions. Admissions committees should also pay attention to recruitment of students from culturally and linguistically diverse groups and rural backgrounds in order to produce professionals most likely to practice in areas with populations with the greatest needs. Recent articles have suggested such strategies as dental intern programs, mentoring support, accommodation and travel assistance for dentists moving to rural areas, rural allowances, and international campaigns for recruitment to the public dental system.

Additionally, to increase rural exposure, dental schools have introduced programs in the final years of their curricula to encourage students to consider practicing in rural areas by providing positive, high-quality clinical education and training experiences for dental students in those areas. This program is supported by the Australian government and helps students to be exposed to the rural practice of dentistry, to deal with social aspects of dentistry and patient care in rural areas, and to communicate with rural communities and better understand oral health needs in those environments. This program seems to be effective at enhancing the future dental workforce’s ability to respond to rural and remote shortages, positioning students to understand the links between dental public health services, the workforce, and the benefits of this synergy.

Although in most cases the achieved response rates in our study were high, the self-selection of participants and self-reporting nature of the data are limitations that should be acknowledged. Additionally, data were collected using an electronic survey, which may have biased the results. As the electronic survey response may be affected by the level of computer literacy, low users of electronic resources may be underrepresented.

Despite these limitations, the results contribute to improved knowledge of the current oral health profession student population. The study addressed the need for a better understanding of career choice among Australia’s oral health professionals, as well as health professions students in countries where students come from culturally and ethnically diverse groups. This study was designed to contribute to that understanding and to inform policy development for the provision of community-oriented oral health services for the public.

Australia relies on a strong workforce to provide appropriate oral health care to its population, and the need to address shortages of oral health professionals has been highlighted. In response, the last ten years have seen significant increases in opportunities for students wanting to pursue careers in oral health. This study provides some insight into how these policies have affected the future workforce, identifies issues for analysis, and clarifies the role of each university in addressing the current inequalities in dental education. These inequalities are related to the decreased enrollment of lower socioeconomic groups, limited rural/remote involvement, potential language issues, and support that may be needed for students living away from home.

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