Victorian Allied Health Workforce Research Program

Dietetics Workforce Report

March 2018

VICTORIA State Government
Health and Human Services

Dietetics Workforce Report

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, March 2018

Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. Where the term ‘Aboriginal’ is used, it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

Contents

Contents **4**
Abbreviations and acronyms 6
Executive summary **7**
Overview 7
Key findings 7
Conclusions 9
Introduction **10**
Who are dietitians? 11
Method **12**
Macro 12
    Environmental scan 12
Meso and micro level data 12
    Focus groups 13
Research governance 13
Distribution approaches 13
Analyses 14
Data limitations 14
Results **15**
Responses and respondents 15
    Allied health workforce questionnaire 2 15
Capacity 17
    Key findings 18
    Workforce distribution 19
    Demand 27
    Supply 28
    Organisation of the workforce 38
    Scope of practice 44
    Workforce movement 47
Capability 53
    Key findings 54
    Evidence / knowledge base 54
    Training and continuing professional development 55
    Clinician knowledge and skills 60
    Support contexts to enhance capability 64
Engagement 68
    Key findings 69
    Individual role engagement 69

Intra-professional engagement....72
Inter-professional engagement....73
Engagement with the community and society....74

Conclusion 76

References 77

Appendix 78

Abbreviations and acronyms

ABS	Australian Bureau of Statistics
AH	Allied health
AHA	Allied health assistant
AHPRA	Australian Health Practitioner Regulation Agency
AHWQ2	Allied Health Workforce Questionnaire – 2
APD	Accredited Practising Dietitian
CPD	Continuing professional development
DAA	Dietetic Association of Australia
DCC	Dietetic Credentialing Council
DVA	Department of Veterans Affairs
GP	General practitioner
HEN	Home enteral nutrition
IT	Information technology
MBS	Medical Benefits Scheme
PEG	Percutaneous Endoscopic Gastrostomy
NDIS	National Disability Insurance Scheme
NFP	Not for profit
TPN	Total parental nutrition

Executive summary

Overview

This report provides an overview of the dietetics workforce in Victoria in 2017. It is based on survey responses from 1,422 individual dietitians (approximately 38% of Victorian dietitians registered with the Dietitians Association of Australia (DAA) in February 2018 (DAA, 2018)) four focus groups involving 17 participants, and surveys from 89 employers and managers of organisations that provide dietetic services in Victoria.

When contrasted with 2018 membership data from the DAA, the respondent cohort included an over-representation of individuals who were female, employed in the public sector, and those living in regional and rural areas. The age breakdown of respondents was comparable to the DAA membership data.

Key findings

Dietetics	AHWQ2 survey	DAA, 2017[a]
Victorian population	526	1,422
Female	96%	88%
Aboriginal and / or Torres Strait Islander	0.2%	
Age 35 years and under 55 years and older	54% 10%	55% 9%
Median age (years)	34	34
Median income	\$60,000 to \$69,999	
Public sector	78%	
Not for profit sector	8%	
Private sector	3%	
Principal area of practice	Chronic disease management (21%) Nutritional support (21%)	-
Reporting advanced practice role	53%	-
Work with allied health assistants	34%	-
Reported use of telehealth	20%	
First qualification to practise	Bachelor degree – 42%	
Hold PhD	2%	-
Intention to stay in profession for more than five years	72%	-
Work for two or more employers	23%	
Of those with a clinical supervisor, dietitian as supervisor	57%	-
% of workforce in rural areas	7%	

[a] *Source: DAA membership data, 2018*

The dietetics workforce in Victoria is a young, female-dominated and growing profession. Dietitians worked across public, private and not-for-profit and sectors, with the majority employed in the hospital inpatient setting (40%). Nutritional support and chronic disease management were the most common primary areas of practice for dietitians. Advanced roles were carried out by 53% of dietitians, most commonly percutaneous endoscopic gastrostomy, home enteral nutrition management and total parental nutrition. Formal multi-disciplinary team structures were wide spread with the majority of dietitians (69%) working with adults and older adults.

Participants in this research reported good job satisfaction. Key contributors to this satisfaction included work-life balance, the type of work and the clients they worked with. The vast majority of dietitians (72%) intended to stay within the dietetics profession for six years or more. Across their careers, dietitians are moving away from rural and remote areas towards metro and regional areas and from other states to Victoria.

Key areas of concern were inadequate resourcing to meet population needs such as the increasing prevalence of obesity and diabetes. Lack of funding and changes in funding models has resulted in dietitians not providing services to all of those who would benefit from seeing them.

A recurrent theme was an absence of career development opportunities and difficulty in securing permanent employment. Career pathways are not clear and a lack of post-graduate training pathways and opportunities were highlighted. Although dietitians had the skills to complete their work, there was evidence of a need to improve non-clinical skills, particularly in management and communication, and marketing skills. Dietitians working in the private sector reported a need for business skills to be included in degree courses. Dietitians wanted to develop more innovative evidence-based practices, particularly in prevention and early intervention activities.

The dietetics profession in Victoria has experienced high-level growth with an increase of 95% in student completions from Victorian universities between 2010 and 2016. Difficulty in gaining employment was reported by recent graduates and also more experienced dietitians wishing to move positions, particularly those who want to move from the community sector to the acute setting.

Despite working in a clinical role 30% of dietitians had no clinical supervisor. Dietitians were concerned with post first-year supervisory structures in the private sector and highlighted the need for early career graduates to be supported.

Dietitians perceived the understanding of their role to be low within the general population and with other health professionals. To support the development of the dietetic professions there was a desire for mandatory registration similar to other allied health professions. In addition, corporate sponsorship of dietetics activities was considered to discredit the profession.

Conclusions

Key areas of consideration for the dietetics workforce going forward include:

- Ensuring there are enough publicly-funded, secure positions, and other funding options, to meet the growing demand of an ageing population with increasing prevalence of chronic conditions such as obesity and diabetes, and to address the need for increased prevention and early intervention.
- Need to strengthen the evidence and knowledge base of the profession to improve referrals and develop business cases for optimal staffing levels to help improve patient outcomes.
- Provide more opportunities for career development and a clear career progression pathway, taking into consideration the need for secure employment and balancing parental responsibilities.
- Developing post-graduate training pathways to provide a broad range of skills to support dietitians in developing practice areas. As well as supporting clinical practice, such as extended scope of practice, this should include developing non-technical skills of professionals particularly management and communication skills. Business skills should be included into existing dietetics training pathways.
- Review the supply of dietitians from Victorian universities to ensure supply does not outstrip demand. This is particularly important due to a potential increase in the number of Victorian universities delivering dietetics training in the near future.
- Consider the availability and appropriateness of supervision and support structures within the profession and ensure these can be utilised across all sectors.
- Improving the understanding of the profession amongst the community and other health professionals and consideration of issues that would support the professional status of dietitians.

Introduction

The Victorian Allied Health Workforce Research Program (the program) aims to contribute to the evidence base of 26[1] selected Victorian allied health (AH) professions in the public, private and not-for-profit (NFP) sectors in Victoria. The data will be used to inform the policies and programs of the Department of Health and Human Services, provide a platform of evidence on which to build further understanding and development of the AH workforce, as well as guide any improvements to the associated education and training system.

This report presents the data arising from research on the dietetics profession workforce in Victoria.

Please note:

Terminology used in this report reflects that used in the survey process by Southern Cross University, rather than standard Department of Health and Human Services terminology.

The 11 profession specific reports which form the meso and micro levels of this research (as described in the methods section) are based on similar but not identical surveys varied to meet the individual requirements of each investigated profession. Comparative data reflecting the Victorian state context is included wherever possible. While significant effort has been made to make each of these reports as consistent as possible in its presentation of material, differences in available comparative data and other profession specific differences have resulted in some variations in the material included and its presentation.

Throughout these reports the terms *grade* (e.g. 1, 2, 3 etc.) or *level* (junior, intermediate, senior) are used in both the text and quotes from research participants. The term grade refers to the different employment classifications used in the enterprise bargaining agreements (EBA) that individuals may be employed under. These EBAs (awards) generally cover the public sector employees and larger private sector organisations. These grades determine pay rates and benefits, and in some cases job responsibilities and job titles. The exact description and meaning of each grade will vary with the different awards. For individuals who were not employed under these awards (e.g. private business owners, contractors etc.) the term level was used to try and equate their job responsibilities and pay to those employed under the formal EBA structure. These terms were also used to determine the breakdown and specific issues relating to junior, intermediate and more senior members of the specific professions in Victoria.

[1] In the earlier reports from this project (2016 and 2017), the Department of Health and Human Services (Victoria) recognised 27 allied health professions in Victoria. In 2017 the Department of Health and Human Services combined the two aspects of medical physics (diagnostic imaging and radiation oncology) into one profession – Medical Physics, resulting in 26 allied health professions being recognised in the State.

Background

Who are dietitians?

Dietitians are primary contact health care professionals who contribute to health prevention and treatment by optimising the nutrition of communities and individuals. The primary goal of dietitians is to apply the science of nutrition to influence the environmental factors affecting food intake and eating behaviour (Dietitians Association of Australia, 2015). Dietitians work in many different fields including patient care, private practice and community and public health; food industry; research and sports nutrition.

Dietitians are differentiated from nutritionists through the completion of an accredited program of study. Therefore, in Australia, all dietitians are considered to be nutritionists; however nutritionists without a dietetics qualification cannot take on the role of a dietitian.

In Australia, dietitians work with people to help treat a wide range of conditions at any stage across the lifespan. That is, babies and children, adolescents, adults and older people. Dietetics practice is person-centred, and may be delivered directly to individuals and groups of individuals, or strategically to communities and society. In Victoria, dietitians work in a wide range of public, private and not-for-profit (NFP) settings, including, but not limited to:

- hospitals
- community health centres
- aged care facilities
- people's homes, including group homes
- community settings
- childcare centres, kindergartens, preschools, schools and other educational facilities
- correctional facilities
- corporate and industrial settings
- government departments and services

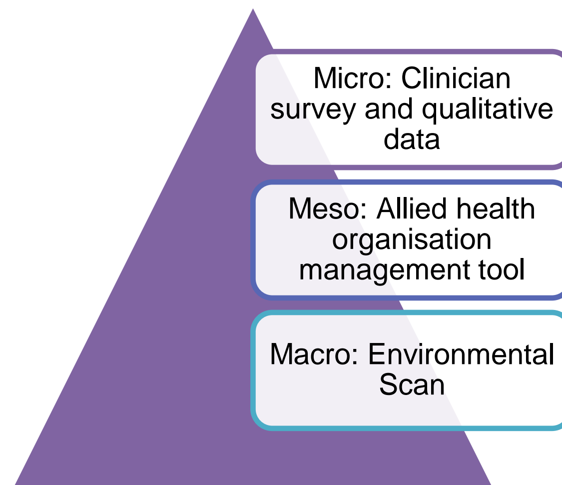
The dietetics profession is not registrable under the *National Registration and Accreditation Scheme / Australian Health Practitioner Regulation Agency* (AHPRA). The *Dietitians Association of Australia* (DAA) provides self-regulation for the profession and is a member of the *National Alliance of Self Regulating Health Professions*. Dietitians can be credentialed by the DAA as an *Accredited Practising Dietitian* (APD). The credentialing program is overseen by the *Dietetic Credentialing Council* (DCC), an independent council of the DAA Board. Only APDs are eligible for funding under Medicare or the Department of Veterans' Affairs (DVA).

The minimum level of qualification to be eligible to practise as a dietitian is a four-year accredited undergraduate degree or a two year full-time graduate entry masters degree.

Method

A three-tiered approach was used to capture workforce data at macro, meso and micro levels (Figure 1).

Figure 1: Three-tiered research approach



Macro

Environmental scan

The environmental scan examined 26 AH professions in Victoria during the first six months of the research program. The process involved engagement with each of the professional associations regarding workforce trends and issues alongside an analysis of a range of existing data sources. A 'snapshot' was generated for each profession which included key workforce statistics, workforce trends and issues presently affecting the profession, and those likely to affect the profession in the future. An environmental scan has been produced as a stand-alone document for each profession. Relevant findings from the dietetics profession environmental scan have been incorporated into this report.

Meso and micro level data

Subsequent to the environmental scan, four professions (physiotherapy, sonography, speech pathology and allied health assistance) were analysed in-depth in 2015 – 16, and a further three professions (occupational therapy, social work and psychology) were analysed during 2016 – 17. In the final phase of this project (2017) an additional four professions were included in the in-depth analysis (audiology, dietetics, exercise physiology and medical laboratory science). This analysis included organisational and individual level approaches as described below. These professions were selected by the Department of Health and Human Services for further study because they were either high priority professions or they were unregistered professions with limited existing data available. The in-depth analysis involved the use of a standardised survey and focus groups with both standardised and profession specific questions.

In year one of the research program, three separate surveys were used to access data at an individual (Allied Health Workforce Questionnaire), team (Allied Health Organisation Mapping Tool) and organisation level (Allied Health Human Resources Tool). For year two and three of the program, the questions from the three surveys were combined into a single tool (Allied Health Workforce Questionnaire 2 (AHWQ2)), and internal survey logic was used to direct respondents to the appropriate questions according to their role/s or perspective within an organisation.

The AHWQ2 collected the following information:

At the organisational level, team leaders, managers or directors of human resources were asked to provide information about the geographic location, numbers and grades of staff, skill set, recruitment and retention issues, and organisational contexts of the profession. It was completed at a regional or organisational level, typically by a team leader or human resources department, to provide detailed information about the workforce structure and organisation.

Individual clinician data captured information about education and training, the nature of work, location of work, job satisfaction and career development opportunities, as well as open ended questions exploring issues that the profession specifically identified as being important.

Participants who completed the AHWQ2 were invited to provide their contact details for future follow-up.

Focus groups

Survey respondents who agreed to be followed-up via email were invited to participate in one of four focus groups. One group was specifically for early career professionals, while the remainder were heterogeneous, but designed to include a mixture of participants according to rurality and public, private and NFP sectors. The focus groups explored issues that were highlighted in the survey responses. The questions were developed in consultation with the reference groups and Department of Health and Human Services. Each focus group was held via teleconference using Zoom and was approximately 90 minutes. The focus groups were recorded and detailed contemporaneous notes were taken and used as the basis for analysis. Where necessary the recordings were accessed for clarity or confirmation.

Research governance

The research was overseen by an overarching research advisory group comprising experts from many health disciplines and sectors. In addition, each of the four professions had a discipline specific reference group comprising members of the profession who represented specific sectors or subgroups (such as new graduates, public, private and NFP sectors, and academics). The advisory group and the reference groups were consulted about the research approach, survey distribution methods and engagement strategies, as well as providing substantial input into the survey content and piloting. The discipline specific reference groups also advised on the content of the focus group questions, aided the interpretation and verification of the final reports, and provided feedback on the penultimate drafts of the discipline specific reports.

Distribution approaches

Surveys were initially distributed through the reference groups, the professional associations and Department of Health and Human Services contact lists. In addition, a communications database was developed comprising employers, professional networks and associations, individual professionals and relevant contacts for each profession. This database has continued to be developed throughout the research program.

At the launch of the survey, the research project team distributed over 2,000 emails to employers of dietitians. These emails provided information about the research program and a link to the survey. The following organisations received emails:

- Public hospitals (94) and private hospitals (61), as listed by the Victorian Government
- Relevant National Disability Insurance Scheme providers in Victoria (357), as listed on the National Disability Insurance Agency website
- Community services (138) as listed by the Victorian Government
- Aboriginal Community Controlled Health Organisations (23)
- Relevant Comcare providers (35), as listed at https://www.comcare.gov.au/
- Victorian City and Shire Councils (79)
- Rural Workforce Agency of Victoria

- Services for Australian Rural and Remote Allied Health
- Indigenous Allied Health Australia
- Victorian Primary Health Networks (5)
- Victorian Primary Health Network Alliance

In addition, emails, the survey link and information about the survey was sent to professional groups associated with dietetics including DAA, Nutrition Society of Australia, Victorian Dietitians in Management, and Dietitian's Connection; and Victorian universities that offered dietetics courses.

A reminder email was sent to all relevant organisations two weeks prior to the close of the survey.

Although the intention was to send a third and final email to all organisations in the final days of the survey, the strategy was changed to specifically focus on use of social media and direct communication to members through professional associations. This change was made due to feedback that stakeholders were frustrated by the repeated communication in the context of high expectations to contribute to a range of research that also involved survey completion.

Other methods of distribution and marketing included Department of Health and Human Services newsletters, marketing on social media (e.g. Facebook and Twitter), a presentation at the Victorian Allied Health Research Conference, regional conference presentations, and presentations to individual professions.

The survey was circulated between 7 September 2017 and 30 October 2017.

During the time the survey was open the program's Facebook page made 160 posts, had 292 new followers, received 50 comments, 121 shares, 411 clicks on the link and 12 inbound messages. The Twitter account made 108 tweets, had 20 followers, and made 40 points of engagement.

Analyses

The Qualtrics survey tool generates descriptive statistics (frequencies, means, standard deviations, etc.) for all questions which are downloadable in Microsoft Word and Microsoft Excel formats. Further analyses were undertaken using cross tabulations of specific questions results, and comparisons with other available data from the Australian Bureau of Statistics (ABS) Census, Health Workforce Australia, Department of Health and Human Services, and profession specific associations.

Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services and private providers means that the data may not be representative of the profession.
- It was difficult to engage with the NFP and private dietitians. As a result, it is not possible to determine the representativeness of the data for these groups.
- The focus group participants were invited from the AHWQ2 respondents who agreed to be followed-up. This may have resulted in selection bias as only 36% of all survey respondents agreed to further follow-up.

Results

The source of data in the tables and figures going forward is the AHWQ2 survey data unless otherwise stated.

Responses and respondents

Respondent numbers for each of the different data collection methods are presented in Table 1 below.

Table 1: Responses and respondents

AHWQ2 (individual respondents)	AHWQ2 (organisational respondents)	Focus groups
536	89	Group 1 – 7 participants Group 2 – 2 participants (early career) Group 3 – 4 participants Group 4 – 4 participants

Allied Health Workforce Questionnaire 2

The AHWQ2 survey was completed at both the organisational and individual practitioner level. The respondents to the organisational / managerial level questions were presented with 12 questions, plus four questions that were conditional on answers to previous questions; the individual clinicians were presented with 66 questions plus seven questions that were conditional on the answers from previous questions. Completion of the survey was voluntary and respondents, both organisational and individual, had the opportunity to choose if they wished to answer a question or not. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 536 dietitians completed at least one question on the survey and submitted their survey. This represented 38% of the 1,422 individuals working in Victoria as an APD in 2017 (DAA, 2017). The survey was completed[2] by 375 individual dietitians. The range of responses to an individual question was from 50 to 2,732[3]. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not (Figure 2).

A total of 89 employers or managers of dietitians completed the AHWQ2. The organisations they represented employed a total of 546 full time equivalent (FTE) dietitians, with a range of one to 67 dietitians employed by a single organisation. The vast majority of these people were team leaders of a single or multiple teams, and five per cent (5%) were CEOs or human resources representatives of a large organisation.

[2] A survey was considered complete if the respondent answered the last survey question and submitted the survey, even if they did not provide answers to every survey question.

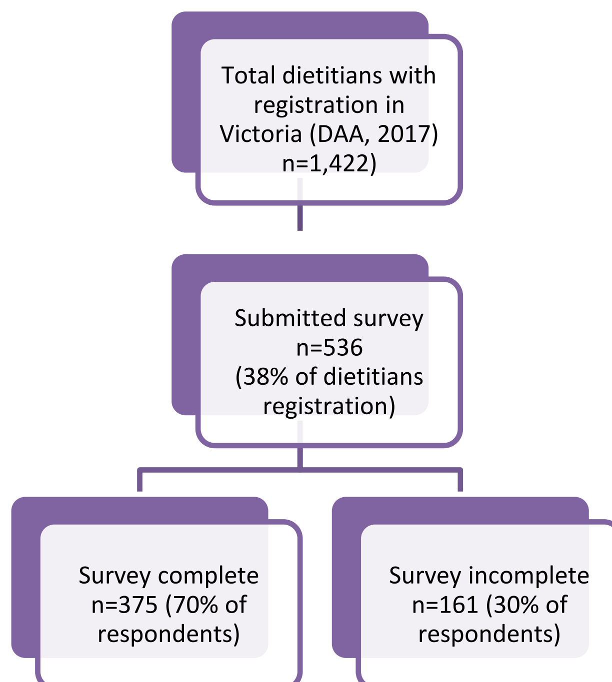
[3] Some questions allowed for multiple responses

Table 2: AHWQ2 respondents compared to other data sources

Demographics	AHWQ2		Dietitians Association of Australia (2017)[a]		Victorian Public Service Commission (VPSC)[b]		ABS Census (2016)[c]	
	n[a]	%	n	%	n	%	n	%
Total	526		1,422					
Female	452	96	1,257	88	2,587	98	1,237	94
Aboriginal and / or Torres Strait Islander	1	0.2	-	-	-	-	-	-
Australian citizen / permanent resident	468	99	-	-	-	-	-	-
Age 55 and over	48	10	-	9	238	9	111	9
Age 35 and under	249	54	-	55	1,610	61	717	58
Median age (years)	34	-	34	-	36	-	-	-

[a] *based on the number of respondents to each question in the demographics section of the survey*
[b]*VPSC data is based on payroll categories and includes more than APD*
[c] *ABS Census data is for 'Nutrition Professionals' and therefore has a wider scope than just dietitians*

Figure 2: Survey responses



Capacity

Capacity refers to the ability of the profession to meet the needs of the community in terms of workforce numbers and allocation of staff, skill mix, ratios, geographic distribution, organisation of the workforce, and their ability to influence these factors at a political, professional and organisational level (Figure 3).

Figure 3: Workforce capacity framework

Key findings

- Fifty-four per cent (54%) of respondents were 35 years and under, with the age range being from 23 to 70 years.
- Although most respondents (59%) were from metropolitan regions, there was an over-representation from regional areas relative to DAA data (DAA, 2017).
- Most participants were employed in the public sector (69%), were in permanent employment (77%), and worked Monday to Friday during the day (89%).
- Sixty-three (63%) of respondents were employed at an intermediate level (grade 2) or below. Grade 2 (46%) was the most prevalent employment level.
- Adults and older adults were the age group supported by the greatest proportion of respondents (41% and 28% respectively). Sixteen per cent (16%) of respondents worked across the age groups of infants, children, adolescents or young adults. Fourteen per cent (14%) worked across all age groups.
- On average, respondent caseloads included 6% of people from Aboriginal and / or Torres Strait Islander backgrounds and 30% from culturally and linguistically diverse backgrounds.
- The most prevalent service delivery settings were hospital inpatient (40%), community (20%), and hospital outpatient (14%).
- Nutritional support (21%), chronic disease management (21%), diabetes (8%), paediatrics (7%), aged related conditions (6%) and overweight and obesity (5%) were the most frequently reported primary areas of practice.
- Annual numbers of students completing dietetic qualifications leading to eligibility for APD has increased by 95% from 65 in 2010 to 127 in 2016.
- Eighteen per cent (18%) had two employers, 23% and 33% had non-permanent contracts with their first and second employer respectively.
- Changes in location across careers showed a trend to moving to Victoria from other states and from rural and remote areas to working in metro and regional areas.
- Most respondents (72%) intend to stay in the dietetics profession for six (6) years or more.
- Advanced roles were carried out by 53%, of which PEG management (14%), HEN (11%) and TPN (10%) were the most common.
- Telehealth was used by 21%, more frequently in outer-regional and rural areas. Improved IT infrastructure and accessibility was highlighted as a need by clinicians across all sectors.
- Just under a quarter (22%) of organisations reported receiving more than 50 applications for junior positions. No positions were advertised in 43% of organisations. Rural areas reported difficulties in retaining new graduates past 18 months and therefore not capitalising on the on-the-job training they provided.
- Demand for services was reported to be high and exceeds available resources. Reported staff impacts included reduced job satisfaction, increased sick leave and burn out.

Workforce distribution

Demographics

Based on the most recently available data, in December 2017 there were 1,422 APDs registered in Victoria with DAA.

Of the total cohort of 536 AHWQ2 respondents, 89% (n=424) were employed in the dietetics workforce in Victoria at the time of completing the survey. (See Appendix Table 1 for reasons why respondents were not working as a dietitian.)

As detailed in Table 2, the dietetics respondents were predominantly female (96%, n=452). This is higher than the DAA proportion of 88% female dietitians in December 2017.

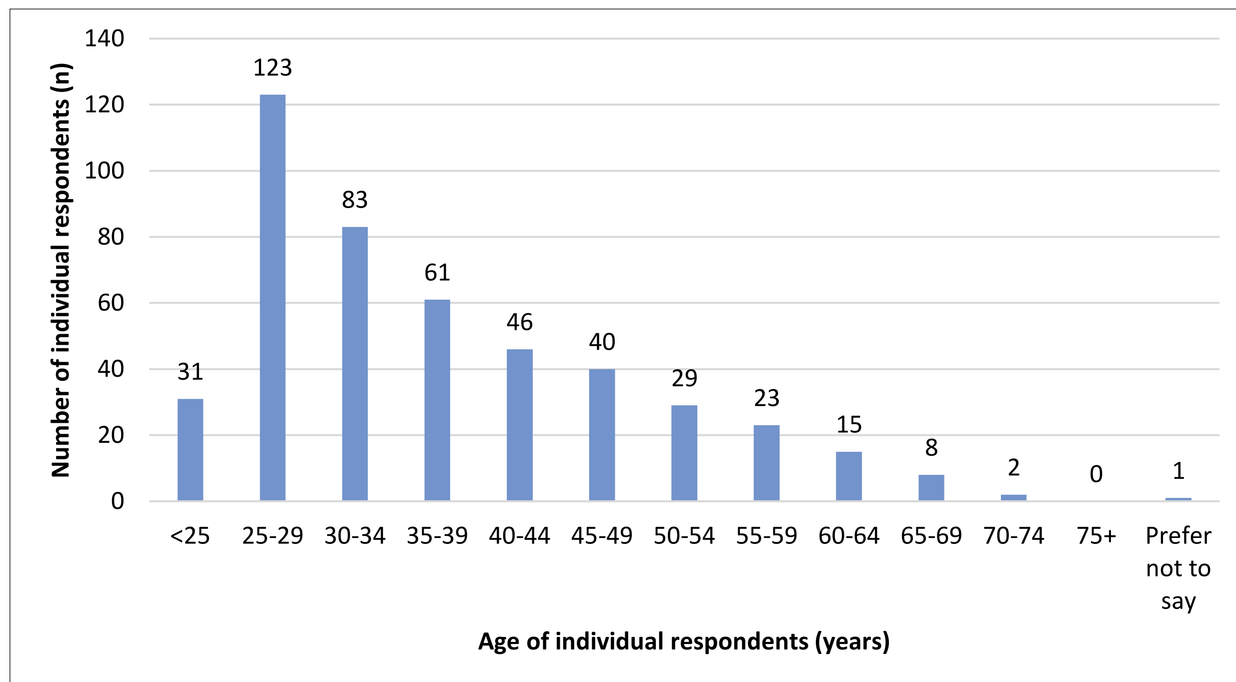
Over half (54%, n=249) of the AHWQ2 respondents were age 35 years and under, and 10% (n=48) were age 55 and older. The mean age of dietetic respondents was 37 years (range 22 – 73 years) and the median age was 34 years. This is very similar to the current membership data from DAA (December 2017) which showed 55% of members were age 35 and under, 9% age 55 and older, and the membership had a median age of 34 years (Table 3 and Figure 4).

Table 3: AHWQ2 respondent demographics (n=537) compared with DAA APD data (2017)

Demographics	AHWQ2		DAA 2017	
	n[a]	%	n	%
Female	452	96	1257	88
Aboriginal and / or Torres Strait Islander	1	0.2	-	-
Australian citizen / permanent resident	468	99	-	-
Age 55 and over	48	10	-	9
Age 35 and under	249	54	-	55
Median age (years)	34	-	34	-

[a] *based on number of respondents to each question in the demographic section of the survey*

Figure 4: Age in 2017 (n=462)



Geography

The dietetics respondents were predominantly from metropolitan areas (64%, n=251), including 46% (n=182) who described their main region of work as inner-metro and 17% (n=69) as outer-metro. This is similar to the 65% reported by DAA as being located in a major city, however if the 23% of DAA members who did not specify a region of work are removed, then 85% of DAA members reported being located in a major city (DAA, 2017). The actual number of DAA members who work in a metro or large urban area would be expected to be between 65 and 85%. In combination, inner-regional, outer-regional, rural and remote respondents made up 37% (n=144) of the AHWQ2 respondents, substantially higher than the combined 13% reported by the DAA for regional, rural and remote (DAA, 2017) (Table 4).

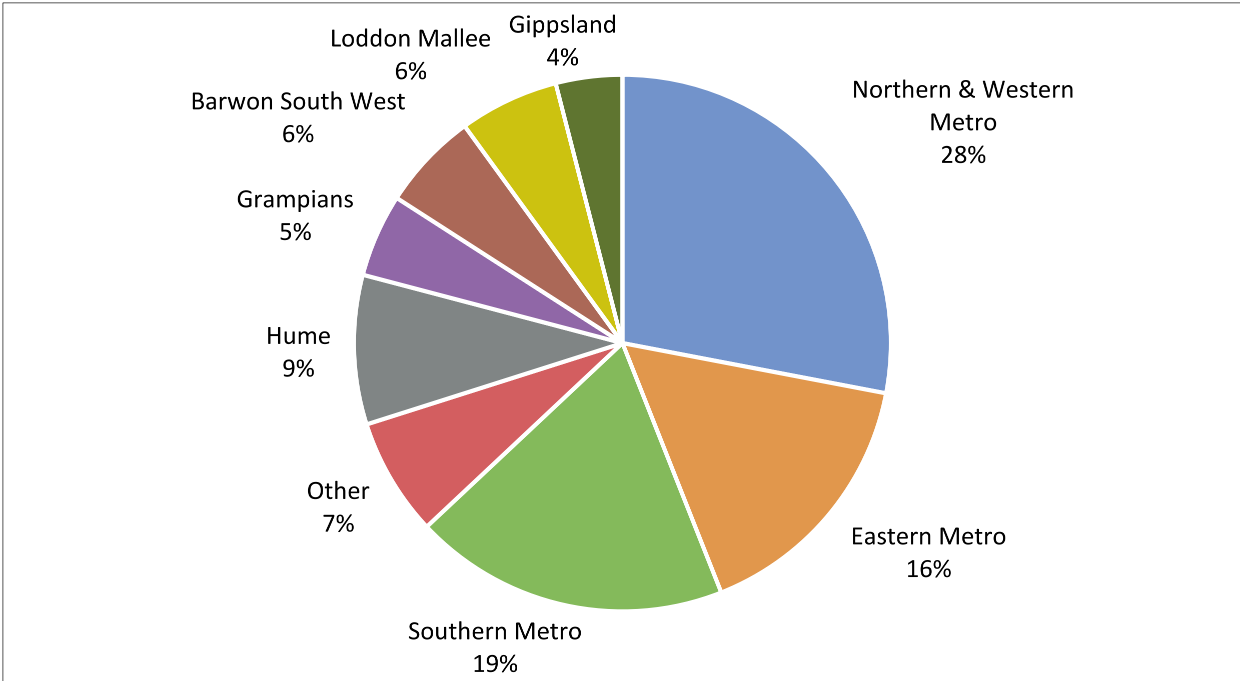
Table 4: Region of work (n=395)

AHWQ2			DAA 2017		
Region	%	Count	Region	%	Count
Inner-metro	46	182	Metro or large urban	65	919
Outer-metro	17	69			
Inner-regional	24	93	Regional Centre	12	166
Outer-regional	6	23			
Rural	7	28	Rural Remote	<1	2
Remote	0	0			
			Not Specified	23	335
Total	100	395		100	1422

The ABS Census 2011 indicated that the highest proportion of dietitian and nutritionists were located in Eastern Metro (0.18 per 1,000) and North and West Metro (0.18 per 1,000), while the lowest proportions

were located in Gippsland (.08 per 1,000) and Grampians (0.11 per 1,000). At the time of this report similar data was not available from the 2016 Census, however the same tendencies as were prevalent in the 2011 Census were found in the survey results. The AHWQ2 survey results show 28% of respondents worked in the Northern & Western Metropolitan region, 19% in the Southern Metropolitan region and 16% in the Eastern Metropolitan region. Thirty per cent (30%) reported working in all the other regions of the state; however, responses were received from dietitians working in each Department of Health and Human Services region. Seven per cent (7%) reported working outside of the state of Victoria (Figure 5).

Figure 5: Main place of work by Department of Health and Human Services' region (n=402)

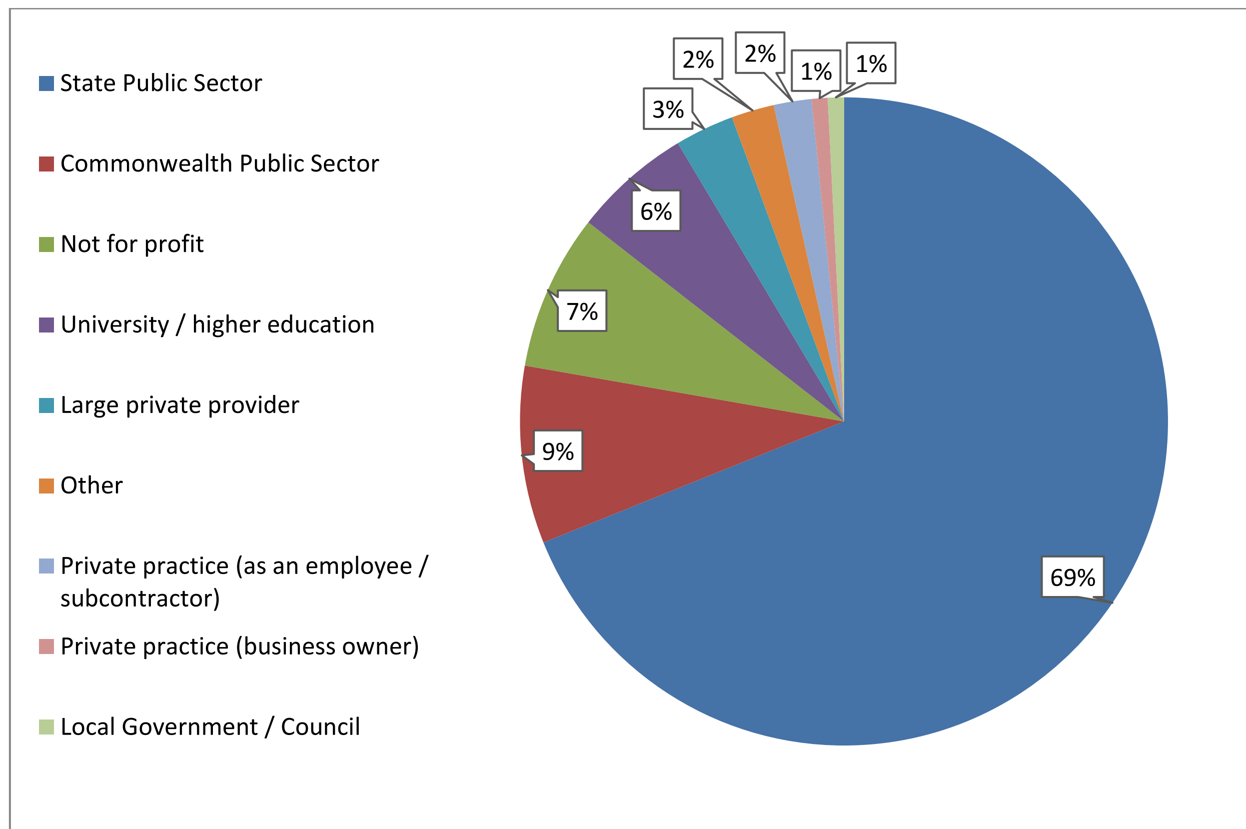


Sector

A total of 78% of AHWQ2 respondents reported working in the public sector, including a total of 69% (n=257) in the Victorian public sector and 9% (n=33) in the Commonwealth public sector and three (3) individuals in local government. It is likely that the AHWQ2 respondent cohort included an over-representation of individuals working in the state public sector due to a greater capacity to distribute the AHWQ2 survey to employees within this sector.

Respondents from the NFP sector comprised 8% (n=29) of respondents. Only 3% (n=10) of respondents were from the private sector, either as a business owner or as an employee / subcontractor (Figure 6).

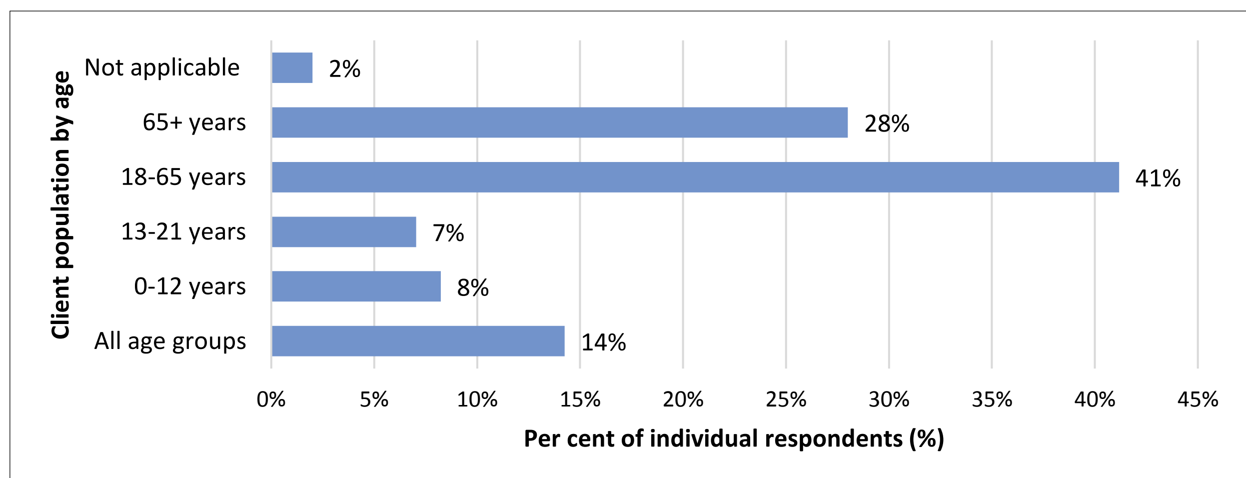
Figure 6: Employment sector of current main employer (n=373)



Clients

The dietitian respondents predominantly reported working with adults (41%), or older adults (28%). A total of 15% worked with children and adolescents/young adults (8% and 7% respectively) (Figure 7).

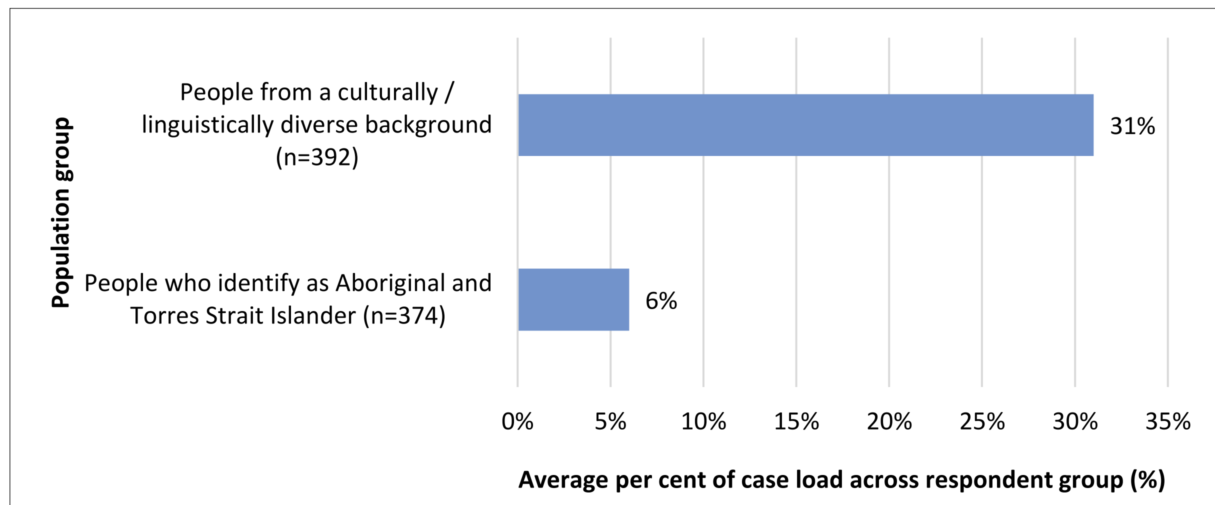
Figure 7: Clients by age (n=583) [a]



[a] *Respondents could select more than one response.*

When considering specific population groups, on average, clients who identified as Aboriginal and / or Torres Strait Islander constituted 6% of the caseload of AHWQ2 respondents. On average, one third (31%) of respondents' caseloads were constituted of people from culturally and linguistically diverse backgrounds (Figure 8).

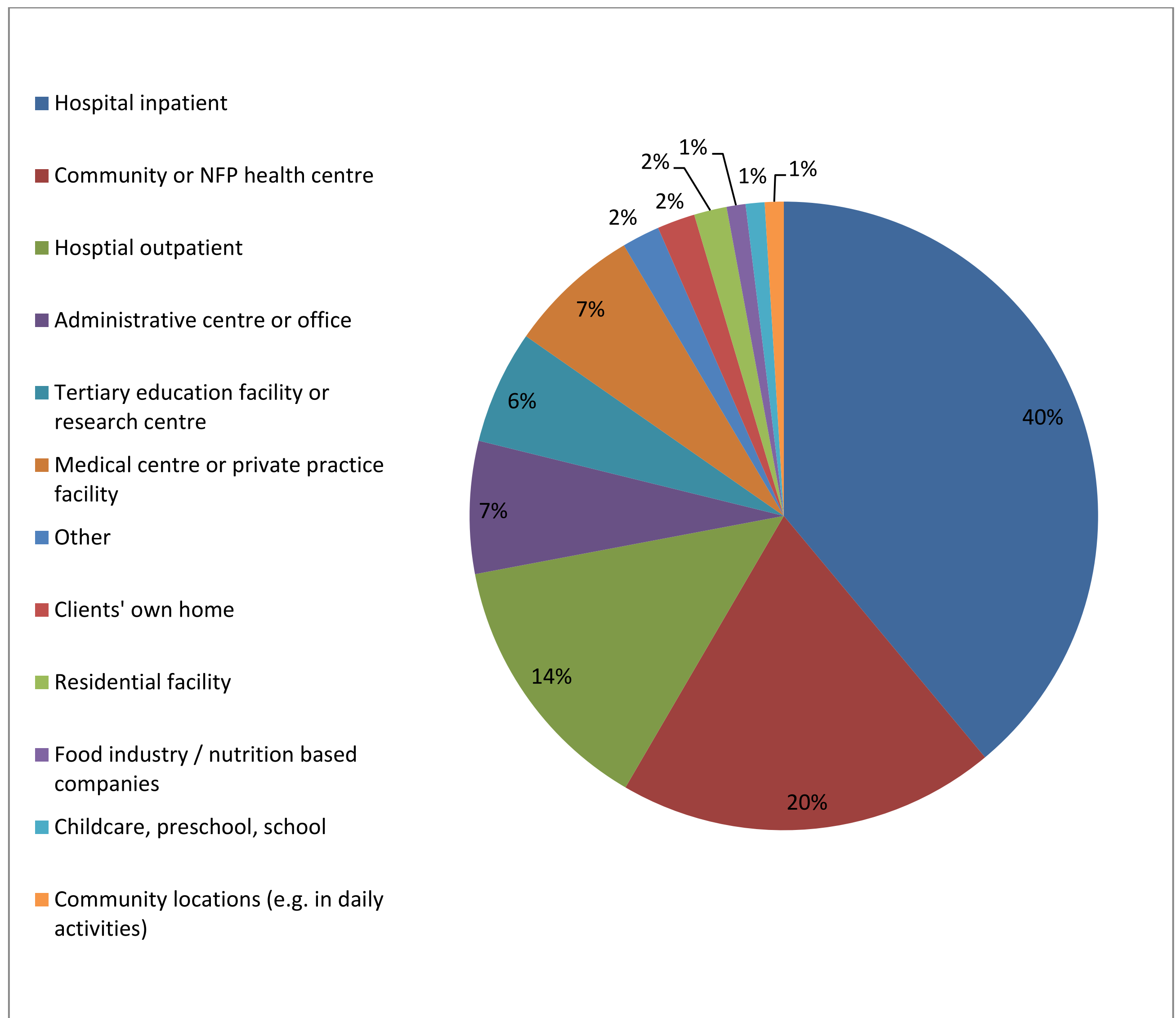
Figure 8: Average per cent of population groups represented within caseloads



Settings

Over a third of AHWQ2 respondents (40%, n=161) indicated hospital inpatient as the setting for service delivery of their main employer. Services within the community (NFP, community health service, etc.) (20%, n=82), hospital outpatient departments (14%, n=58) and administrative centre (7%, n=27) and medical centre or private practice facility (7%, n=28) were the next most prevalent work settings (Figure 9).

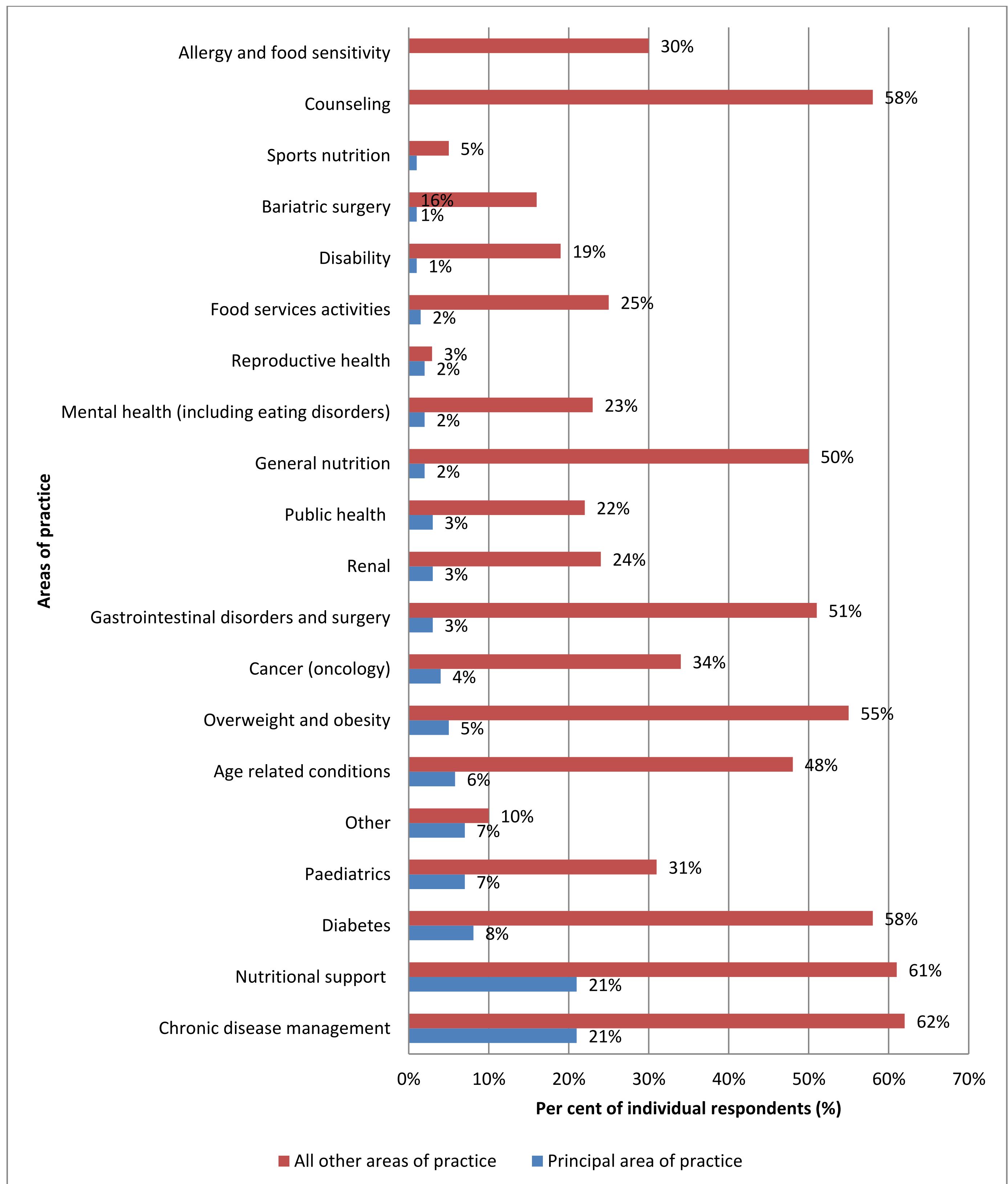
Figure 9: Setting for service delivery of current main employer (n=404)



Area of practice

The predominant principal areas of practice for dietitians reported in the AHWQ2 included chronic disease management (21%, n=87), nutritional support rehabilitation (21% n=87), diabetes (8%, n=32) and paediatrics (7%, n=30) (Figure 10 and Appendix Table 2).

Figure 10: Areas of practice (n=406) [a]



[a] *Respondents could select more than one response to signify 'all other areas of practice'*

Funding sources

There were a wide range of specific funding programs reported as being used to support delivery of services to individual dietetic clients. Chronic Disease Management (Medical Benefits Scheme (MBS)) (38%, n=104) and DVA (38%, n=104) were the two most frequently cited programs. Although 31% (n=81) of respondents were unsure of how they were funded, other significant funding sources included Commonwealth Home Support Program (29%, n=81), National Disability Insurance Scheme (NDIS) (29%, n=80), private health insurance (8%, N =71) Home and Community Care Program for Younger People (19%, n=53), and Diabetes type 2 - Allied health (MBS) (18%, n=51). In addition, there were 27% (n=74) who provided services to self-funded clients (Figure 11).

Private dietitians reported pressure on the Medicare / MBS funding system. The number of appointments and the amount of consultation time given to practitioners under the bulk billing scheme to work with clients with complex health needs was not sufficient to provide quality care. Furthermore, the inability to claim Medicare rebates for telehealth practice was a barrier for providing care to clients who lived in rural and remotes areas or who have difficulty in attending face-to-face appointments.

Within the public system, funding for small rural centres was for community health activity only with no funding for in-patient dietetics work: This caused concern for the quality of service provision in the in-patient setting. Those working in the hospital setting reported the lack of funding has resulted in dietitians not being able provide services to all those who would benefit from seeing them. Respondents from the education sector reported difficultly in attracting funding for dietetics research to improve the evidence-base of the profession. There were concerns regarding a general understanding of the profession and lack of dietitians represented on grant bodies.

Concerns with changes in funding streams have left dietitians working in community health feeling particularly vulnerable to job cuts, even though there are increasing rates of diseases such as diabetes and obesity within the population.

“I feel with the changes in funding streams and the move to client centred care there is a lot of uncertainty regarding the future of health care and in particular community health dietetics.”

“Insufficient funding through Medicare (on Enhanced Primary Care Plans) for dietetic services resulting in at risk patients in the community either missing out completely or not getting enough treatment (due to inability to afford extra sessions/out of pocket costs).”

Due to funding constraints and management responses to this we are being asked to modify our practice. This is not always in the clients’ best interest. Job satisfaction is reduced.”

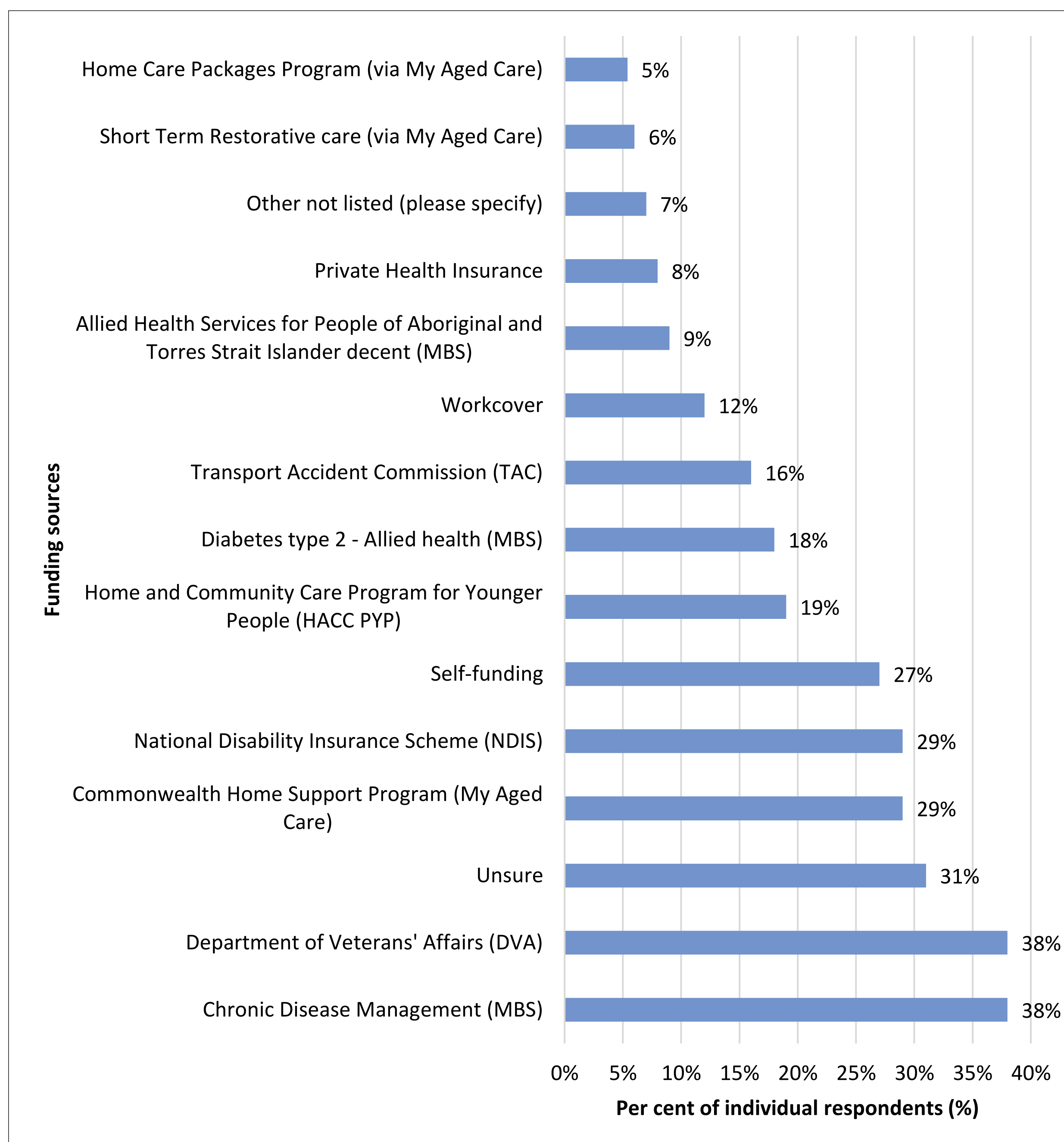
“Less resources and funding despite increased population and workload plus increased acuity of patients is demoralising

“Shortage of funding - there are not enough dietitians working in hospitals to provide basic dietetic care, thus we are forced to redefine our core business on a continual basis to ensure we are meeting patient demands. This means that many patients who could be educated in hospital, are being missed e.g. patients who require secondary stroke prevention education (which is best practice after a stroke). With more dietitians funded to work in hospitals, there would be more emphasis on prevention of chronic conditions and hopefully a less reactive approach is needed.”

“It is very common for allied health to be overworked. We don't get the extra funding that our medical colleagues seem to get.”

“The importance of the role of clinical dietitians in the public health sector, particularly in hospitals and community health centres is under recognised. As a result the dietetic workforce in the public health sector is severely underfunded by state governments and the workload carried by individual dietitians is unreasonably high”.

Figure 11: Per cent of respondents providing services funded by specific packages (n=277) [a]



[a] *Respondents could select more than one response.*

Demand

Organisational and individual respondents to the AHWQ2 did not provide quantifiable measures of demand for dietitians. However, respondents described concern regarding the obesity epidemic and inadequate resources for the needs of clients, and an increasing need to contribute unpaid overtime to respond to client needs. These pressures were predominantly voiced by professionals working in public and NFP sectors.

The Australian Government, Department of Employment's *Job Outlook* initiative does not include dietetics.

Supply

There are a number of factors that interact with and influence the supply of dietitians. These include the size of the dietetics workforce, the number of graduating dietitians, the age and gender profile of the workforce, employment grades, remoteness, remuneration and local approaches to recruitment.

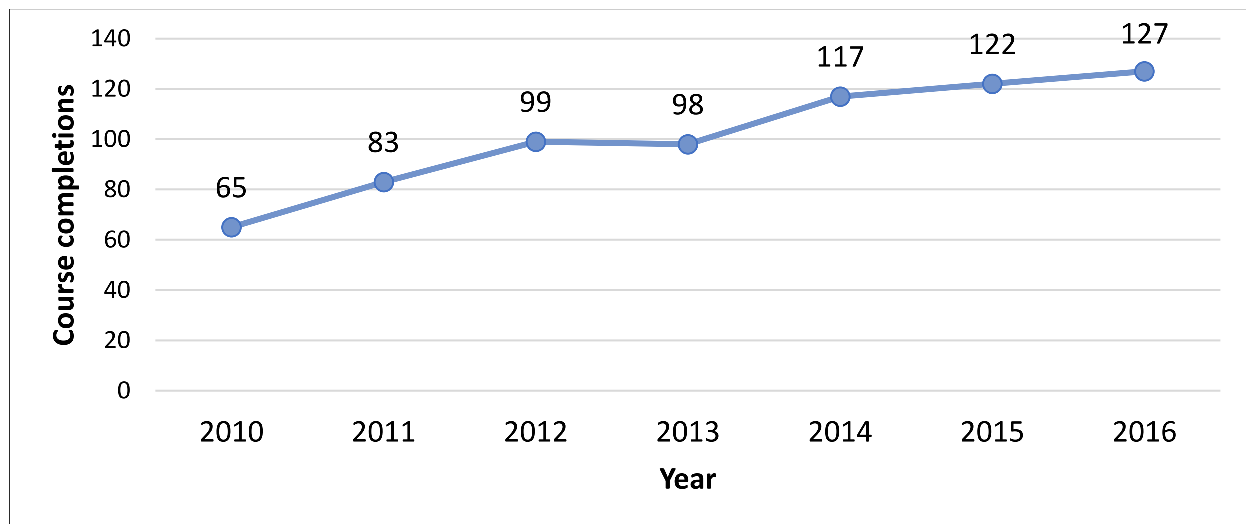
Dietetic workforce

In December 2017, there were 1,422 dietitians with DAA APD registration in Victoria.

Student completions

Between 2010 and 2016 the number of domestic graduates in Victoria increased from 65 per year to 127 per year, this is a 95% increase in graduates over this seven year period (unpublished data, Department of Education and Training[4]) (Figure 12).

Figure 12: Victorian university domestic course completions 2010-2016



Source: Department of Education and Training

Workforce oversupply / job shortages

Evidence of workforce shortages were reported by 38% (n=33) of AHWQ2 organisational respondents, 15% (n=13) did not know if they had any, and 48% (n= 41) indicated that did not have any. Of those that reported workforces shortages the most common impact was increased pressure on staff (21%, n=28), increased wait times for services (18%, n=24), reduced access to services for clients (16%, n=22), reduced service quality (13%, n=18) and reduced breadth and / or depth of services relevant to meeting client needs (12%, n=16).

For individual respondents, when asked what the single most important issue that dietitians would like addressed by their profession, the most common issue cited by a third of respondents (30%, n=128) was ‘more jobs or less graduates’. Respondents reported that there was an oversupply of graduates for which there were limited job opportunities. Concern was raised relating to the number of dietetics graduates Victorian universities were producing, particularly when potentially two more Victorian universities are offering nutrition and dietetics courses, and whether there was adequate strategic planning between

[4] The Department of Education and Training (DET) conducts the Higher Education Statistics Collection, which provides information on the number of student commencements and completions in higher education courses. While DET data does not identify those courses that lead to professional-entry for most disciplines, using information supplied by DET (in a particular field of education and course name), the Victorian Department of Health and Human Services has estimated the number of domestic and overseas students completing professional-entry courses for selected disciplines. Given this is an estimate; caution should be used in interpreting these data.

universities and the State Government to ensure an oversupply did not occur. New graduates consistently reported difficulty in finding employment, some of whom had been seeking dietetic work for up to 12 months post-graduation. Voluntary working was often used as a way to gain experience in the profession but this left new graduates open to being exploited, particularly in the private sector. Members of the new graduate focus group reported providing voluntary work for more than six months.

Job opportunities were also a concern for those already employed with some expressing there is a shortage of positions leading to understaffing and increased pressure to meet workload demands.

Consequences arising from this situation were identified to include:

- reduced quality of clinical services
- compromised outcomes for clients
- increased staff sick leave and burnout, and associated reduced job satisfaction

Those working in the private sector reported increasing numbers of private practitioners, particularly new graduates, leading to concerns that the market for dietitians will soon reach saturation in some areas.

Not all services reported challenges meeting demand. Private practitioners reported little to no wait for services they provide and some community health services reported a similar scenario.

“There are not enough jobs available for dietitians, despite the need for nutrition education/promotion in health and preventative care.”

“There are too many graduates for the number of dietetic positions available. We have a large number of disheartened, young people who have studied hard for a qualification and deserve to gain employment in the area they studied. Reduce the number of university places available.”

“Unfortunately for graduates the job market is quite difficult, and we are encouraged to look for similar jobs to get experience e.g. allied health, research etc. but hearing it from the recruiters point of view, they won't hire dietitians, OTs [occupational therapists] etc. for these roles because they know they will leave when they have found a graduate role.”

“The private practise area will shortly be saturated as nearly all the new grads go straight into private practise now. I have seen many home visiting jobs for physiotherapists/occupational therapists with government bodies, private health insurance companies etc. but dietetics is never included in the funding.’

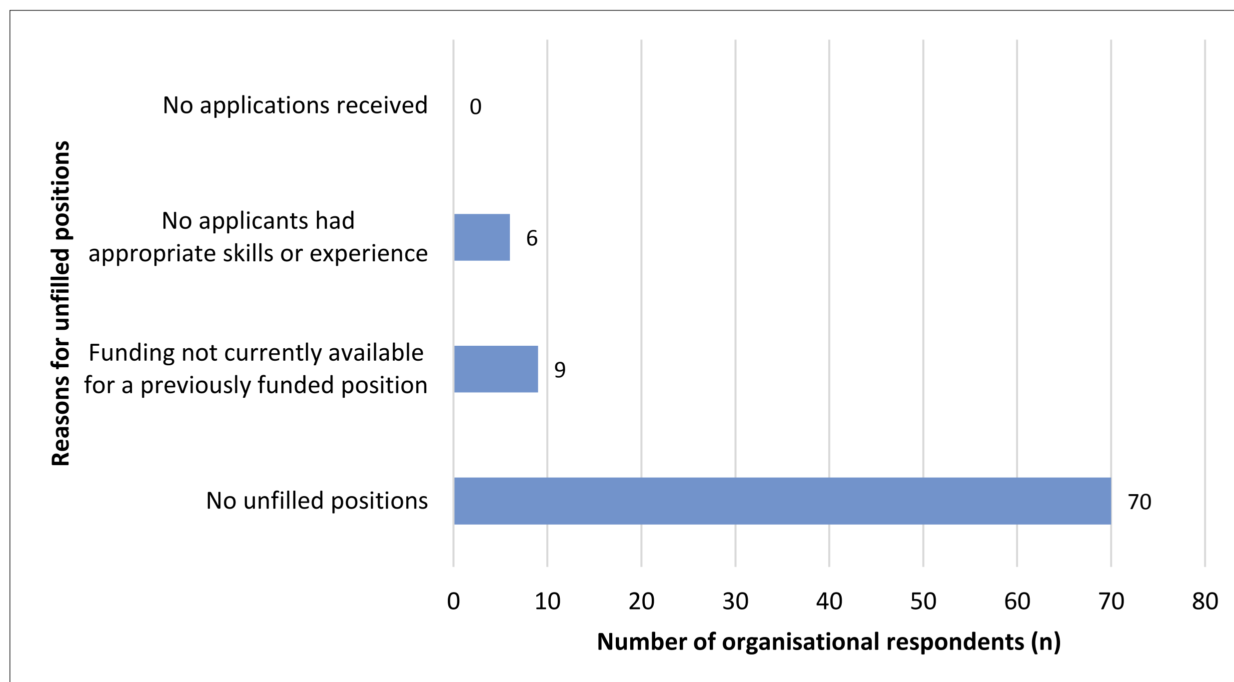
“I often wonder where all the AH professionals being trained are going to work and whether universities are really working with professional bodies on numbers required or whether they are just training people to fill their courses. Medicare rebates for AH have changed private practice enormously and dictated fees for service more than I expected. I would like to know how much forward planning really happens.”

"It is really, really tough for new grads…I was doing some volunteering for six months….for new grads there is this perception that people can just put out jobs and say that this is volunteering because they know that you are desperate for it.”

Unfilled positions

Of the organisational respondents to the AHWQ2 that employed dietitians, 82% (n=70) indicated they currently have no unfilled positions. Of those that did report having unfilled positions, funding not currently being available for a previously funded position (n=9) was the predominant reason, followed by an inability to recruit due to lack of applicants with appropriate skills or experience (n=6) and (Figure 13).

Figure 13: Reasons for unfilled dietetics profession positions (n=122) [a]



[a] *Respondents could select more than one response.*

Recruitment

Number of applicants

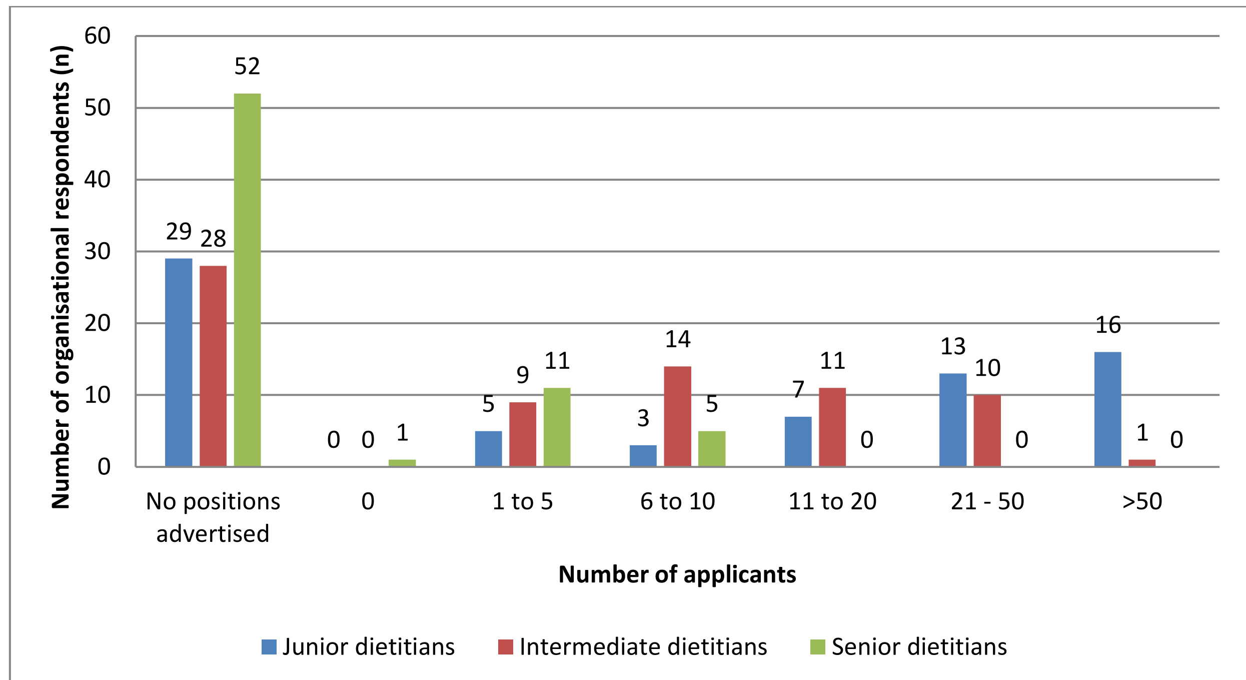
Organisational respondents to the AHWQ2 were asked about the size of the applicant pool for positions advertised at different grades in the preceding year. A high proportion of responding organisations had not advertised any positions.

Of the 73 organisations that reported having advertised junior positions, 22% (n=16) received more than 50 applications. Across junior, intermediate and senior levels, 40%, (n=29), 38% (n=28) and 75% (n=52) respectively, of organisations reported no positions advertised in the past year. Not surprisingly, 75% (n=287) of individual respondents indicated agreement with the statement that 'there are too many new graduates in my profession'.

Focus group and survey qualitative findings confirmed this concern relating to the ability of the increasing numbers of new graduates to secure employment. The two new graduates who participated in focus groups indicated that most of their peer group had eventually found employment but for some this had taken up to 12 months post-graduation. Concerns were also raised that employers may be taking advantage of new graduates who want to gain experience by undertaking voluntary work. Some employers reported difficulties in recruiting to positions with part-time hours.

In contrast to junior positions, greater difficulties were experienced filling intermediate and senior positions. Of the 69 organisations that advertised senior positions, 16% (n=11) received between one and five applications and for intermediate positions 19% (n=14) of the 73 organisations received 6-10 applications (Figure 14). These findings are also consistent with qualitative feedback from the survey and the focus groups.

Figure 14: Number of applications received for positions advertised in the past year by level (n=122) [a]



[a] *Respondents could select more than one response.*

Time to recruit

Of the organisations that responded to the AHWQ2 and advertised dietetics positions in the preceding twelve months, 98% (n=42) filled junior grade positions within 10 weeks and 84% (n=37) filled intermediate grade positions within 10 weeks. This suggests that these positions are being filled with relative ease (Figure 15). This was in line with qualitative findings which reported that there was strong demand for dietetic jobs.

The time to fill senior positions was consistent with findings on the number of applications received for these levels. Although 76% (n=12) of organisations reported filling positions within 10 weeks, three organisations (19%) reported more than 31 weeks to fill positions of which two organisations (13%) indicated a recruitment period of over 52 weeks.

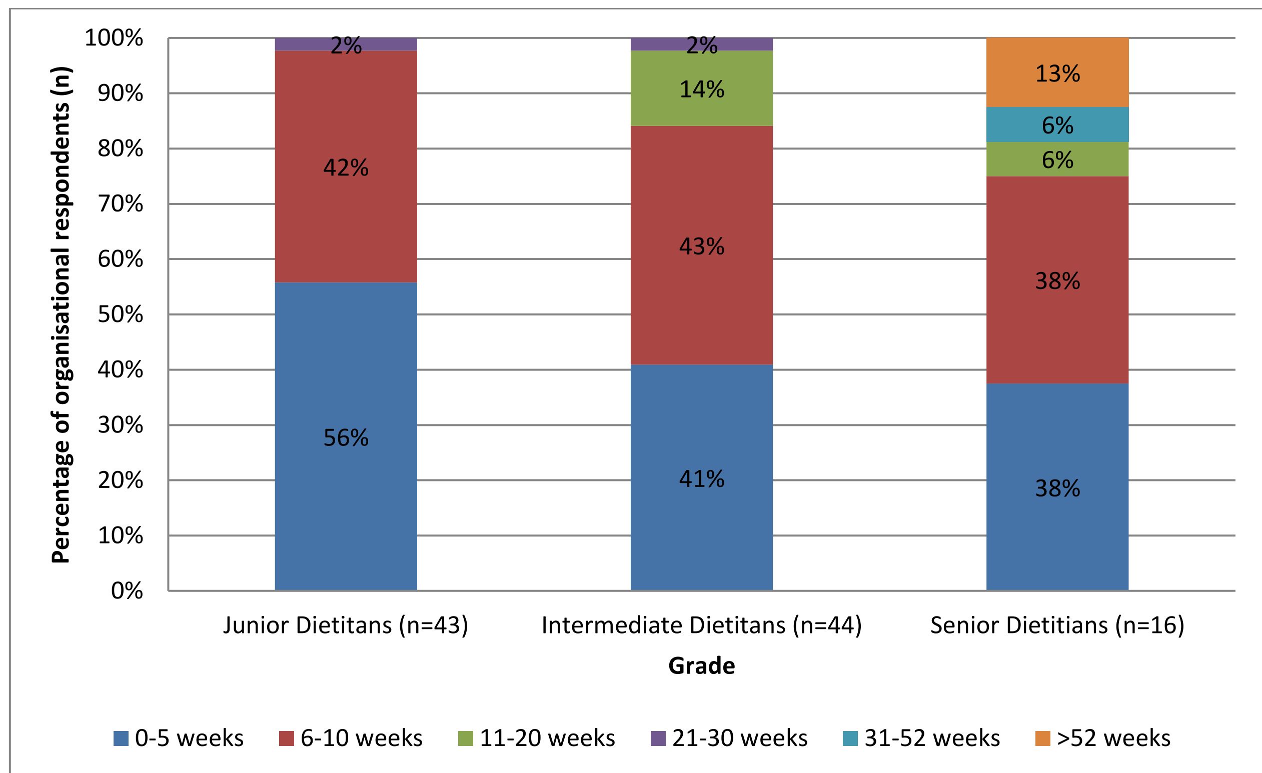
Recruitment in rural areas was not a difficulty for roles that were permanent; however they struggled to attract staff for short term roles.

The dietetics workforce is relatively small compared to other AH professions. As a result, dietitians found it hard to compete for more senior multi-disciplinary roles and were less likely to be successful. The secondary effect of this was that dietitians were under-represented in management roles and there was lack of dietetic input into strategic planning.

As a young, female-dominated workforce, maternity leave locums were viewed as an opportunity for early career dietitians to find employment.

"Based on my current situation, I have been in the job market for six months and the environment is difficulty. Employers are having to make tough decisions and turn candidates away because someone has more experience. There is a bottleneck effect occurring, where there are too many graduates looking for work and too many with appropriate experience."

Figure 15: Time to fill vacancies (n=74) [a]



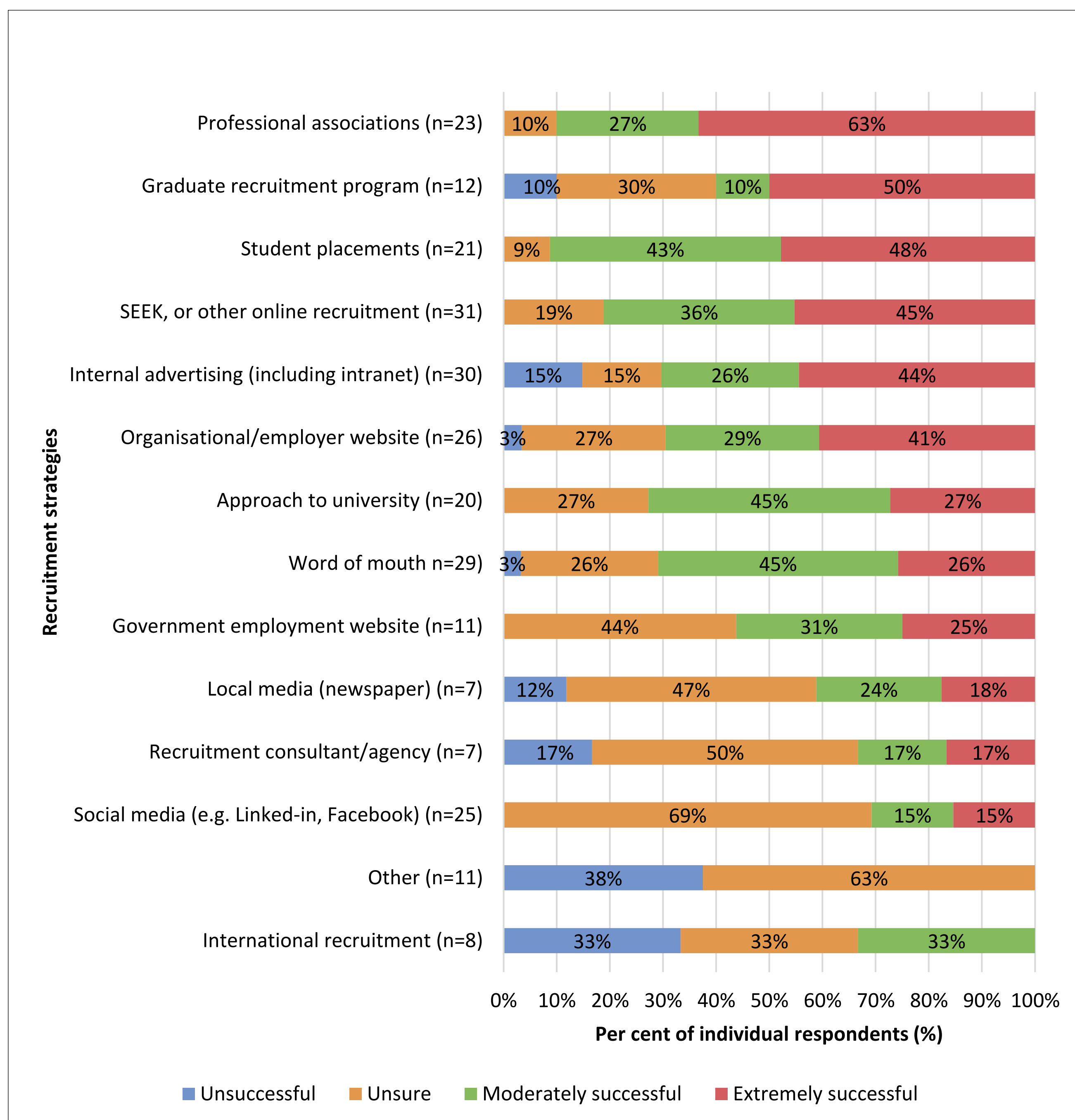
[a] *Although 74organisations responded to this question, data is only included for organisations that indicated they had vacancies in the prior 12 months.*

Recruitment strategies

Eighty nine (89) organisational respondents answered the AHWQ2 questions relating to the different recruitment strategies they use. Professional associations (n=60), organisational website (n=59), internal advertising (n=54) and SEEK (n=53) were the strategies used by the greatest number of organisational respondents. Other strategies included student placements (n=23), local media (n=17) and government employment website (n=16). Only a small proportion of organisations reported use of international recruitment (n=6) and recruitment consultants (n=6).

Strategies most likely to be identified as extremely successful were professional association (63%, n=38), graduate recruitment program (50% n= 5), student placement (48%, n=11) and internal advertising (44%, n=24). The strategy reported to be most unsuccessful by the greatest proportion of respondents that used the specific strategy was organisational website (3%, n=2) and word of mouth (3%, n=1) (Figure 16).

Figure 16: Relative success of strategies used to recruit dietitians (n=89) [a]



[a] *Although 89 organisations responded to this question, for each recruitment strategy data is presented based on the number of organisations that reported that they used the strategy. For some strategies, such as international recruitment, a high proportion of respondents indicated they 'do not use' the strategy.*

Retention

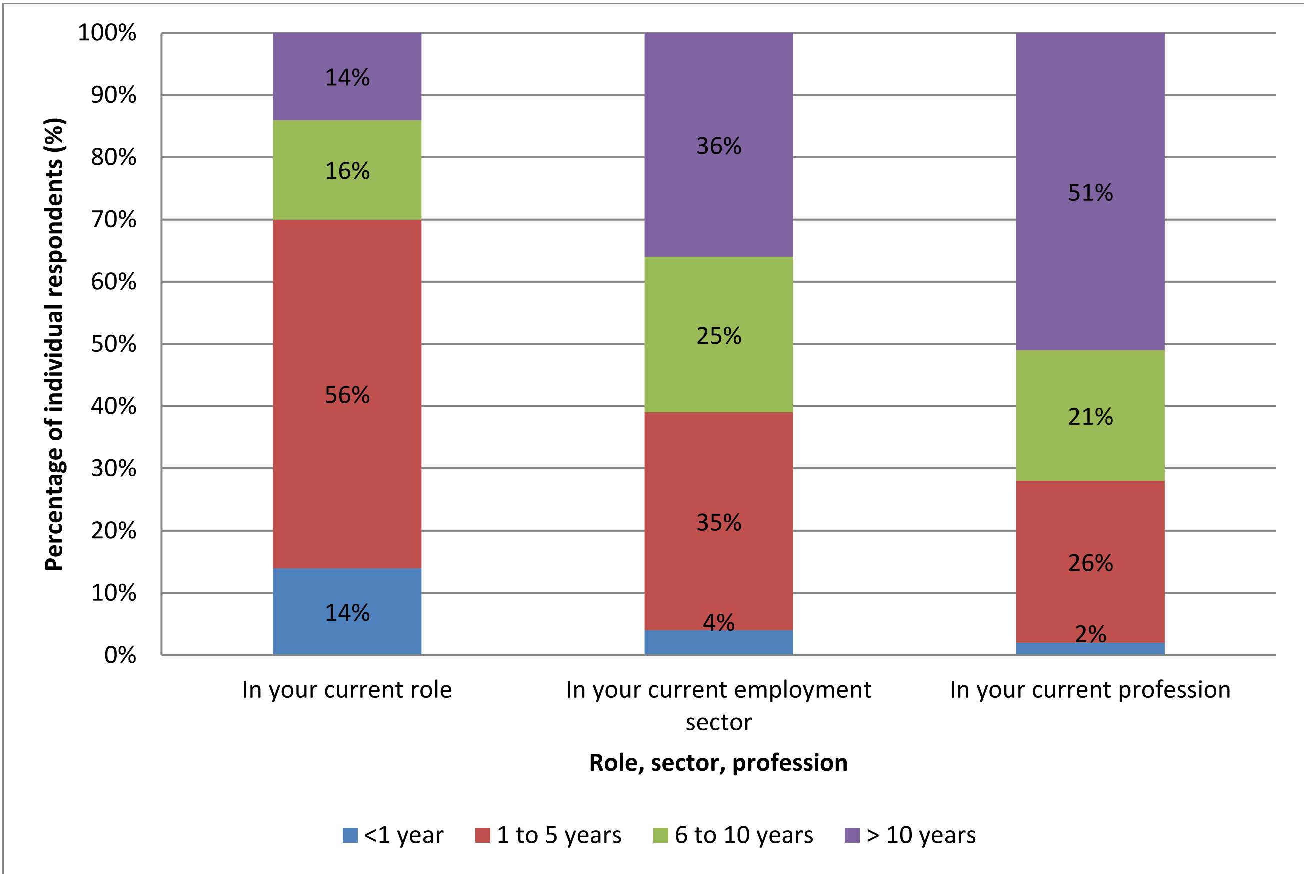
Dietitian respondents to the AHWQ2 were asked about their intention to remain in their current work situation. Fourteen per cent (14%, n=53) indicated an intention to remain in their current role for less than one year, whilst 56% (n=217) intended to stay in their current role between one to five years. Four per cent (n=15) indicated an intention to remain in their current sector for less than one year, and 2% (n=8) indicated an intention to remain in their current profession for less than one year. Although these results suggested a degree of intended mobility in the roles respondents were employed in, the proportion that indicated an intention to leave the profession in the short term was very low (Figure 17).

When considering the longer term, most dietetics profession respondents indicated an intention to remain in the profession for more than 10 years (51%, n=198), although within this time frame most expected to change their role (86%, n=331) and employment sector (64%, n=247).

Retention in rural areas was identified to be harder with new graduates often not staying beyond 18 to 24 months, therefore the services were often not fully benefitting from these employees due to the time it takes to orient and train new graduates to their role.

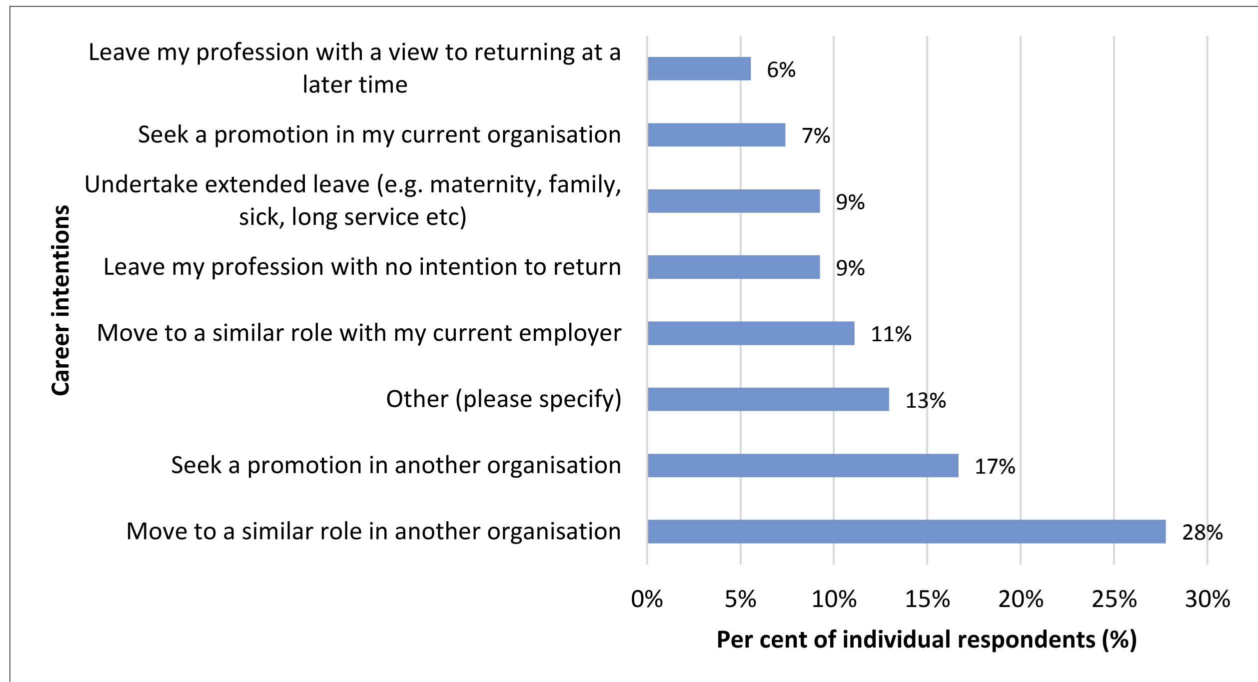
For those who take career breaks, it was felt that many either did not come back to dietetics or had great difficulty in finding employment.

Figure 17: Intention to stay in current role, sector and profession (n=387)



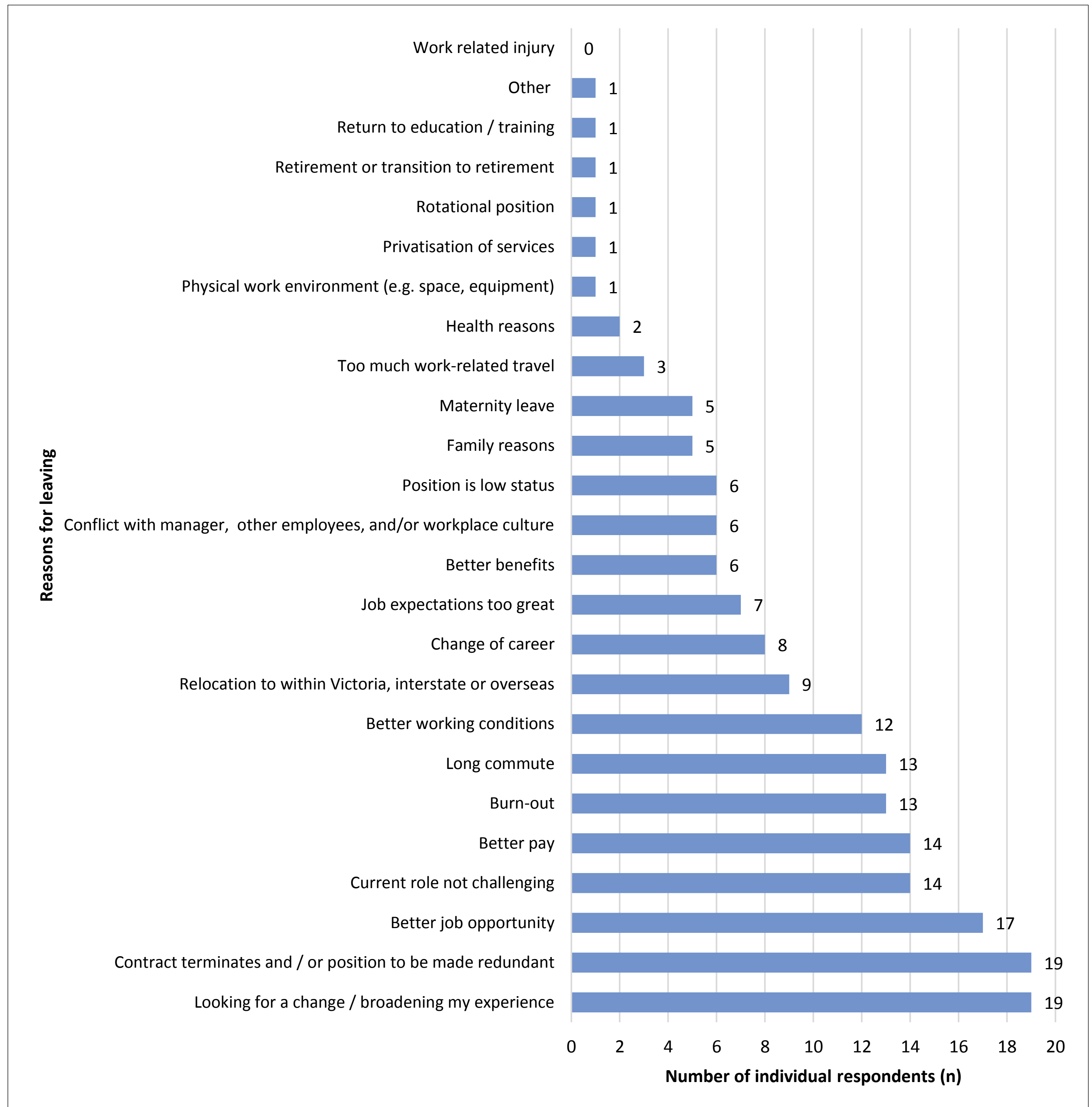
Of those who intended to change their role in the next 12 months (14%, n=54/387), the majority reported an intention to move to a similar role in another organisation (28%, n=15/54), followed by seeking a promotion (25%, n=13/54) in either another organisation (17%, n=9/54) or their current organisation (8%, n=4/54) (Figure 18).

Figure 18: Career intentions of respondents indicating an intention to stay in their current role for 12 months or less (n=54)



When asked about the reasons for changing roles, AHWQ2 individual respondents were offered the opportunity to select more than one possible reason. The most prevalent reason was looking for a change/broadening my experience (10%, n=19). Other reasons included looking for a better job opportunity (9%, n=17), contract terminates and/or position to be made redundant (8%, n=15), better working conditions (8%, n=37), their current role was not challenging (7%, n=14), better pay (7%, n=13), long commute, (7%, n=13) and burn out (7%, n= 13) (Figure 19).

Figure 19: Reasons for leaving (for respondents indicating intention to change roles within 12 months) (n=54) [a]



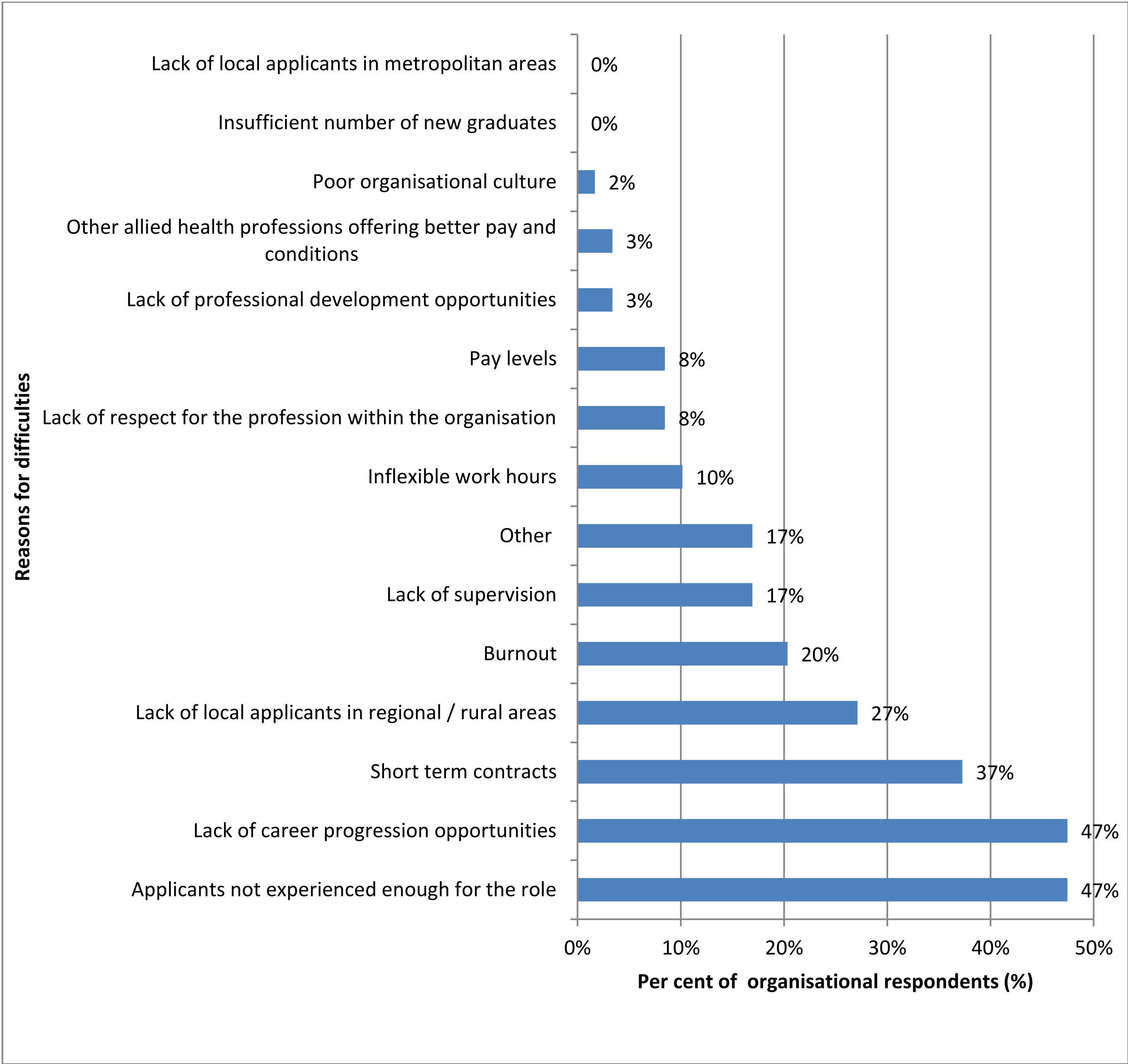
[a] *Respondents could select more than one response.*

The vast majority of respondents intended to stay within the dietetics profession. Other jobs which people intended to move to included lecturer, researcher, management roles or moving between jobs within the community and hospital setting or vice versa.

At the organisational level, 59 respondents reported specific barriers to the recruitment and retention of dietitians. Most of their responses reflected that the applicants were not experienced enough for the role (47%, n=28) or that there were not retained due to a lack of available career progression opportunities (47%, n=28). Other reasons for difficulties included short term contracts (37%, n=22), lack of local

applicants in regional / rural areas (27%, n=16), burnout (20%, n=12) and lack of supervision (17%, n=10) (Figure 20).

Figure 20: Employer reasons for recruitment and retention difficulties (n=59) [a]



[a]Respondents could select more than one response.

Organisation of the workforce

Pay level

The median annual earnings for dietitians responding to the AHWQ2 were between $60,000 and $69,000. Nearly half (51%, n=178) of all respondents had earned between $50,000 and $89,000 in the prior year and 40% (n=183) earned less than $60,000 (Figure 21).

Numerous dietitians expressed the need for greater pay equity. Respondents spoke about Victorian pay levels being lower than that of other states and the need for equity across the country. It was felt compared with the other health care professions, particularly nurses, the pay rates were inequitable and there should be greater parity.

Private dietitians reported that there was pressure from general practitioners (GPs) to provide bulk billing services but the Medicare payments were not sufficient to provide a quality service. Ultimately this has a negative impact on the profession as a whole, since clients are less likely to return if they are not satisfied with the service. Dietetics is an evidence-based profession that has strong competition from non-dietetic qualified professionals offering 'quick-fix' solutions. Dietitians indicated that more appropriate remuneration that will enable a quality service which should provide longer lasting results.

Finally, many individuals reported concern at their inability to advance their earning potential beyond grade 2 with few opportunities unless they progressed to a role with a strong focus on management rather than clinical responsibilities.

"There is an increased expectation to see bulk-billed patients at a loss."

"There is no pay increase once you reach grade 2 year 4 as a dietitian - it seems difficult to increase your pay in the public sector from here, despite ongoing skill development and growth as a clinician. Reaching the limit for being a grade 2 so early doesn't recognise the increasing value in your work as a clinician as time goes on."

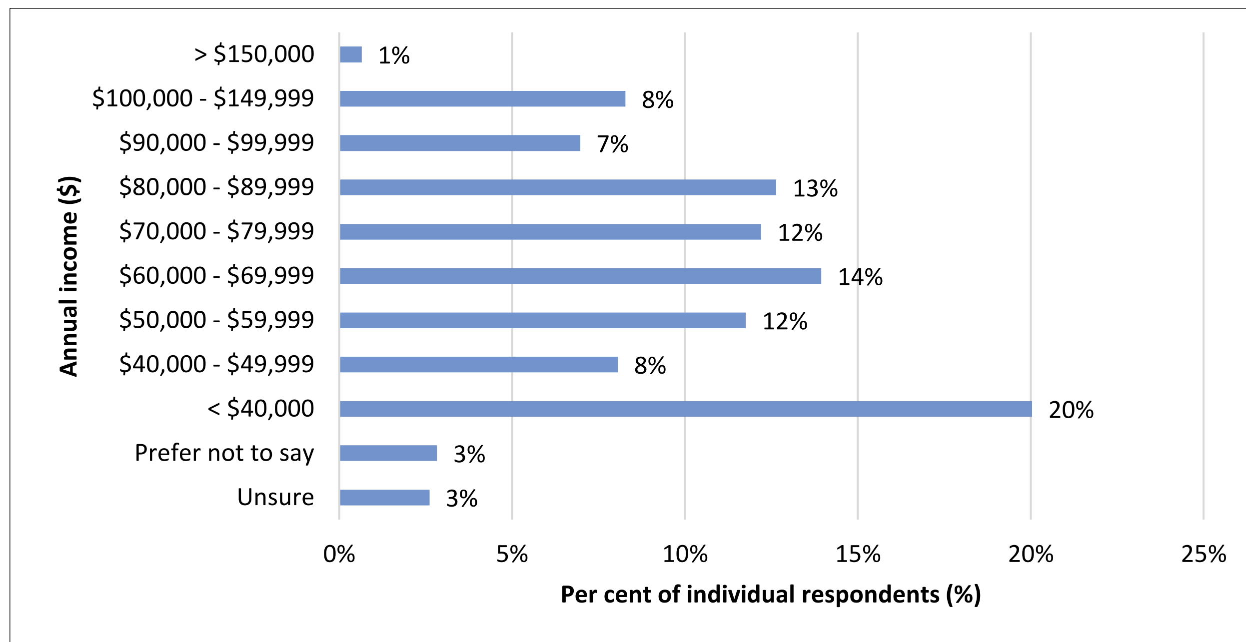
"AH professionals care a lot about their work and this can often lead to working overtime/long hours or under stress due to excess demand/under staffing and often this is not appreciated / reflected in pay or acknowledged."

"Our pay rates are appalling. I come from Qld where the state government aligned AH rates with nursing rates in 2010. I currently work alongside nurses who I am more qualified and more experienced than, and they are earning $20,000 per year more than me."

"Dietitians in this state do not receive equitable pay rates to dietitians in other states."

"The Victorian award also needs to recognize that dietitians are a part of the AH workforce and not medical scientists. This needs to be changed so that higher grade (specialist) positions can be created across the state and experienced dietitians can be paid in accordance with the work that they do. Higher grade positions should not be limited to dietetic managers or those employed in large metro tertiary hospitals."

Figure 21: Total annual income last year, before tax (n=459)

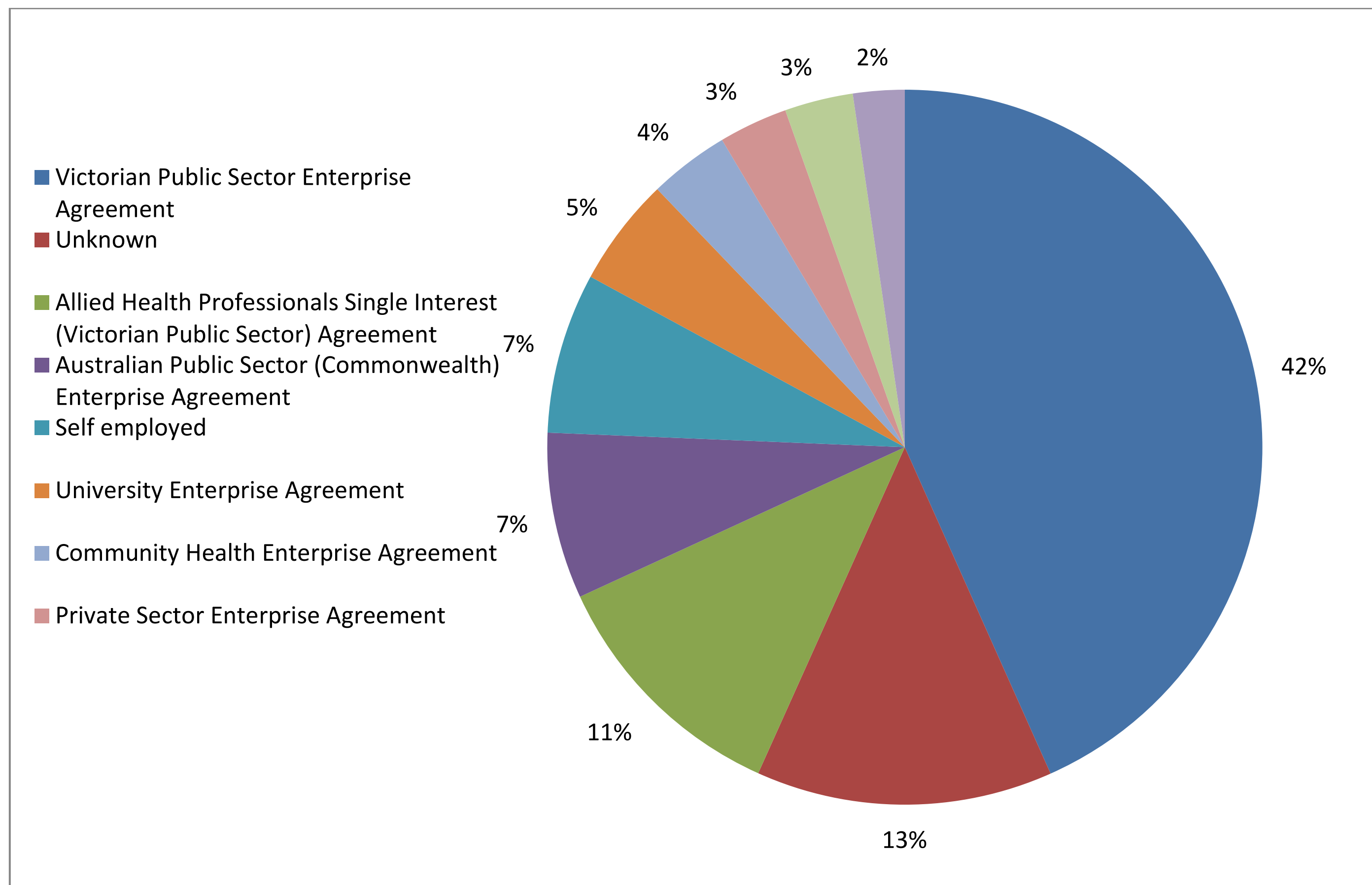


Awards

The Victorian Public Sector Enterprise Agreement was the employment award of 42% (n=166) of the AHWQ2 respondents. A further 11% were employed under the Allied Health Professionals Single Interest (Victorian Public Sector) Award and 7% (n=29) were employed under the Australian Public Sector (Commonwealth) Enterprise Agreement. The remaining respondents were employed against a range of other awards and employment arrangements. Examples include the Community Health Enterprise Agreement, the NFP Enterprise Agreement, the University Enterprise Agreement, individual contracts, and self-employment. As noted previously, public sector awards were likely to be over-represented in the respondent cohort due to the greater ease of distribution of the survey within the public sector.

Seven per cent (7%, n=78) of respondents did not know what award they were employed under (Figure 22).

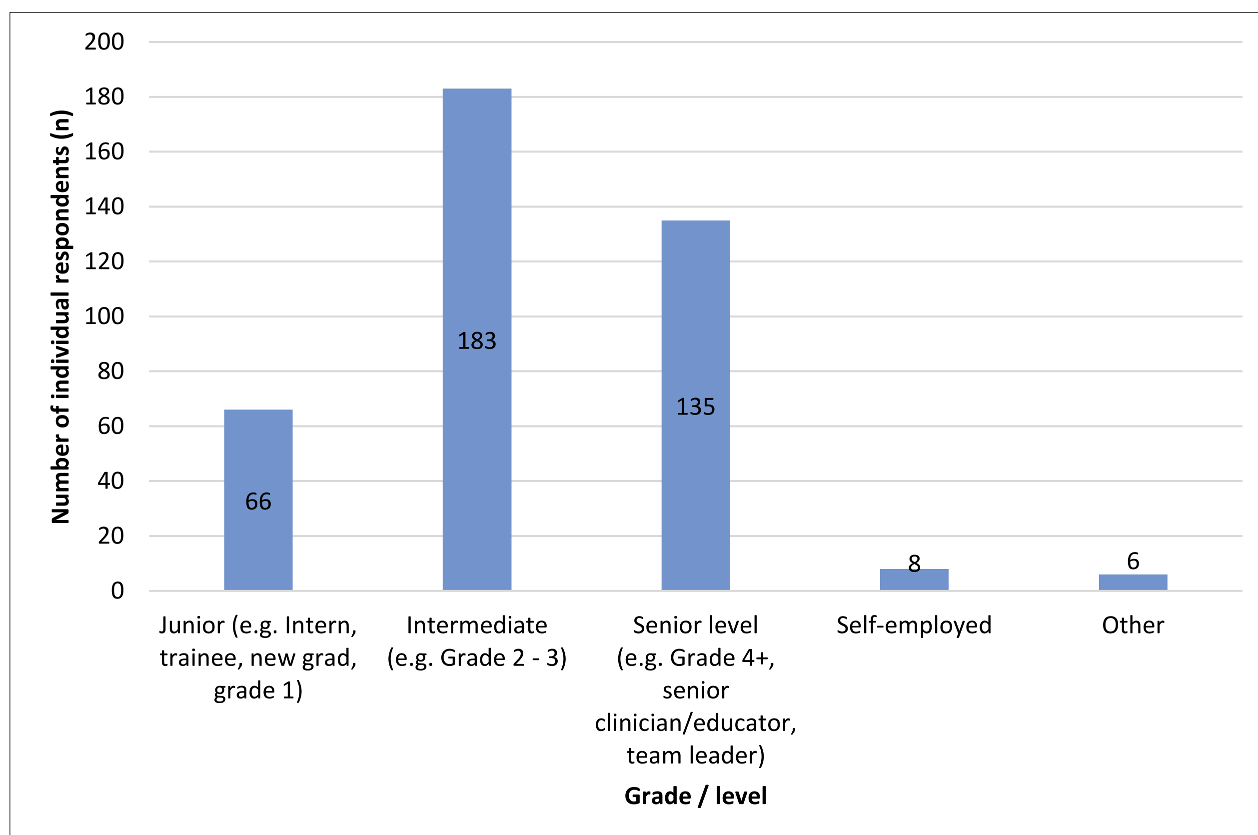
Figure 22: Current award or employment agreement (n=398)



Employment grade / level

Nearly half of all respondents (46%, n=183) reported being employed at an intermediate level (e.g. grade 2 (or equivalent). Over a third of respondents were at senior level (34%, n=135) and junior level respondents represented 17% (n=66). Self-employed dietitians accounted for only 2% (n=8) (Figure 23). The number of university-employed respondents was low (n=18).

Figure 23: Current grade (non-academic) (n=398)



Employment status

The majority of dietitians responding to the AHWQ2 indicated they were currently employed in permanent roles (77%, n=288) (Table 5). However, it is worth noting that just under a quarter of respondents (23%, n=85) did not have secure employment. This was consistent with respondents who had temporary or casual contracts reporting the lack of job security negatively impacted on their well-being and career opportunities. Despite respondents indicating that graduates were volunteering because they could not get jobs, no respondents indicated that they were volunteers in either their main or second employer.

Table 5: Nature of employment with current main employer (n=373)

Employment status	%	Count
Permanent	77	288
Temporary	4	16
Contract	14	54
Casual	4	14
Other	<1	1
Total	**100**	**373**

Number of employers

The majority of dietitians (69%, n=282) had just one employer, just under a quarter (23%, n=93) had two or more employers, and 8% (n=31) were fully self-employed (Table 6). Of those who were fully self-

employed, they were most likely to be practising in an inner-metro area (48%, n=15) followed by an inner-regional area (11%, n=10).

Respondents with two employers were more likely to live in an inner metro area (48%, n=34) compared with an inner-regional area (22%, n=16).

Table 6: Current number of employers (n=406)

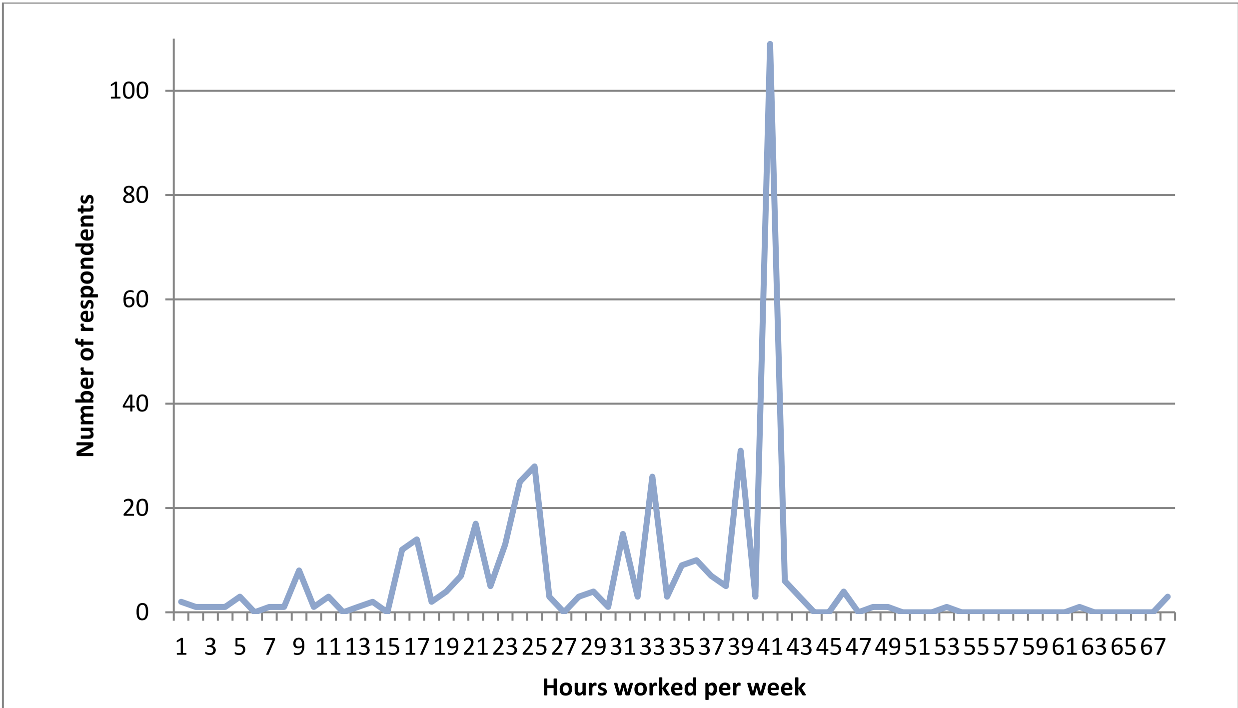
Number of employers	%	Count
1	69	282
2	18	73
3	3	13
4	<1	2
5 or more	1	5
I am fully self-employed	8	31
Total	**100**	**406**

Hours of work

On average, dietitians reported working 30 hours per week in their main role (n=404), with a range of one to 67 hours worked per week. The largest number of respondents (n=109) worked 40 hours per week, and 5% (n=20) worked more than 40 hours per week (Figure 24). The average total hours of paid work may be a little higher because nearly a quarter of respondents (23%, n=93) reported being employed by more than one employer (Table 6). On average respondents had worked in their main role for six years (n=404).

For second employers, respondents worked an average of nine hours per week and on average had been in this employment for four years (n=90). Thirty six per cent (n=33) were on a permanent contract and just over quarter worked on a casual basis (26%, n=24).

Figure 24: Number of hours worked per week (n=404)



Most dietetic respondents indicated they perform their duties Monday to Friday, mostly during the day (89%, n=385). A small proportion indicated they worked on Saturdays (5%, n=22), Sundays (2%, n=7) and in shifts that change from day to day, or week to week (2%, n=7) (Table 7).

Table 7: Working pattern during a normal working week (n=432)

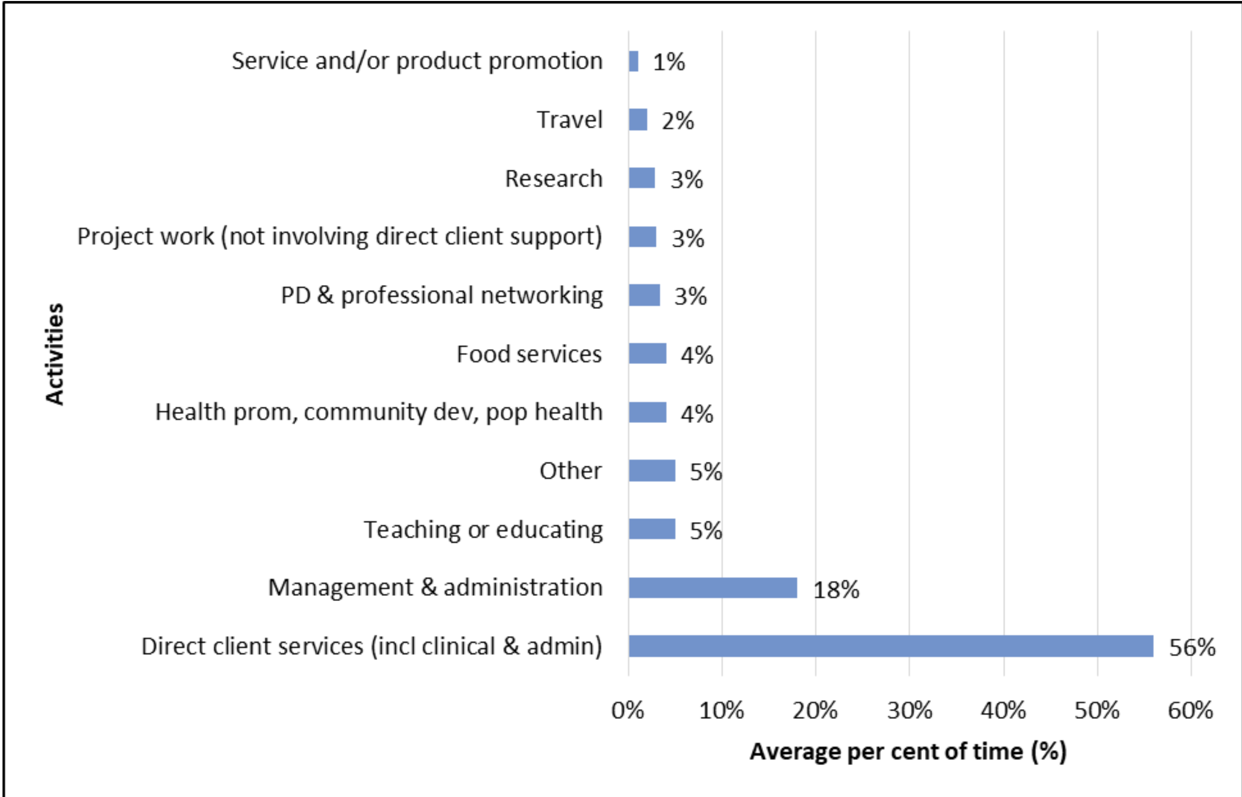
Working pattern	%	Count
Monday to Friday (mostly day time)	89	385
Monday to Friday (mostly night time)	3	11
Saturday	5	22
Sunday	2	7
Shifts that change from day to day, or week to week	2	7
Total	**101[a]**	**432**

[a] *Due to rounding*

Roles

On average, AHWQ2 respondents spent a little over half of their time (56%) on client related activities, including clinical and administrative support as well as clinical supervision. The average time spent on other management and administration including attending meetings was 18%. When averaged across the workforce, teaching, health promotion and associated activities, food services, research, project work, professional development and travel accounted for only a small proportion of time (Figure 25).

Figure 25: Average per cent of time spent on work activities (n=391)



Scope of practice

Prevention and early intervention

Participating dietitians expressed frustration at the lack of funding, jobs and innovative evidenced-based prevention and early intervention activities. They stressed that the growing prevalence of obesity and diabetes in the population requires the healthcare system to have a greater focus on prevention issues. Furthermore, the acute setting has more developed career pathways for dietitians compared with community and public health settings: This leads to a lack of senior dietetic roles in prevention.

"I would like more diverse and well remunerated career paths for dietitians who work in settings other than the acute hospital setting, such as community health and public health. This would show value for illness prevention."

"Currently the main career path leading to better remuneration is through seniority/specialisation in large hospital departments or making a move into management. This doesn't attract, or lead to retention of, the best practitioners in the prevention space."

"Moving to prevention by changing the system to facilitate the healthy choice as the easy choice, rather than focusing on acute needs so much, this is a band aid solution to a much larger complex problem."

"Less focus on clinical dietetics, more on community consulting, food preparation and disease prevention."

"We are just considered irrelevant to early intervention and this is happening with the NDIS [National Disability Insurance Scheme]. Dietitians are not included as registered therapists in early intervention."

"I think dietitians should be leading, developing the evidence for what is effective is part of the problem, there has been some fantastic work done but we are muted out by the bariatric surgery and the dollars spent on lap band surgery - $15,000 for a lap band could have been spent on dietitian appointments, programs, processes and group programs, innovation and telehealth."

Expanding areas of practice

The NDIS and aged care were highlighted as areas in which dietitians could make valuable contributions.

Private practitioners reported difficulties in engaging with the NDIS process. A lack of understanding about the role of a dietitian by policy makers and National Disability Insurance Agency has resulted in clients being directed to access dietetic services though community health or the local hospital, rather than with through their NDIS plan. Greater lobbying to policymakers regarding the role of dietitians within the NDIS was highlighted as a need.

"I thought the NDIS would be a great opportunity for dietitians but we are really being pushed back as the planners are telling clients dietetics is a health issue not a disability issue. We as a profession really need to push our skills. I went to see my local member [who was part of setting up the NDIS] about the lack of dietitians in disability and when I explained to her what I did, she said 'I did not know that dietitians did that'."

"In NSW [New South Wales] they have a more structured working party [for the disability sector] but we are trying to do more advocacy and lobbying ….. we are struggling with this because we need more lobbying and who does the lobbying because the DAA does not have the resources and is not as powerful as food industry."

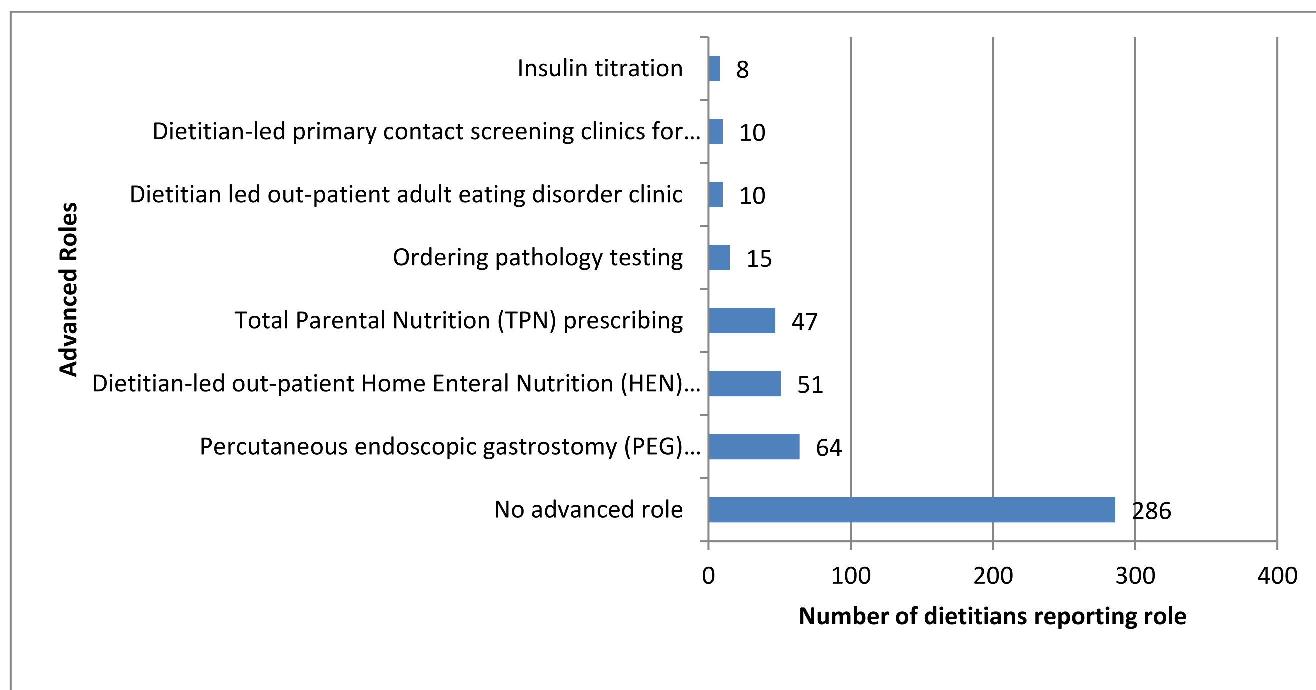
Advanced practice and extended scope of practice

The Department of Health and Human Services defines advanced practice roles as:

Work that is currently within the recognised scope for a profession, but through custom and practice are performed by other professions.

The department has a number of recognised advanced practice roles for dietitians; these roles and the number of dietitians reporting undertaking these activities is listed in Figure 26.

Figure 26: Advanced practice roles (n=390) [a]



[a]*Respondents could select more than one response.*

The DAA has the following definition of extended scope of practice.

"A discrete knowledge and skill base additional to the recognised scope of a profession and/or regulatory context of a particular jurisdiction. These would be tasks usually undertaken by other professions e.g. doctors, nurses or other allied health professionals. Extending scope should be permitted where it allows more efficient management and care of the patient and decreases the number of visits or transactions in the patient journey.

For dietetics, this extended scope could include tasks such as taking blood glucose levels, adjusting insulin dosages, inserting nasogastric feeding tubes and other procedures pertinent to the field of practice" (DAA, 2018).

Dietitians should only practice an extended scope if they have:

- Undertaken necessary additional education and training, clinical practice supervision and support,
- Certification and credentialing through their workplace,
- Ensured that they have appropriate professional indemnity insurance cover for that practice (if in private practice, self-employed), and
- Established and maintained their ability to work safely and competently (DAA 2018).

The DAA also credentials Advanced Accredited Practising Dietitians (AdvAPD) which recognises a level of dietetic practice beyond entry level. To achieve this, applicants must meet established criteria in the form of competency standards which demonstrate leadership skills and high-level dietetic knowledge. This credential is required to be renewed every five years.

Respondents were also asked if there were other advanced roles that they felt would be appropriate for dietitians to perform if they had the appropriate training and competency. The suggested activities included:

- Prescribing of supplements and medications
- Diabetes management, including assessment, insulin titration, dietitian led-clinics
- Pathology ordering
- Nasogastric tube insertion and management
- Gastrointestinal tube replacement
- Dietitian-led paediatric feeding clinics

“I think we are missing a few course for advanced area of dietetic practice, I would like to see qualifications developed in insulin adjustment, to order pathology and to prescribe a limited range of supplements.”

Allied health assistants (AHA)

Over a third (34%, n=133) of the dietitian respondents reported that their work involves delegation to AHAs. Those working in the State public sector were most likely to utilise AHAs (76%, n=101), followed by Commonwealth public sector (12%, n=16), NFP organisations (5%, n=7) and large private providers (e.g. private hospital) (4%, n=5). A small number of public sector respondents (n=8) also indicated that they utilised dietetics assistants.

Telehealth and Information Technology

Use of telehealth was reported by 20% (n=79) of respondents. The use of telehealth was higher in the outer regional and rural areas that the metropolitan and inner regional areas. Outer-regional and rural respondents accounted for 13% of respondents and 22% (n=17) of telehealth users, while inner regional and metro respondents accounted for 87% of respondents and only 78% (n=61) of telehealth users. Respondents reported using telehealth to deliver services to people in regional, rural and remote areas or where clients are not able to access services in person, e.g. prisons. The modes of telehealth described by respondents included videoconferencing, teleconferencing, email and SMS. The clinical purposes for which telehealth was reported to be used included:

- facilitating case conferencing between clients and medical specialists
- providing consultations to clients
- providing coaching and monitoring (including using apps) to clients
- providing reviews to clients
- delivering rehabilitation services
- conducting group work and client education

Respondents also reported using telehealth for non-clinical purposes including meetings, receiving and providing professional and clinical supervision, participating in interest groups, and providing and accessing education. A number of respondents qualified the nature of their use of telehealth by describing it as ‘occasional’ or that it was available and they intended to use it in the future. Poor information technology (IT) infrastructure prohibited telehealth use in many public sector settings. For private practitioners, the lack of Medicare rebate for a telehealth consultation prohibited telehealth’s use despite an understanding that it would be useful tool to improve the geographical reach of consultations and accessibility for clients.

“At present with the resources and [IT] systems in place I don’t see how it could be feasible to make it [telehealth work] – trying to find a computer is challenging enough.”

“Telehealth is working really well with the prisons……but we haven’t thought about expanding it [telehealth].”

“How we are innovating in universities is introducing more online delivery of courses which offers more flexibility,…and I don’t see why we should be exploring online delivery using telehealth. The biggest factor holding it back is there is no Medicare funding for it.” I

“In my private practice I know a lot of clients would prefer to do telehealth consultations because it would be more time efficient and cost efficient to them. No-one is going to pay $70 or $80 to see a dietitian online, even a gap payment is difficult for some people. A lot of lower SES [socioeconomic status] people will not come if they know they have to pay.”

Workforce movement

To identify patterns in the career pathway of dietitians, participants were asked to provide details regarding their first position, their position prior to their current position, and their current position/s. Questions focussed on position locations, roles, settings, and sectors. They were also asked about the number of years they had worked in each role. The results are presented as percentages as not all respondents had worked in three roles. The numbers of respondents for each position and each question are presented in the relevant figures, which illustrate the broad trends across respondents’ careers to date.

Changes in location

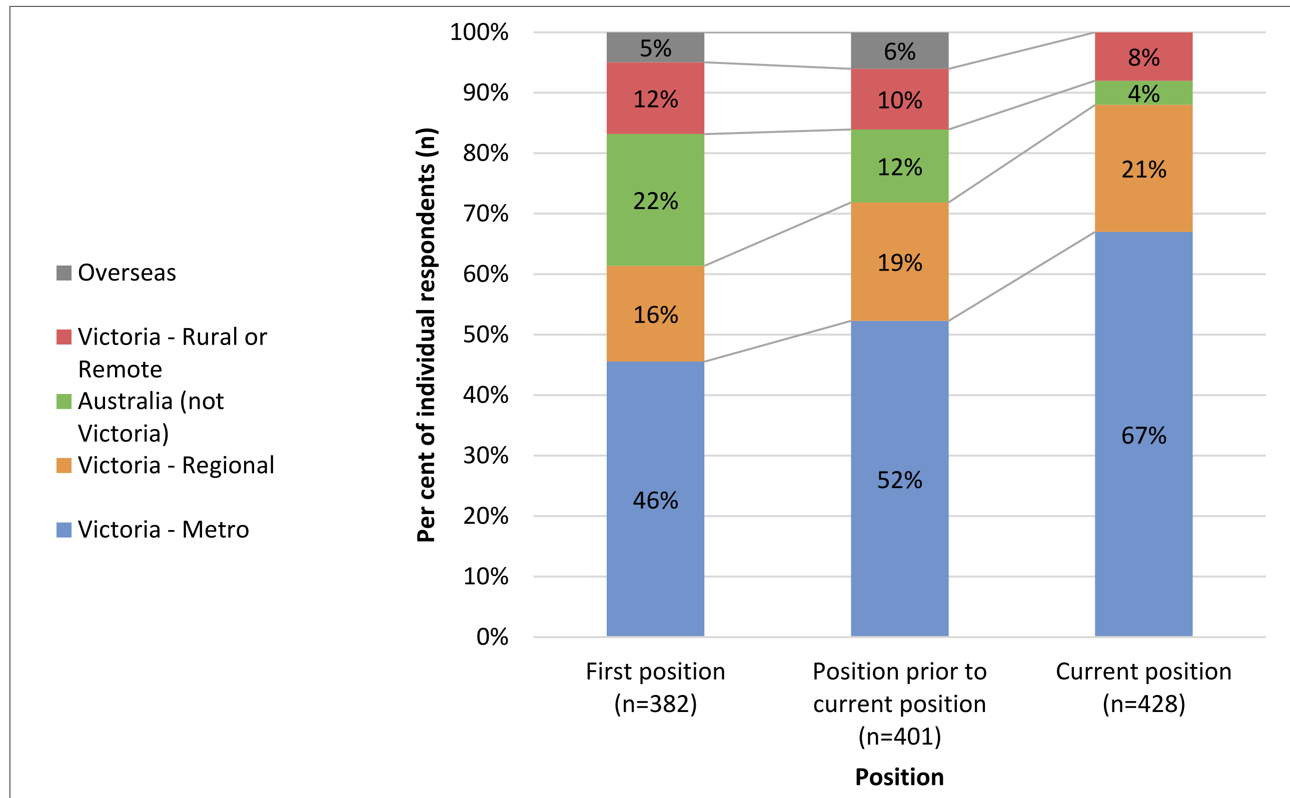
The AHWQ2 data shows that the proportion of respondents working in metropolitan areas increased from 46% (175/382 respondents) to 52% (208/401 respondents) between an individual’s first role and the role they were in immediately prior to their current role. This proportion continued to increase between their immediately prior position (52%) and their current position (67%, n = 287/428) (Figure 27).

Employment in regional areas increased slightly from 16% (n = 62/382) to 21% (n = 89/428) between the respondents’ first position and their current position at the time of the survey. In contrary, employment in rural or remote areas decreased slightly from 12% (n = 44/382) to 8% (n = 35/428) between respondents’ first position and their current position. This is confirmed by qualitative data reporting graduates who take up rural positions often leave to return to more populated areas.

“People are taking up rural positions because there is nothing else or because there is so much competition….however rural and remote tends to be classed as new grads nurseries. In a rural area you get the opportunity to gain lots of different experience in a generalist position and then they leave. Their primary goal is to do that for a year or so and then try and get a position back in a metropolitan area…the turnover is hard for us as a health service, you finally get someone trained up and they leave.”

Interestingly, data indicated an increase of respondents moving interstate to Victoria from other Australian states between their first position (22%, n= 83/382) and their current position (4%, n = 15/428).

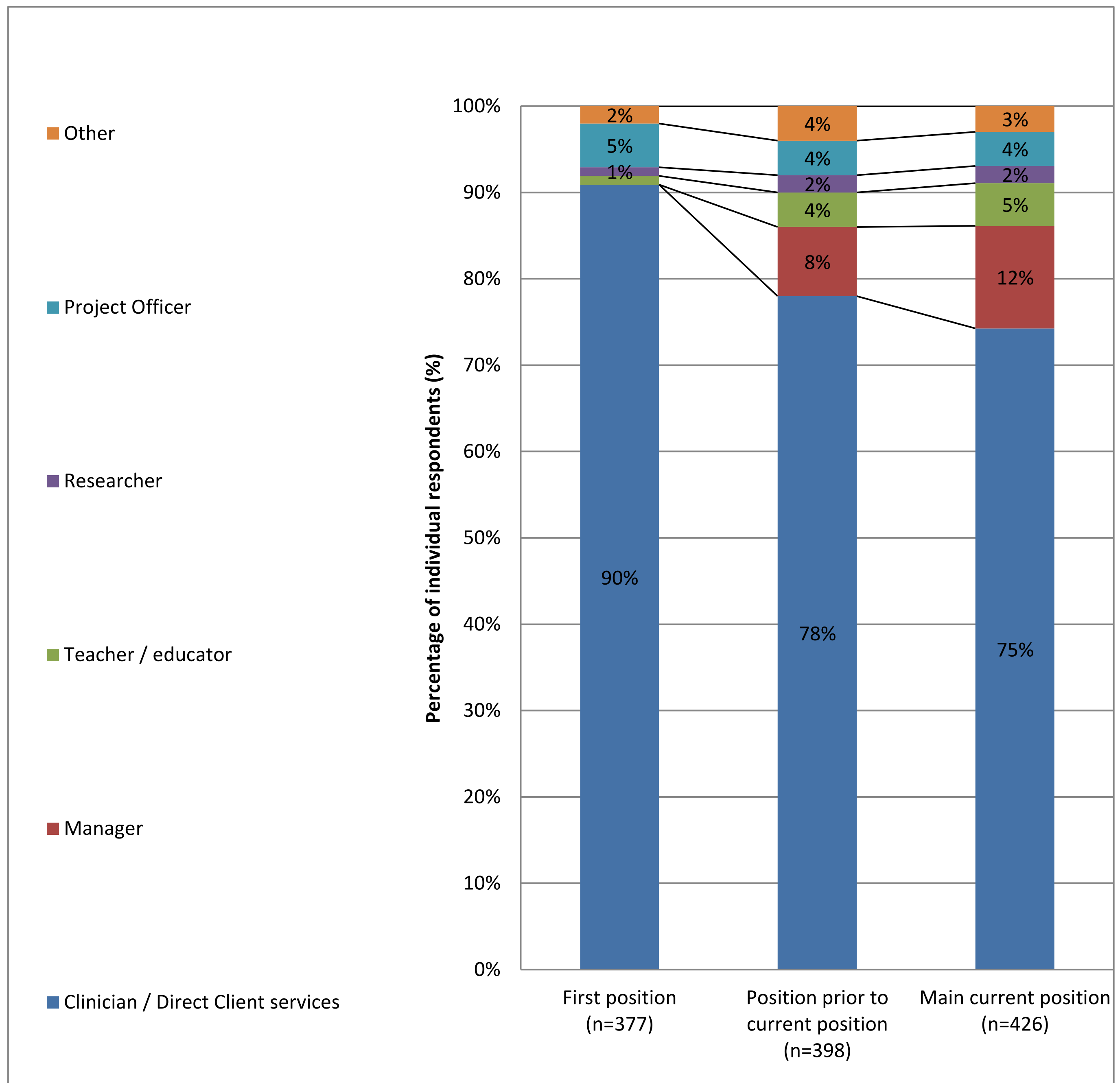
Figure 27: Changes in location across career path (n=382 - 428)



Changes in role

When employed in their first role as a dietitian, the vast majority (90%, n=341) were employed as clinicians providing direct client services. This proportion decreased to 78% (n=310) for their immediate prior position and 75% (n=320) for their current position. Manager roles increased from 8% (n=33) to 12% (n=51) between the prior and current positions. The number of respondents employed in the other roles such as researchers, project officers, and teachers / educators has ranged been between 1% and 5% across the career path (Figure 28).

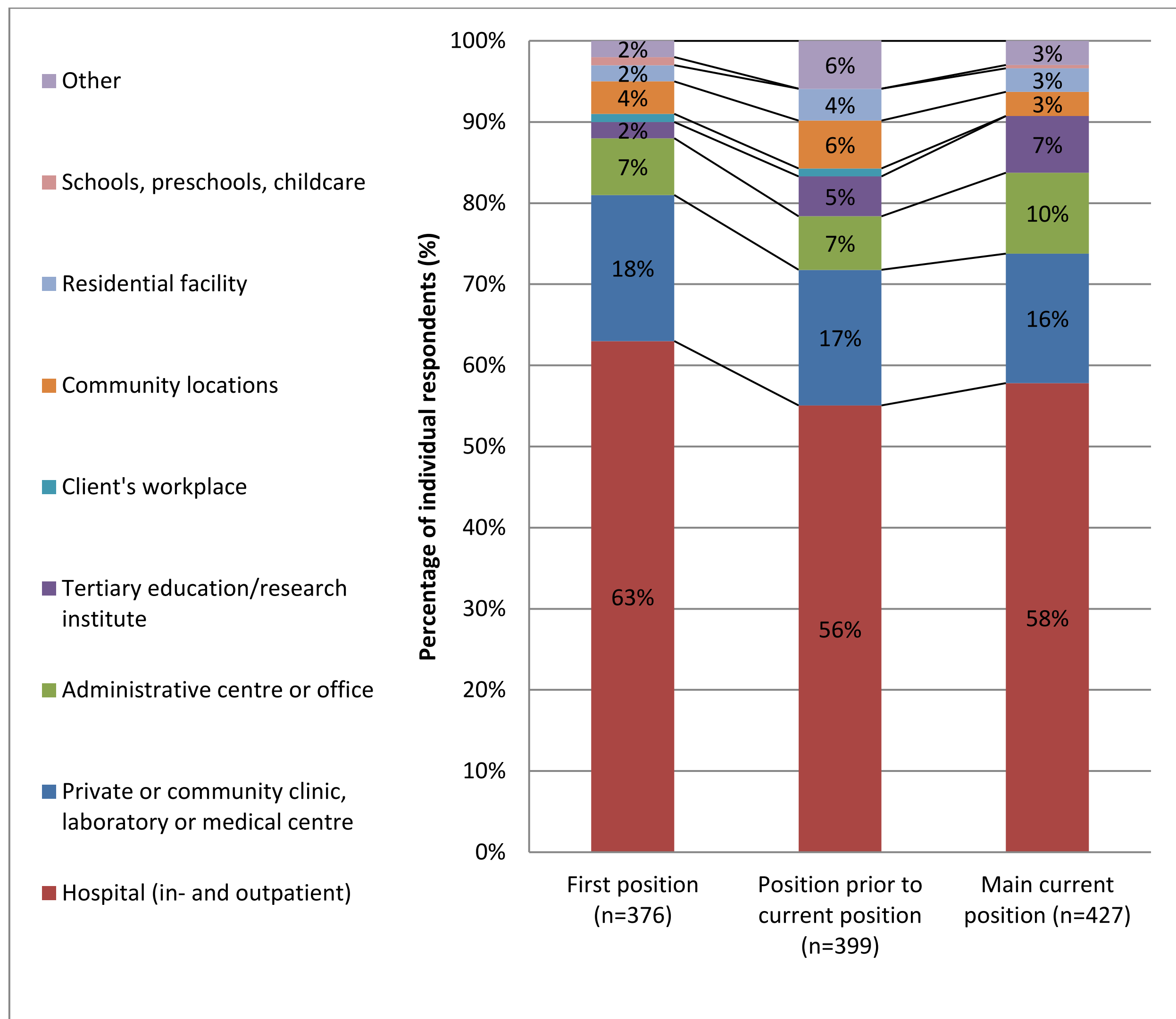
Figure 28: Changes in role across career path (n=377 – 426)



Changes in setting

Figure 29 shows changes in the work setting of dietitians across their first position, their position prior to their current position, and their current positions. Respondents' roles have been predominantly in the hospital setting across their career path with 63% (n=237) in their first position to 58% (n=247) in their current position. Small changes have also occurred between first position and current position in the tertiary education /research institute and administrative centre or office settings from 2% (n=7) and 7%,(n=27) to 7% (n=28) and 10% (n=44) respectively (Figure 29). Qualitative data has indicated difficulties in accessing employment in the in-patient setting, particularly by those who had left the clinical setting to work in the community sector and wanted to return.

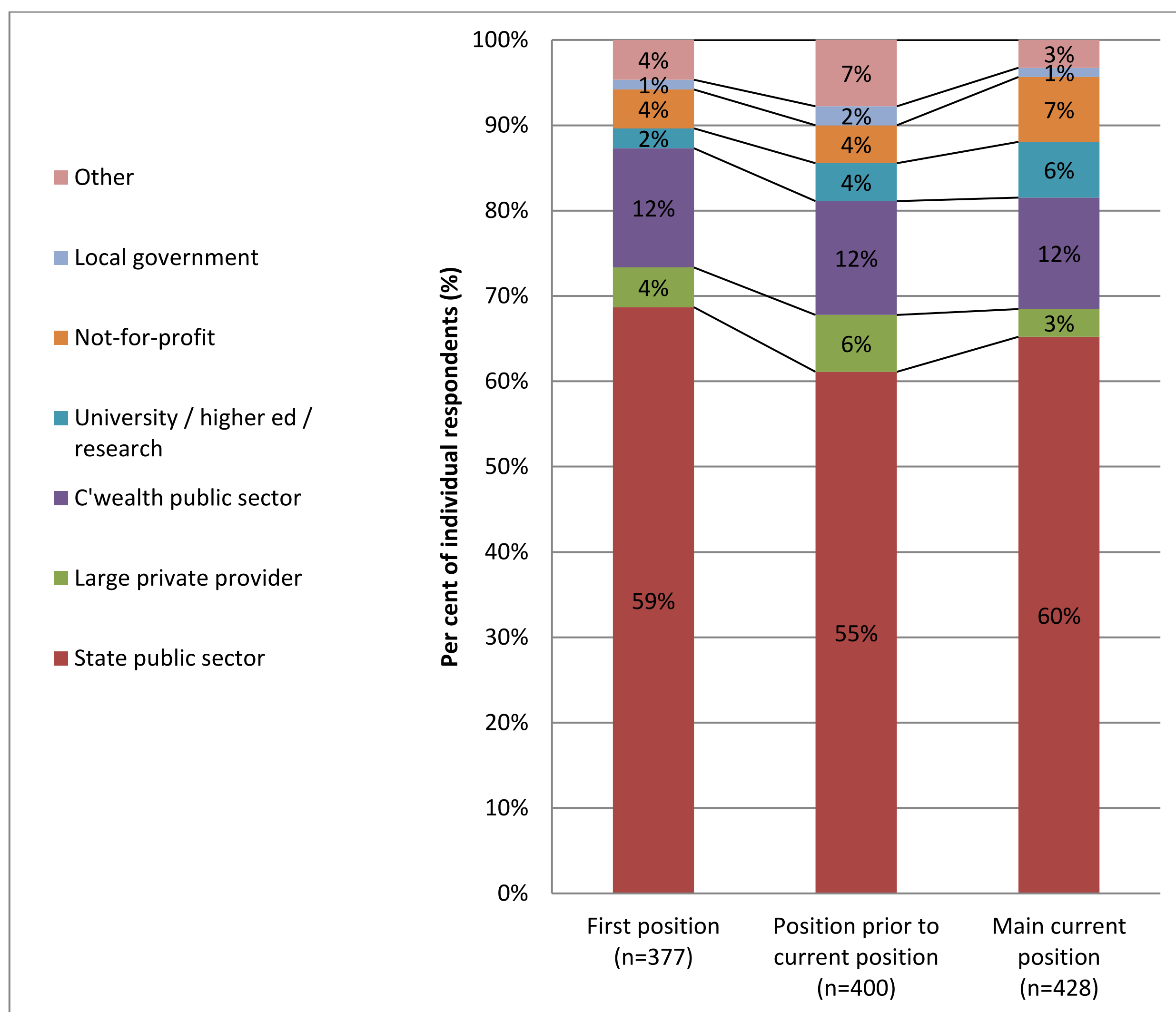
Figure 29: Changes in setting of care across career path (n=376 – 427)



Changes in sector

As noted previously, the cohort that responded to the AHWQ2 is likely to have included an over-representation of individuals working in the state public sector due to greater ease of distribution of the survey in this context. Given this situation, although Figure 30 suggests a trend towards employment within the state public sector across an individual's career, it is not possible to determine the accuracy of this finding. This result may simply reflect the current employment sector of the majority of the cohort. Of interest is the growth of employment in the NFP sector from 4% (n=14) to 7% (n= 28) in current position.

Figure 30: Changes in sector across career path (n 377 – 428)



Additional information relating to changes in employment location, sector and setting is in Appendix Tables 3, 4 and 5.

Years in role

Over time, the number of years that respondents work in a role was shown to increase. The average time in first role was two years and the average time respondents had worked in their current role was four years (Figure 31 and Table 7).

When considered based on sector of employment, the state public service had the longest average duration of employment in their current (5 years), followed by those employed in the Commonwealth public sector (4 years), NFP sector (3 years), university / higher education (3 years) and the state public sector (6 years). The shortest average was for those employed by large private providers and private business owners; however there were few respondents from the business owners sector (Appendix Table 6).

Figure 31: Years in each role over career path

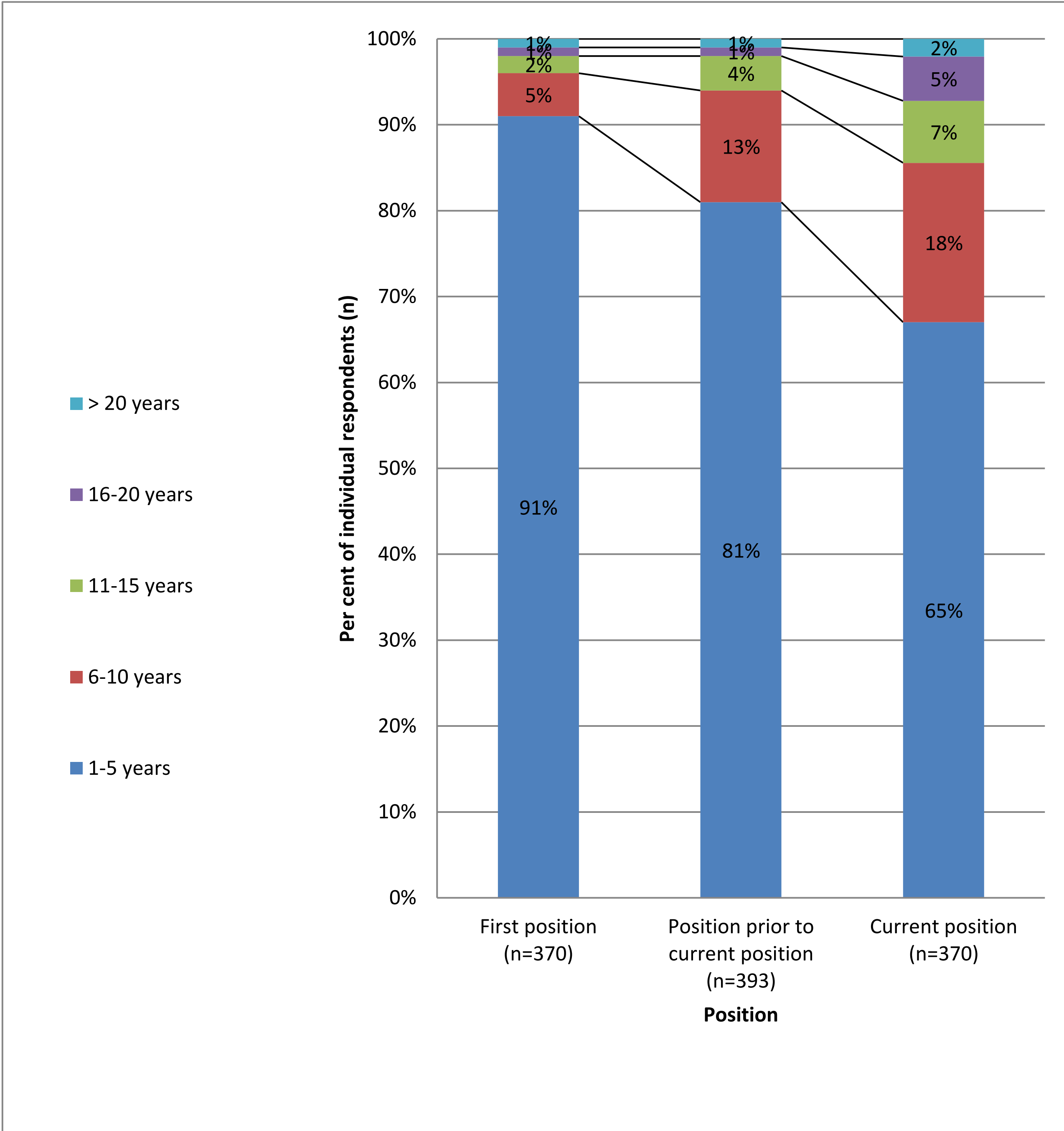


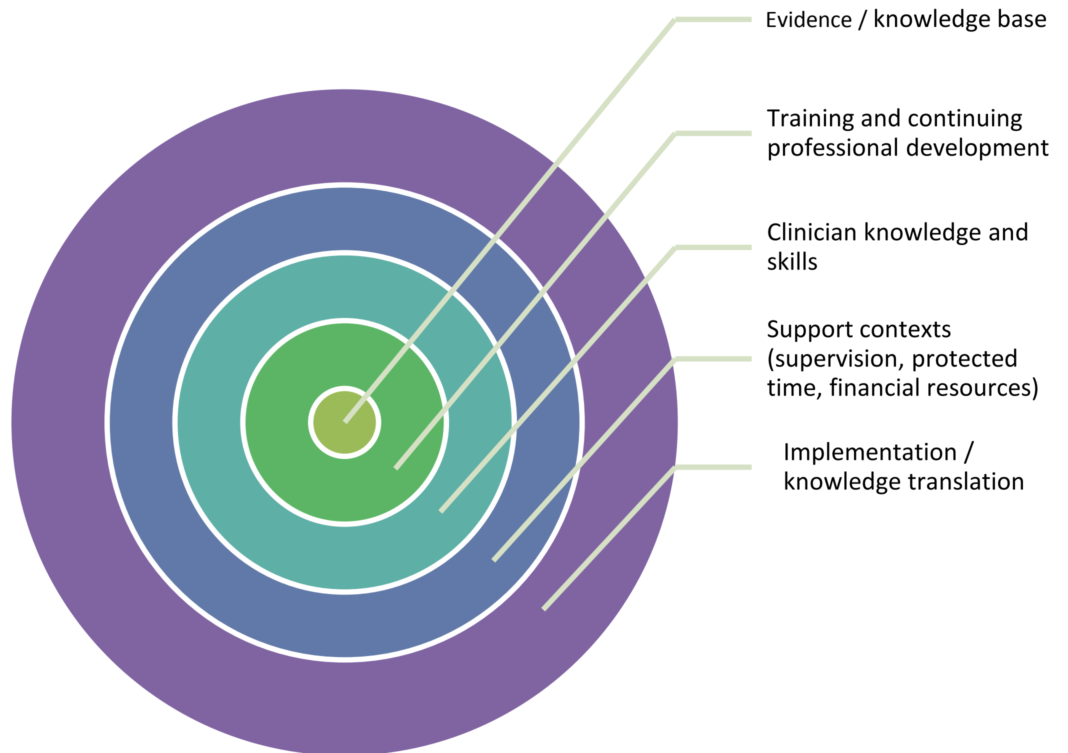
Table 7: Years in each role over the career path

	Mean	Range	Count
Years in current role	4	0 - >25	426
Years in prior role	3	0 - >25	393
Years in first role	2	0 - >25	370

Capability

Capability refers to the strength of the evidence underpinning relevant dietetics profession activities, access to training and continuing professional development (CPD) to develop the appropriate skills, the standard of skills practitioners have to deliver evidence-based services, the contextual supports available (supervision, mentoring, dedicated time and appropriate funding models), and opportunities for change in practice to occur (i.e. knowledge translation and implementation) (Figure 32).

Figure 32: Workforce capability framework



Key findings

- The respondents identified the need to strengthen the evidence base underpinning practice. It was suggested this requires improved capacity to develop the evidence–base and innovative practice. Outcome measures should be developed across dietetic services.
- Under half (42%) agreed that they had career development opportunities and only 24% agreed there was a clear career progression in dietetics.
- Greater need to integrate clinical and research roles to enhance practice and provide career progression.
- Most respondents (93%) said they have the skills needed to complete their work, but only half agreed they have access to adequate training to progress their career (50%) and access to mentorship and mentoring to support their career growth (54%).
- The need for skill development in specialised skills was identified, as was a need for knowledge development about major systems changes, such as the NDIS and My Aged Care.
- Individuals in generic roles have needs for discipline-specific skill development opportunities.
- A lack of training pathways and post-graduate training opportunities was highlighted with respondents indicating specialist and extended scope of practice training at the post graduate level was difficult to access.
- Dietitians in rural areas identified challenges accessing training.
- Poor opportunities for career progression was a strong and recurring theme with 60% reporting a lack of opportunities to develop their career as well as difficulty in securing permanent employment. Respondents were frustrated at the lack of recognition of clinical skills and experience and that they need to work in management roles to achieve career progression.
- Facilitators to career progression included supportive work environments, upskilling by formal training or CPD, opportunities to work in a more senior role, being flexible, and opportunities to do research and project work.
- A formal multi-disciplinary team structure was the most common work arrangement of most participants (75%).
- Skills gaps identified included management, business and professional skills. The need for social media skills by private and community practitioners was also highlighted.
- Seventy per cent (70%) of respondents reported having a supervisor. In most instances supervisors were dietitians (57%) or another AH professional (9%). Thirty per cent (30%) had no clinical supervisor despite working in a clinical role.

Evidence / knowledge base

Respondents identified the need for significant development in the dietetics profession evidence base. Evidence such as outcome measures should be developed at a State-wide level which would help demonstrate the value of AH and develop more cohesion between services. The need for outcomes measures in community health and malnutrition was particularly highlighted.

Participants reported a need for increased valuing of research and greater investment in research. They also noted the importance of more widespread participation in research by clinicians across service contexts.

Dietitians reported the need to develop innovative practice. Some respondents were concerned with the lack of research to expand their evidence-based practice. One dietitian commented that dietetics practice had changed little since she graduated 20 years ago.

Some dietitians were concerned with the role of big corporations and the food industry in funding dietetics activities. It was considered important that the profession was independent source of nutrition advice. For those working in research it was acknowledged that it is hard to attract funding for dietetics research.

"Changing dietetic practices to be less rigid and more patient-centred, evidence based. For example, the way we document in medical files and communicate with other clinical/medical staff."

"We need to be considered as an INDEPENDENT and transparent source of credible nutrition advice. Dietitians are not viewed favourably by the general public for this very reason in my opinion, and so our messages, which are sound and evidence based, are not being considered."

"It worries me to see a tsunami of obesity and diabetes and still seeing the profession stuck in standard methods, I don't necessarily see the practice of addressing and advocating for those issues for sufficient dietitians in the community in settings to support the community in preventing obesity and diabetes. I don't' think we have been innovative enough in those spaces."

"I actually don't see our clinical dietitians doing much different to when I practised 20 years ago."

Training and continuing professional development

Prior work experience

The majority of respondents (71%, n = 301/424) had no prior profession or role before becoming qualified as a dietitian. The remaining respondents (29%, n=123) had worked in another profession or role full-time for more than 6 months before entering dietetics, with just over a third having worked in a health related profession (33%, n=41). For those that had worked in another role or profession, the average number of years worked was five.

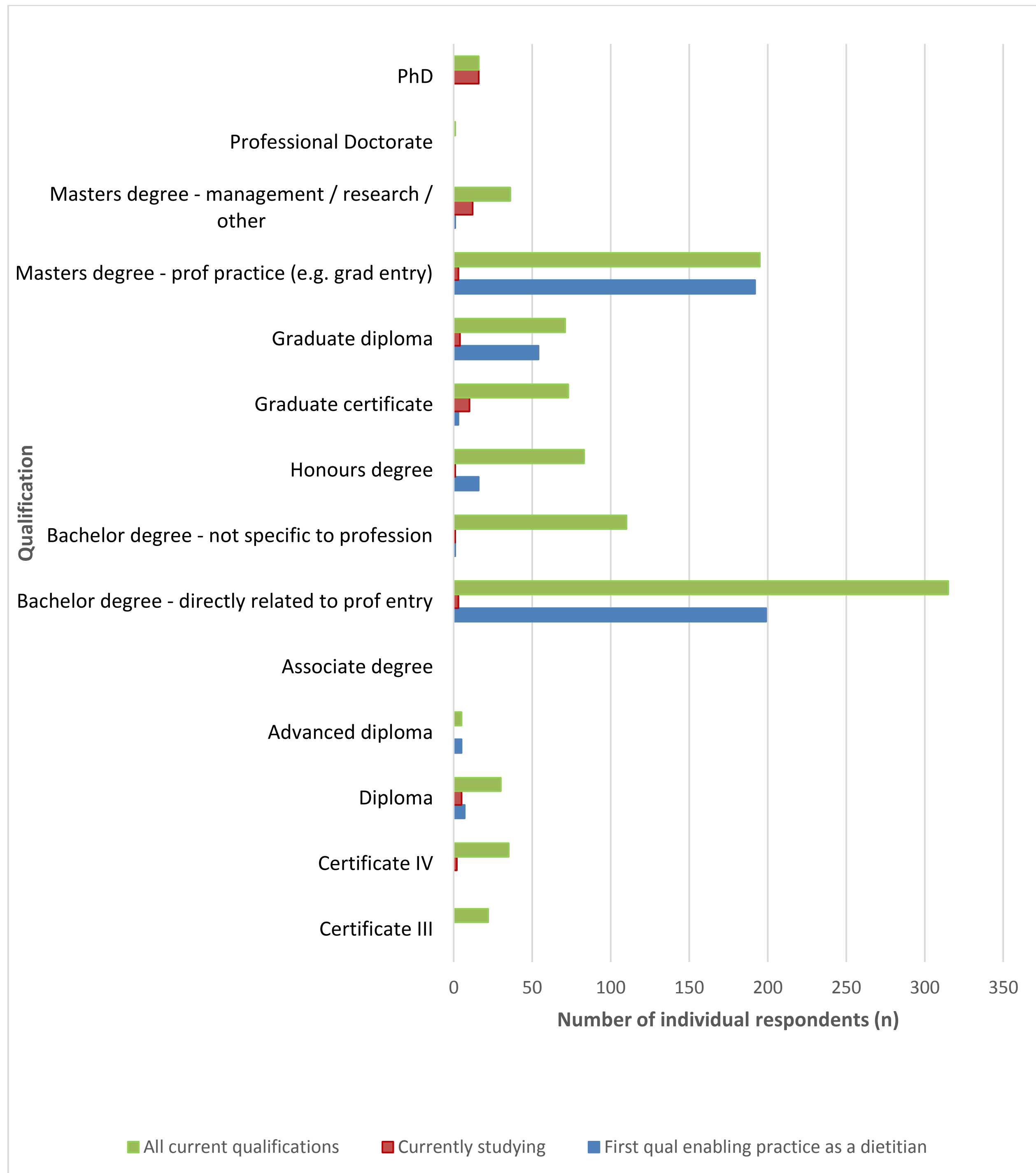
Qualifications

The first qualification that enabled respondents to practise as a dietitian was fairly evenly spread between a bachelor degree (42%, n=199) and a graduate entry master's degree (40%, n=192). A further 11% (n=54) entered the profession with a graduate diploma and 3% (n=16) entered with an honours degree.

Respondents also reported having a range of other post-graduate qualifications including bachelor degrees not specific to dietetics (11%, n=110), honours degrees (n=7%, n=83) graduate diplomas (20%, n=71), master's degree, professional practice or management research degrees (24%, n=231) and professional doctorates or PhDs (2%, n=17).

A further 57 respondents reported that they were currently undertaking post-graduate studies. See Appendix Table 7 for detailed breakdown by respondent numbers to different qualifications.

Figure 33: Qualifications held or currently studying (n=475) [a]

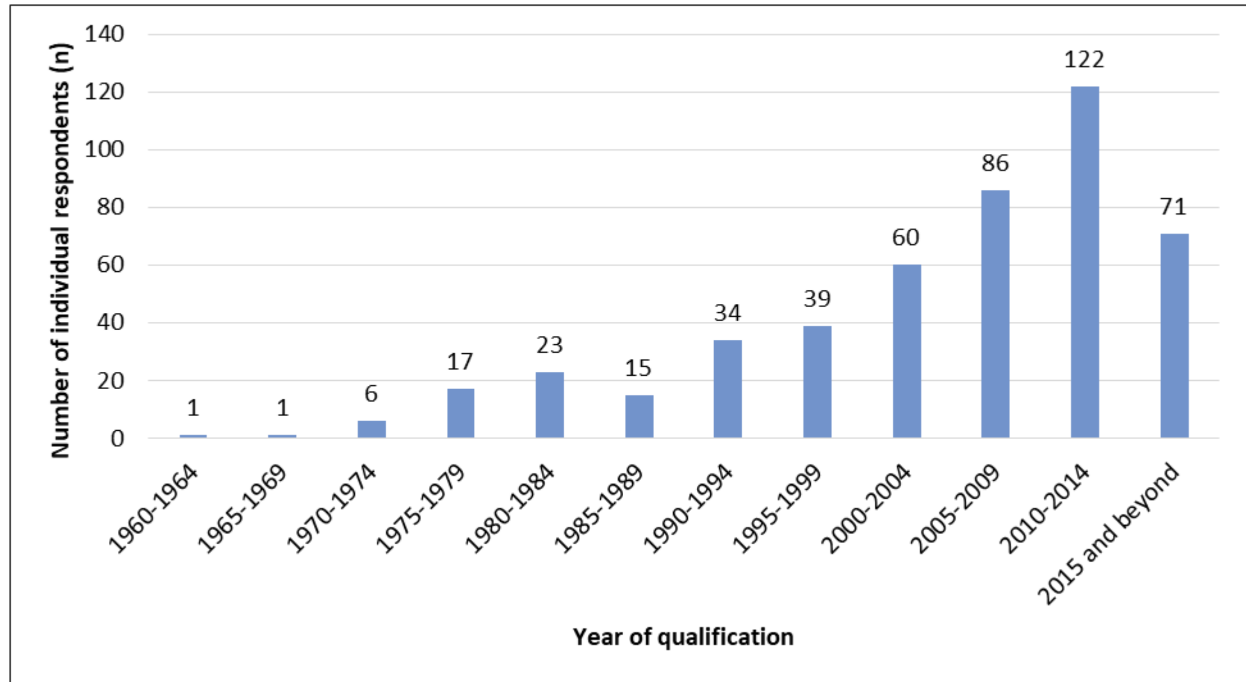


[a] Respondents could select more than one response for 'all current qualification' and 'currently studying'

When considering the total respondent cohort, the mean length of time since completing their first qualification was 13 years.

Forty one per cent (41%, n=193) of respondents received their dietetics profession qualification in 2010 or later (Figure 34).

Figure 34: Year of qualification (n=475)



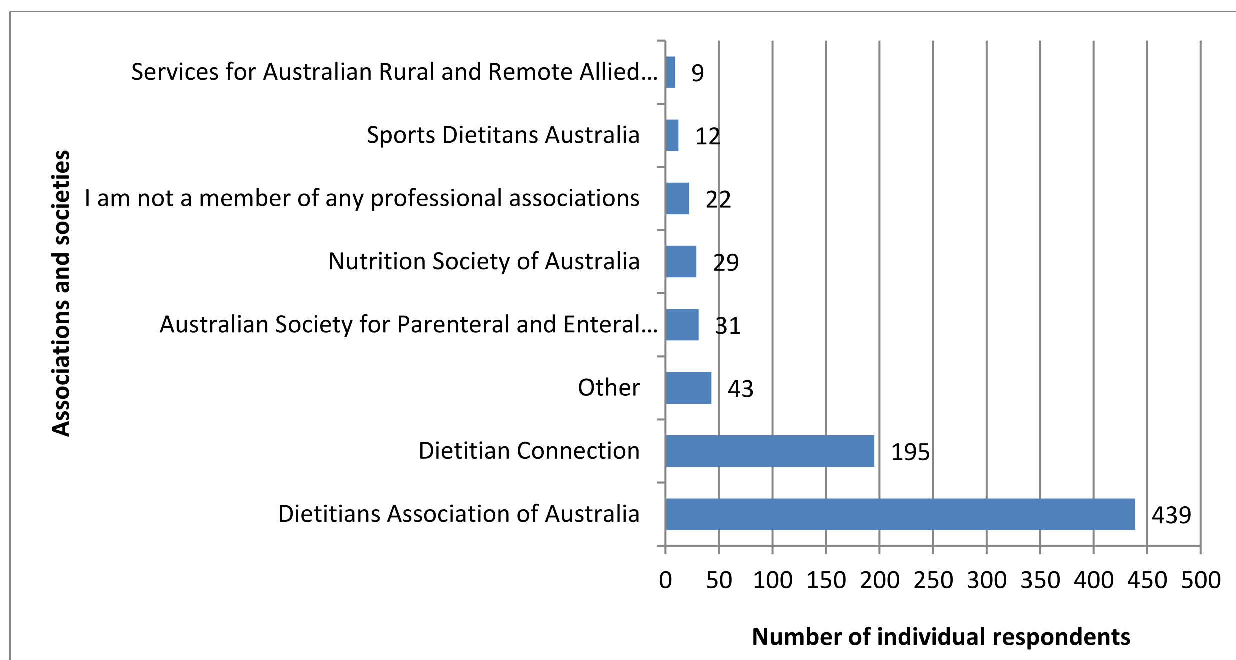
Most respondents qualified to practise as a dietitian in Victoria (72%, n=342), or another Australian state (25%, n=117), predominantly New South Wales (12%, n=59), South Australia (5%, n=22) or Queensland (4%, n=21). The majority trained in a metropolitan area (81%, n=386). Overseas trained dietitians accounted for 3% (n=16) of respondents (Appendix Table 8 and Table 9).

Continuing professional development

Dietitian respondents were asked about their participation in continuing education, whether they belonged to professional associations and societies, and if they felt they had adequate access to professional development and training.

The majority of AHWQ2 respondents were APDs or pending (91%, n=433) and 93% (n=439) were members of the DAA. Other professional associations/organisations which respondents were members of included: Dietitian Connection (41%, n=195), the Australian Society for Parenteral and Enteral Nutrition (7%, n=31), the Nutrition Society of Australia (6%, n=29). Five per cent of respondents (n=22) did not belong to any professional association or society (Figure 35).

Figure 35: Professional associations and societies dietitians belong to (n=474)



Career development and progression

Just over a half of respondents agreed they had access to adequate training to progress their career (50%, n=192) and access to mentorship to support their career growth (54%, n=206). However, on both these measures this leaves close to half of all respondents indicating either a neutral answer to these statements or disagreeing.

Many respondents highlighted the lack of training pathways and post graduate opportunities specifically for dietitians. Unlike other professions, such as nurses, there is very little opportunity to gain further qualifications specific to dietetics. Public and private dietitians reported a need to develop training pathways for dietetic specialties as well as providing continuing professional development that address issues such as extended scope of practice, multi-morbidities and complex conditions. The use of micro-credentialing for specialties was considered a way forward.

For those in the education sector, inter-disciplinary training was considered very important and providing team based clinical placements would be beneficial to students, whilst for those already in dietetic positions accessing training with inter-disciplinary groups would enhance CPD.

Respondents emphasised the need for improved access to professional development in specialised clinical skills and on major service system changes such as the NDIS and My Aged Care.

The cost of professional development was said to be a barrier for some dietitians. Dietitians in rural areas reported a lack of access to CPD.

"We don't have a lot of post-graduate course that support further training in dietetics, this is a significant gap….so it is very hard to come up against, say nurses, who have more robust post-graduate opportunities than dietitians have. I think post-graduate masters qualifications are really important if we are going to keep up with other health professions."

"I have contacted the universities asking "What do you have to offer, I don't really want to do a masters in public health, but saying that I not really sure what direction I should go in, so I would love broader scope of post-graduate courses."

"Overall, I think the allied health professional workforce has started to get more recognition within the hospital setting. However, there isn't acknowledgement of advanced skills in certain areas (recognising

specialists) and limited support to attend professional development events within many organisations (due to time, money etc)."

"Limited CPD for dietitians outside of the metropolitan areas- often we miss out on large meetings, CPD or networking. Cost to attend training (travel, accommodation etc) is also a barrier to career development and progression."

"There are not that many jobs out there, so that is quite difficult knowing where your career is meant to progress to but whether it is possible to get there because there is not that many jobs out there and when people are in jobs they don't tend to move"

With respect to career development and progression, 42% (n=160) agreed they had local career development opportunities however only a quarter (24%, n=90) agreed that they had a clear career progression pathway in their profession (Figure 36). This theme was also expressed very strongly within the qualitative survey responses and focus groups.

When asked about barriers to career progression, 60% (n=188) of respondents reported the lack of opportunities. Lack of opportunities was defined as being 'stuck' at grade 2 / lacking in grade 3 or 4 positions; not being able to secure a permanent position and becoming a parent which curbed career progression. In the focus groups, a common issue raised was the limited capacity to progress beyond grade 2.

Focus groups respondents also expressed frustration that career and pay advancement required them to change into a management role, rather than achieving advancement through a clinical career. Lack of career pathway development was particularly highlighted from those in community health and those in rural locations. Confirming this finding, 52% (n=14) of rural respondents disagreed with the statement they have local career development opportunities. Equally frustrating was the lack of acknowledgement of high levels of clinical expertise and experience as professionals remained in grade 2 roles over many years. Experienced dietitians were keen to develop career opportunities in project management and research roles.

Of particularly concern to dietitians was the siloing between community and clinical practitioners. Respondents reported difficulties in moving from the community sector into the in-hospital setting. For new grads, clinical positions were very hard to get and for experienced practitioners, those leaving a clinical position for any length of time, found it very hard to return as their clinical skills may be perceived as not up-to-date.

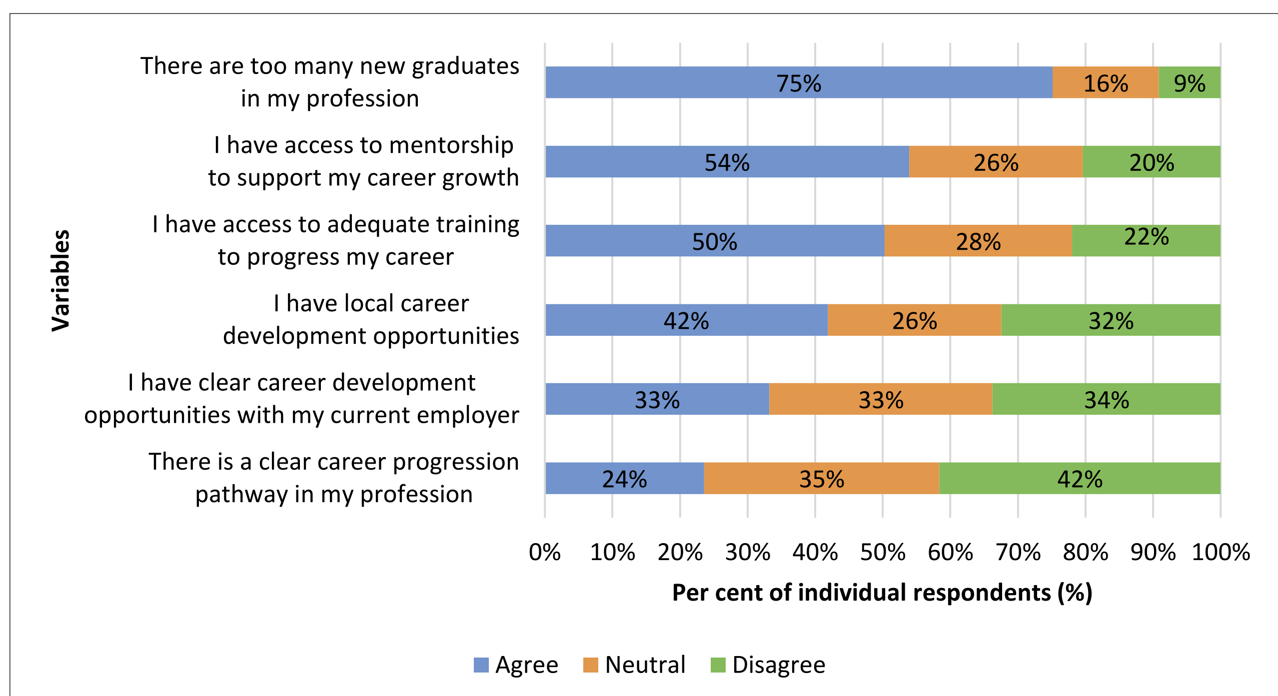
A number of respondents thought that the dietitians lacked career progression opportunities because they were not an AHPRA recognised profession. Many felt that AHPRA recognition would improve their professional standing and provide opportunities to move forward in implementing their extended scope of practice and career progression. In addition, there was a strong desire to link career development with post-graduate opportunities.

When asked about the factors that had supported their career progression, respondents provided the following responses:

- supportive workplace environments that provided good mentoring (21%, n= 60)
- upskilling by undertaking either further formal training or CPD as well as the opportunity to work in more senior roles. All of these opportunities led to a more diverse set of skills (15%, n=44).
- working in a rural setting which provided experience in developing in a broad range of skills (9% (n=27)
- being flexible and taking opportunities as they arose or in the case of private practitioners working hard developing opportunities (8%, n=23)

- *“There should be more emphasis on career development of senior clinicians/allied health, in regards to project management and research. These pathways are unclear and joint positions of clinician and research/project management seem lacking.”*
- *“I left my job in Victoria as there were no career progression opportunities.”*
- *“We need to be on AHPRA, to have recognised standard, advanced and extended scope of practice so that we can have a wider breadth of career progression in hospital healthcare settings.”*
- *“Increased career progression opportunities in community health - more positions that recognise your clinical experience and knowledge that you can bring to the role. More clinical lead/team leader [grade 3 +] type positions.”*
- *“Lack of career progression in rural areas above grade 2, unless going into management. No opportunity for specialisation or acknowledgement of diverse skill based developed working with diverse case load.”*
- *“Clear career progression paths and opportunities to specialise in certain areas with recognised qualifications attached to these areas.”*
- *“For the past three years I have been trying to move out of this position but everyone in the clinical arena feels that once you have done six years in community practice you are no longer up-to-date with the latest practice.”*

Figure 36: Career development opportunities (n=382)

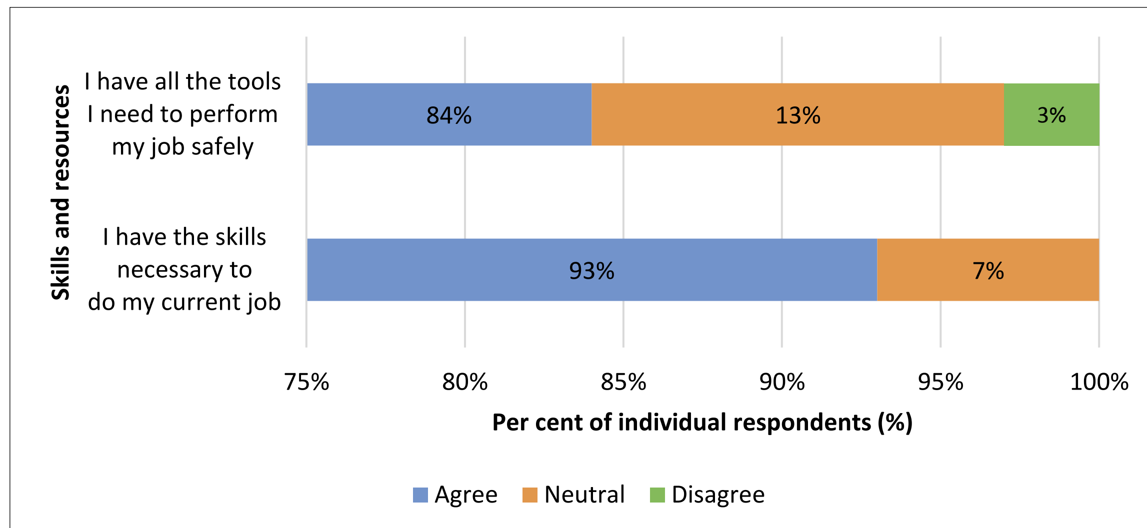


Clinician knowledge and skills

The vast majority of dietetic profession respondents (93%, n=351) indicated they have the skills necessary to perform their job. No-one indicated this was not the case. Somewhat lower than this was the finding that 84% (n=319) of respondents indicated agreement that they have the tools needed to perform their role safely. Although a high proportion, this finding does not diminish the importance of the fact that 3% (n=12) indicated they do not have the tools to perform their job safely and 13% (n=48) gave

a neutral response to this question (Figure 37 and Appendix Table 10 for breakdown by sector of employment).

Figure 37: Clinician skills and resources (n=379)



Some respondents were keen to undertake research activities and to enhance dietetics practice, and they felt it important to integrate research and clinical roles. However there were a number of barriers cited which prevented clinicians undertaking research activities including limited time, funding, lack of clear pathways and backfill. The inability of undertake research activities was also viewed as a barrier to improving the evidence base and career progression, particularly for senior dietitians.

The DAA APD program was viewed as a robust mechanism that provides a model to standardise the credentialing of registered and non-registered dietitians (where an equivalent process is in place).

"I think the APD program has become robust over time and helps dietitians provide evidence that they are working to a particular clinical standard."

"Time constraints in the public system denying opportunities within a position to perform research or quality improvement work.

"There is a clear pathway for clinical work (grade 1 to 4), but the pathway for research positions as a dietitian or joint dietitian/researcher positions in a hospital are less clear and opportunities are lacking for formal clinician/researcher roles."

"Lack of integration between research and clinical roles - you are either in one or the other."

"Inability to perform extra duties/research on top of clinical workload to use as evidence for a higher level position."

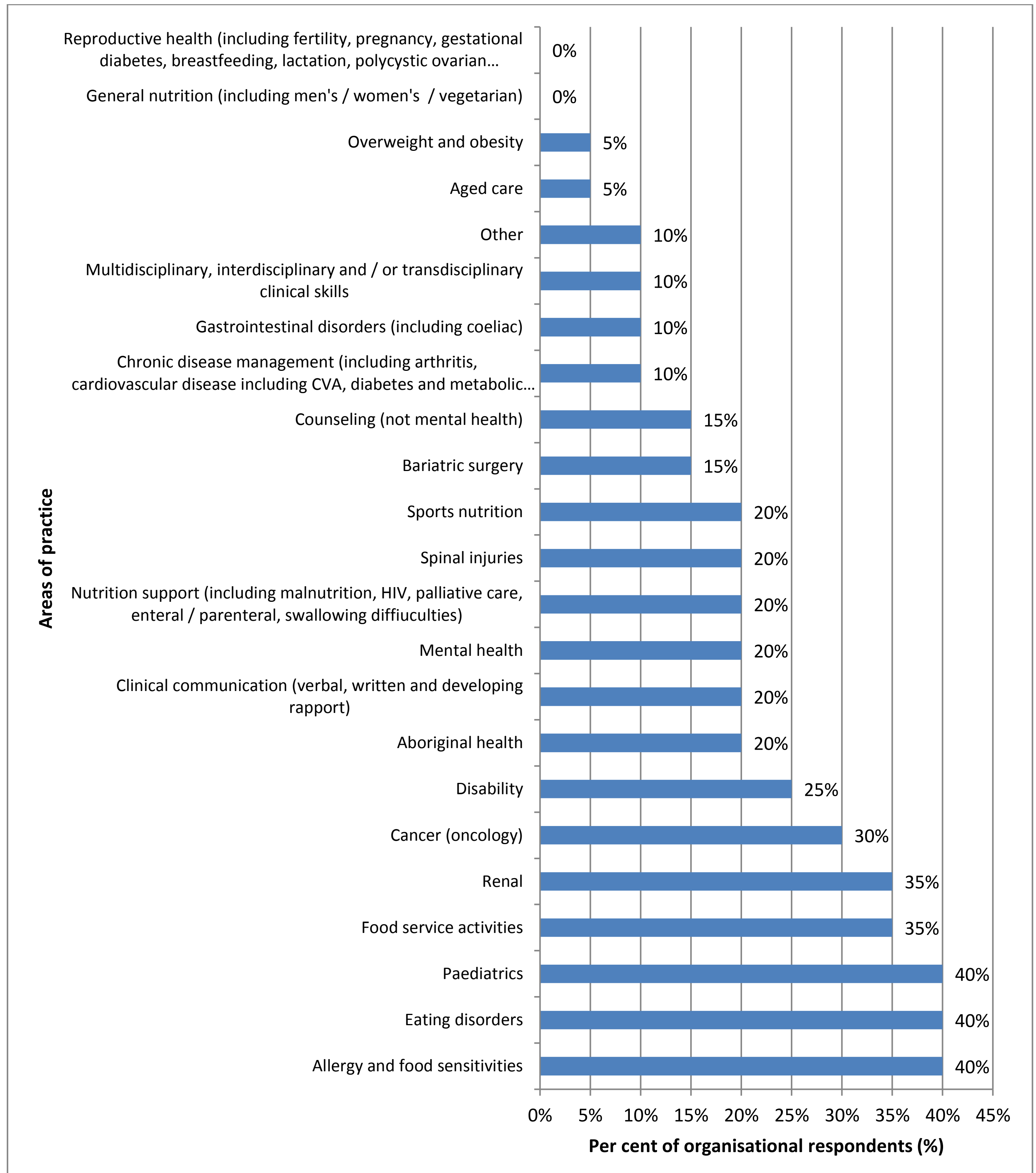
Skill gaps

Eighty nine (89) organisational respondents answered the questions related to skill gaps for dietitians. Of these respondents 53% (n=47) reported a gap in management, business and other professional skills, while 26% (n=23) reported a gap in clinical skills.

Gaps in clinical skills

The gaps in clinical skills that were identified spanned a wide range of areas and were most likely informed by the practice area of each organisation. The most frequently occurring clinical areas in which gaps were identified included: eating disorders (9%, n=8), paediatrics (9%, n=8), allergy and food sensitivities (9%, n=8), food service activities (8%, n=7), and renal (8%, n=7) (Figure 38).

Figure 38: Gaps in clinician skills identified by organisational respondents (n=23)



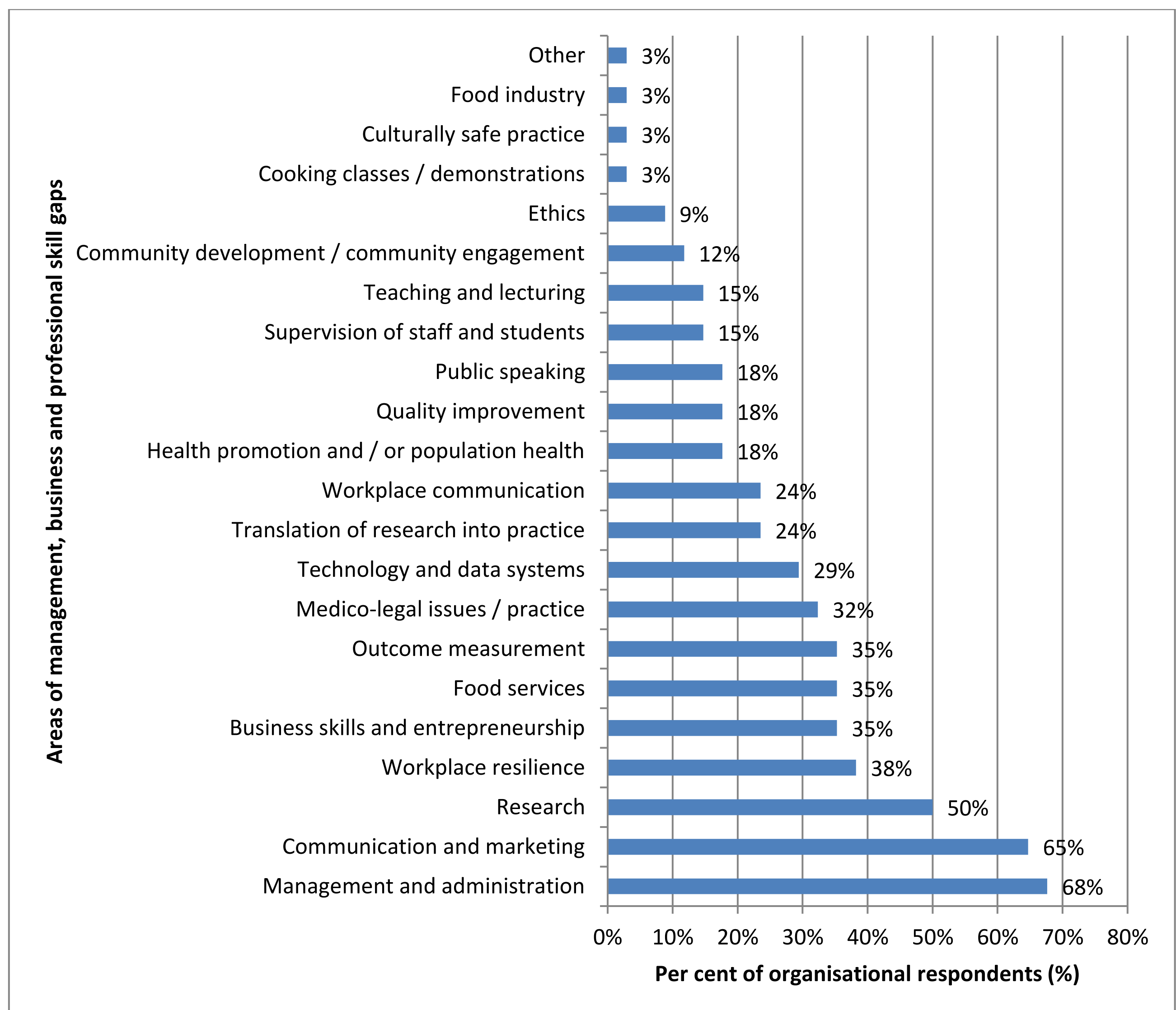
Overall the focus group respondents did not report a wide variety of clinical skills gaps, however those skills they felt lacking included counselling skills and skills for the community setting. They did report the need to develop clinical skills through more robust post-graduate training. In addition, they reported the need to balance the need of developing specialist skills and support generalist roles.

"I think there is a gap where people are working beyond graduate level. The profession has described role statements and areas of work that dietitians can work in (e.g. food services and nutrition support dietitians) but hasn't provided a clear pathway for future training to support dietitians so that they can put their hand up and say "I am a dietitian who is X."

Gaps in management, business or other professional skills

The most frequent professional skill gaps reported were in management and administration 68% (n=23), communication and marketing 65% (n=22), research 50% (n=17) and workplace resilience 38% (n=13) (Figure 39).

Figure 39: Gaps in management skills identified by organisational respondents (n= 47)



Private dietitians consistently reported a lack of business skills being taught at university which is required when working in private practice. Social media skills were cited as being increasing required in dietetics by both private and public practitioners in the community sector. The importance of these

professional skills is increasingly as lack of jobs in the public sector is pushing dietitians to start their own businesses and they require on-going business support in the early years of their career.

"Graduates must be better prepared for private practice, and those starting businesses should receive much more support as they have the potential to create more employment in these professions."

"Support for businesses employing new graduates. There are few jobs available for entry level dietitians and they need support as they enter the profession."

"Choosing to start my own business- I have essentially created my own career where there were insufficient career opportunities."

"Lack of training in business management or preparation for private practice during tertiary training; lack of formal job positions and limited scope of formal dietetics positions (mainly hospital based and nowhere near sufficient for number of graduates)."

"[Private dietitians need] better communications skills from a negotiation point of view, and understanding of what it is like in private practice, more information about Medicare rebates and private health payments, how to market yourself, and basics like how to approach a medical centre."

Support contexts to enhance capability

Supervision and support

The dietitians that responded to the AHWQ2 and contributed to the focus groups emphasised the importance of good quality supervision and support. When asked an open-ended question about the contributors to their career progression opportunities, good mentoring and supervision, and supportive management were identified as the most important factors. Conversely, lack of clinical supervision and support was cited as a barrier to career progression by some.

Clinical supervision

The AHWQ2 showed that 57% (n=222) of dietitians have a dietitian as their clinical supervisor and 9% (n=34) have another AH professional clinically supervising them. However, 30% (n=117) of respondents indicated not having a clinical supervisor (Figure 40). When looking at supervision by sector, 50% of NFP sector respondents did not have a clinical supervisor (n=14).

The mentoring program run by the DAA for new graduates in their first year of work was reported to be highly successful. However supervision post first year and for early career dietitians, particularly in rural areas, was inconsistent. Early career dietitians working in the private sector reported concerns with the lack of supervision and support when dealing with increasingly complex patients. Some respondents highlighted the robust supervision programs in other AH professions such as psychology and felt there was room for improvement in dietetics.

Other methods of support being used included forums, the DAA, Facebook interest groups and informal mentoring.

Administrative supervision

When asked about the professional background of their administrative supervisor, the majority of respondents were supervised by other dietitians 32% (n=126). Just under a quarter received administrative supervision from other AH professionals (25%, n=96), smaller proportions received administrative supervision from professionals from a non-clinical background (9%, n=37) and nurses 7% (n=29). Twenty five per cent (25%, n=98) reported not having an administrative supervisor (Figure 40).

Figure 40: Professional background of clinical and administrative supervisor (n=390)

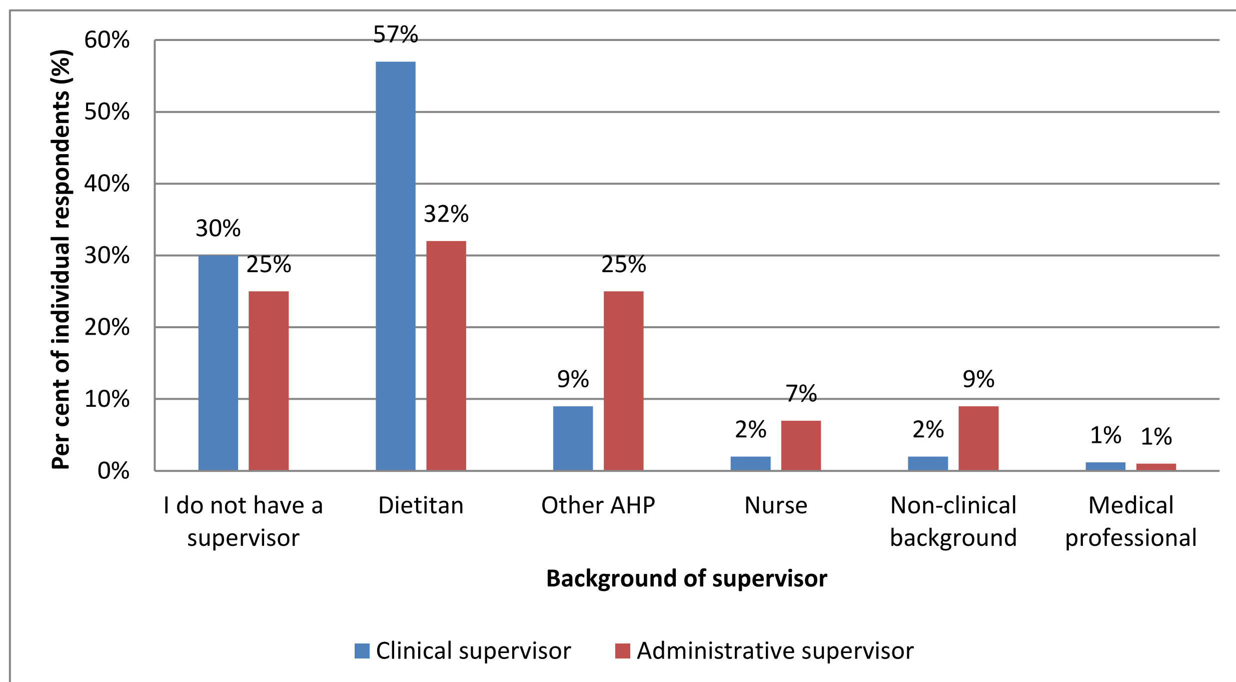


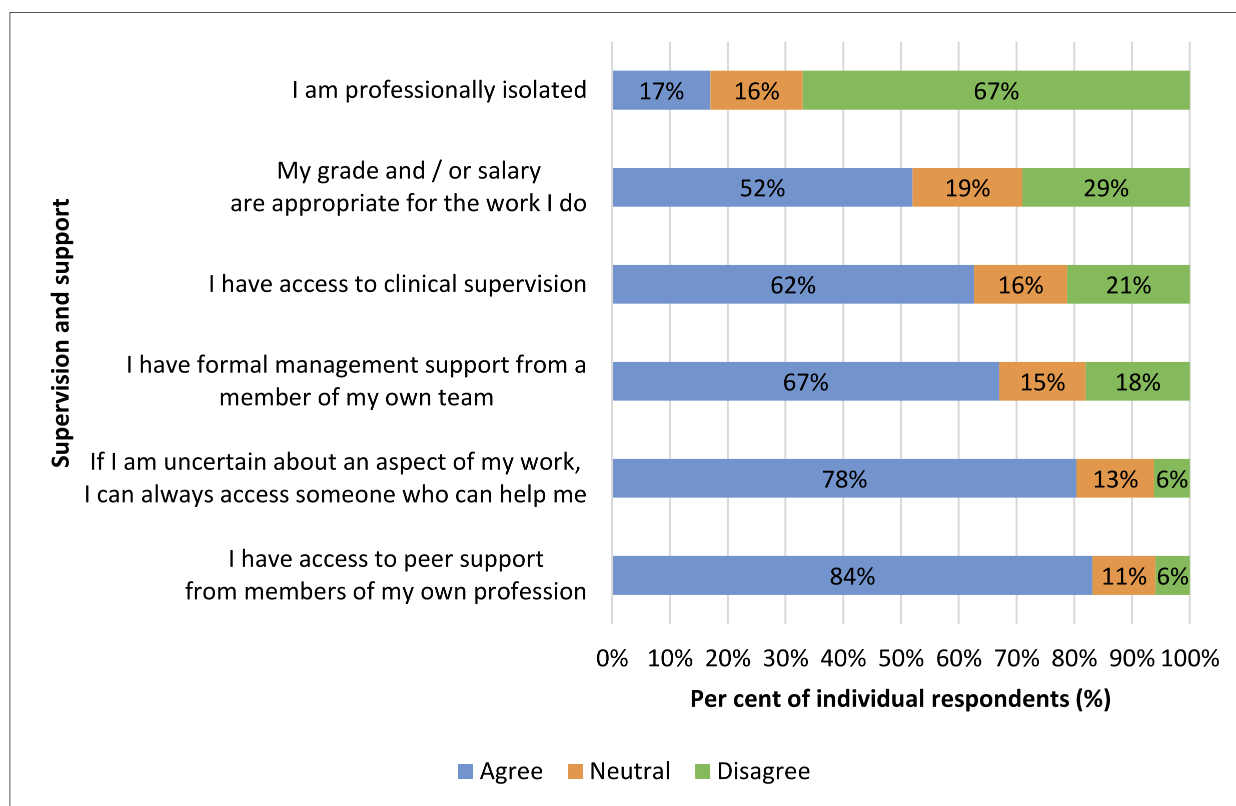
Figure 41 provides further information on the support experienced by dietetic respondents. Most respondents reported that they had access to peer support within their profession (84%, n=315), they had formal management support (67%, n=243), they were not professionally isolated (67%, n=252), and they could access assistance if they were uncertain about their work (78%, n=294). Even so, the context of those who indicated disagreement or a neutral perspective on these issues must not be disregarded. For example, over a third (33%, n=122) disagreed or were neutral regarding their access to formal management support from a member of their own team. Similarly, just under a quarter (23%, n=84) disagreed or were neutral to they could always access someone who could help if they were uncertain about aspects of their work.

A little over half of respondents (52%, n=195) reported their grade and / or salary were appropriate for the work that they do. Conversely just under a third (29%, n=109) disagreed with this statement, this is consistent with focus group and qualitative survey responses which reported having experience and skills that were above their current grade.

When the findings were considered based on the employment sector of respondents, those employed in the state public sector were most likely to report having access to clinical supervision (70%, n=160), formal management support (70%, n=166) and peer support (68%, n=207). Similarly, high proportions of respondents working in the NFP and Commonwealth public sector reported having access to peer support (76%, n=22 and 82%, n=23 respectively). Those employed in university / higher education were most likely to indicate their grade and / or salary was appropriate for the work they did (71%, n=15), that they had access to adequate training to progress their career (71%, n=15), and access to mentorship to support their career (71%, n=15). Individuals employed by a large private provider, such as a private hospital, were most likely to indicate they have formal management support (91%, n=10) (Appendix Table 11 for breakdown by employment sector).

In relation to location, those working in rural areas were least likely to agree with the statements that they had formal management and support (46%, n=12) and had the skills necessary to do their job (89%, n=24).

Figure 41: Access to supervision and support (n=341 - 377)



"[I have had] good mentoring and supervision opportunities when employed."

"My experience with the DAA mentor program was that it was quite flexible, I could tailor it to my needs and I had a really awesome mentor."

"Going rural for my first job gave me experience although I was the sole dietitian and had no supervision, only mentoring from another dietitian from a regional centre - it was a big challenge as a new grad without support. My second job (still work 2 days) was in private hospital with little supervision or support. My more recent role (3 days) in a larger public hospital offers more support and development but in my area there is not much career growth."

"I do have concerns about supervision outside of the very structure setting of the public service, I look at our psychology colleagues, they are very strict, I think dietitians are stilling learning and what it entails, we do reflection but not actual case discussion and the nitty gritty."

"More structured mentoring/supervision program for new graduates who wish to go into private practice."

"In my experience across three community health organisations, there has only been capacity to provide operational supervision, not clinical supervision."

"There is a very large volume of new graduates (and more courses starting) with no growth in clinical hospital-based positions (which in general are the most supportive, team-based and effective supportive roles in my opinion). Many new graduates have to volunteer their time and / or go into private practice (or equivalent) roles that are often in isolation and not into a supportive team environment/workplace. Universities do not seem to design their curriculum to best support these pathways."

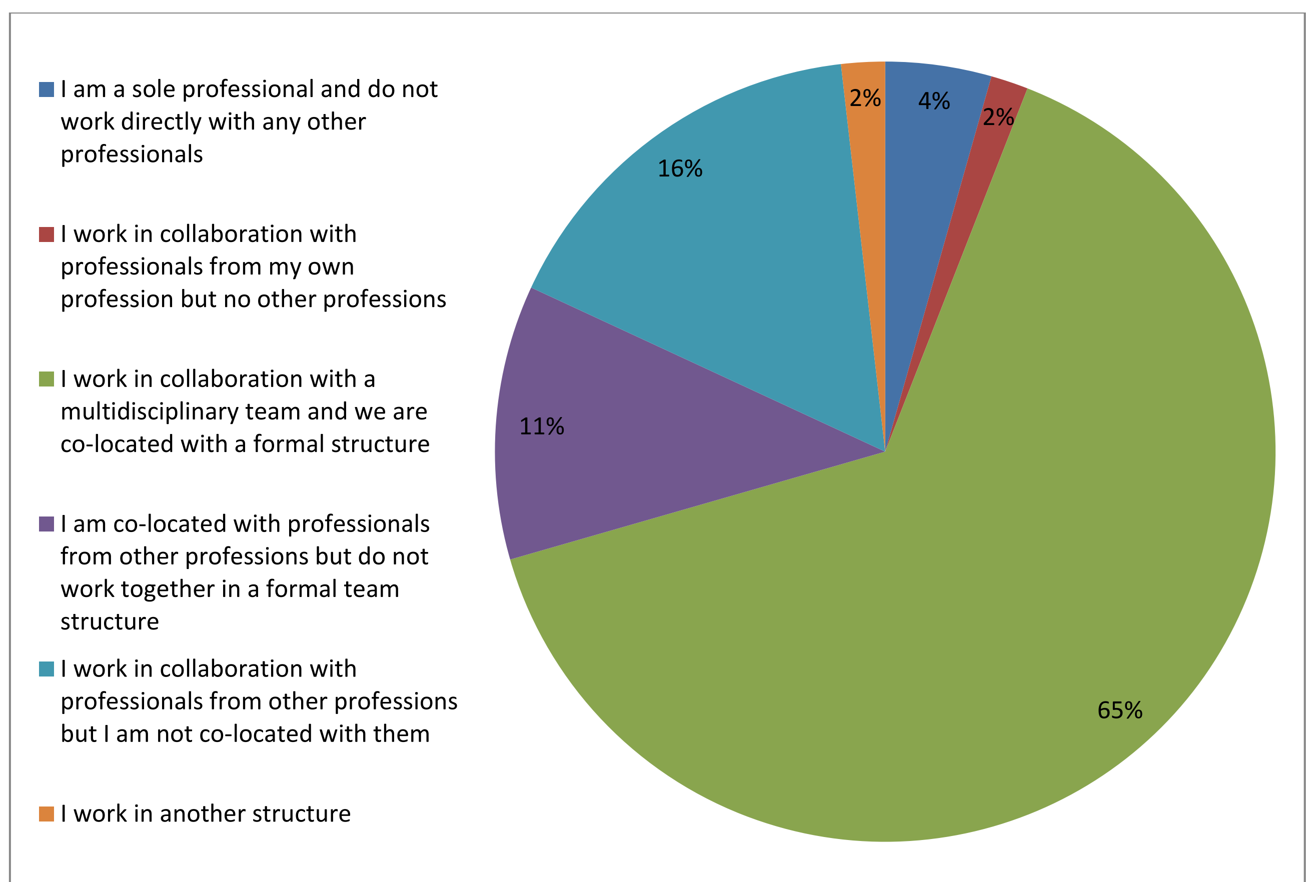
Team structure

The majority of dietitians (65%, n=250) work in a co-located, collaborative, multidisciplinary, formal team structure, and another 16% (n=63) work in a similar fashion but are not co-located. Smaller proportions (11%, n=44) were co-located with other professions but did not work with them in a formal manner. A small proportion of individuals reported being sole practitioners who do not work directly with other practitioners (4%, n=17) (Figure 42). Multidisciplinary teams which worked well were considered a key factor in enhancing career progression.

“Supportive team, encouragement to pursue personal interests, financial support to engage in professional development.”

“Having a fantastic team and manager [has enhanced career]”

Figure 42: Practice structure (n=387)



Private practice respondents identified that collaboration with their colleagues may be more challenging and happen less often.

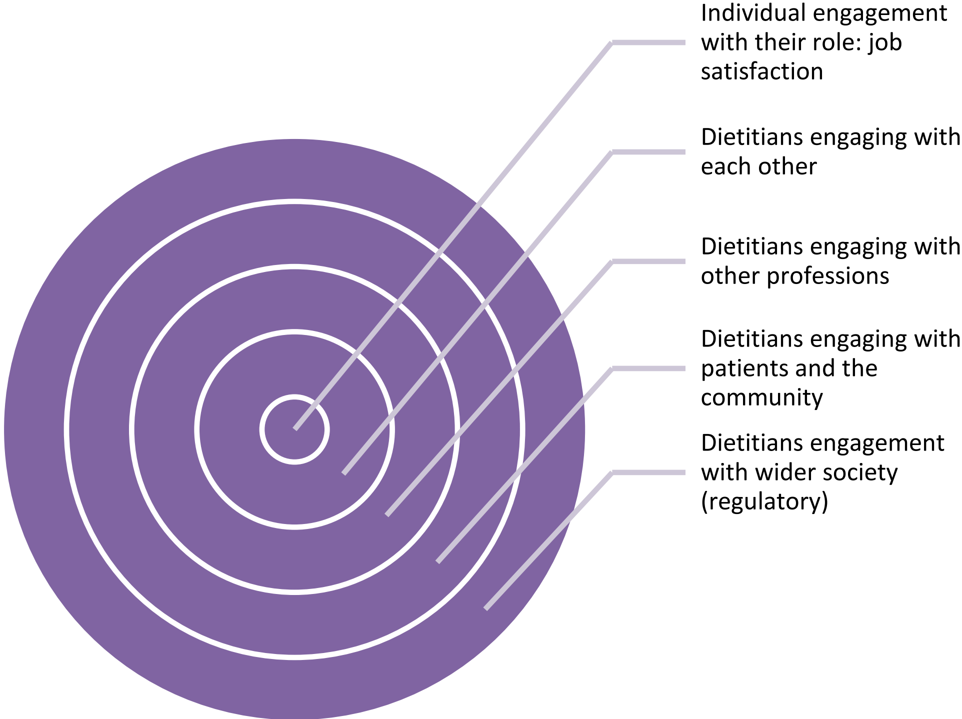
“It’s like you are islands in private practice,…it’s been my experience and others experience that we don’t in general talk to each other. I might talk to a couple, particularly who I refer to because of what I specialise in, but the reality is, the time taken out doing that sort of stuff is time taken away from other aspects.”

“

Engagement

Engagement involves a continuum from the individual practitioner's engagement with their role to the wider engagement of the profession with society through regulatory mechanisms. Within this continuum there is engagement with the profession, engagement with other professions, and engagement with patients and the community (Figure 43).

Figure 43: Model of engagement



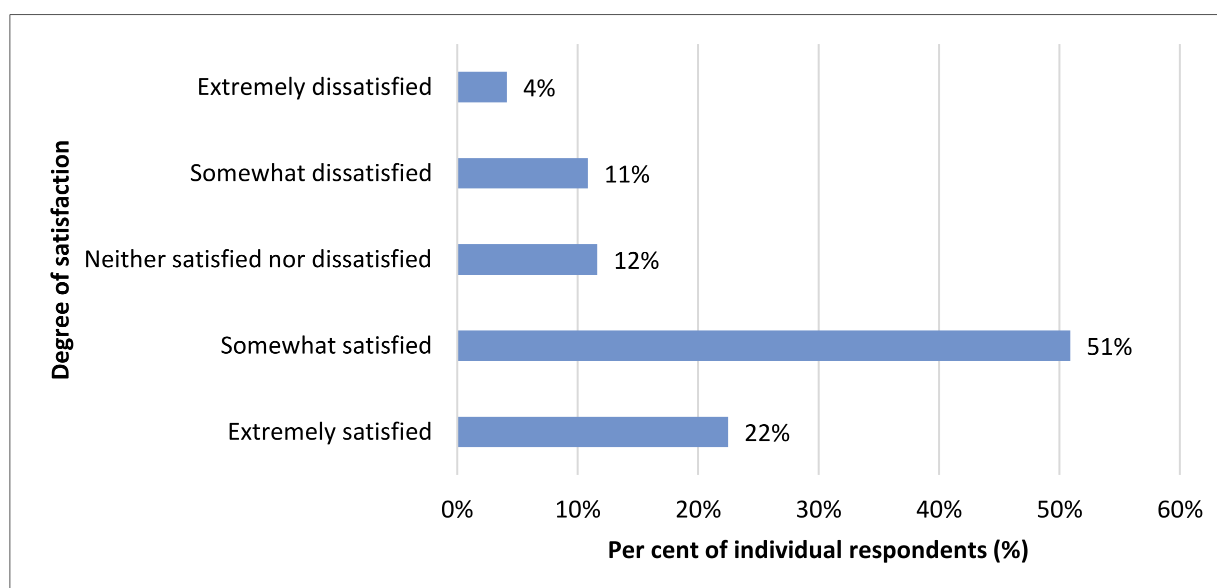
Key findings

- Most participants expressed being extremely satisfied (22%) or somewhat satisfied (51%) with their careers.
- Job satisfaction was reported to be supported by work-life balance, the type of work and clients, location, professional development opportunities and support.
- Career advancement was the issue for which the highest proportion of respondents reported dissatisfaction in their current working life (36%).
- Job insecurity was expressed particularly those working in the community sector with the introduction of market-based funding mechanisms.
- *The Dietitians Association of Australia* was reflected as an important enabler of intra-professional engagement, including professional development and conferences, mentoring program, and interest groups.
- Some dietitians wanted registration similar to other AH professions and viewed this as important to develop the profession's role and practices.
- A strong and recurring theme was the need to build community understanding of the role of the dietetics profession to enable referrals and best practice performance. A need for strong advocacy at all levels was highlighted.
- Dietitians reported a siloing of the profession between clinical and community focused employment. Movement from community to clinical roles was difficult.
- Corporate sponsorship of dietetic activities was considered to discredit the profession.

Individual role engagement

Just over half (51%, n=197) of all dietetics respondents reported being somewhat satisfied with their current work situation. A further 22% (n=87) indicated being extremely satisfied. Twelve per cent (12%, n=45) were ambivalent regarding their satisfaction, and 17% (n=58) stated being either somewhat or extremely dissatisfied (Figure 44 and Appendix Table 12 for breakdown by employment sector).

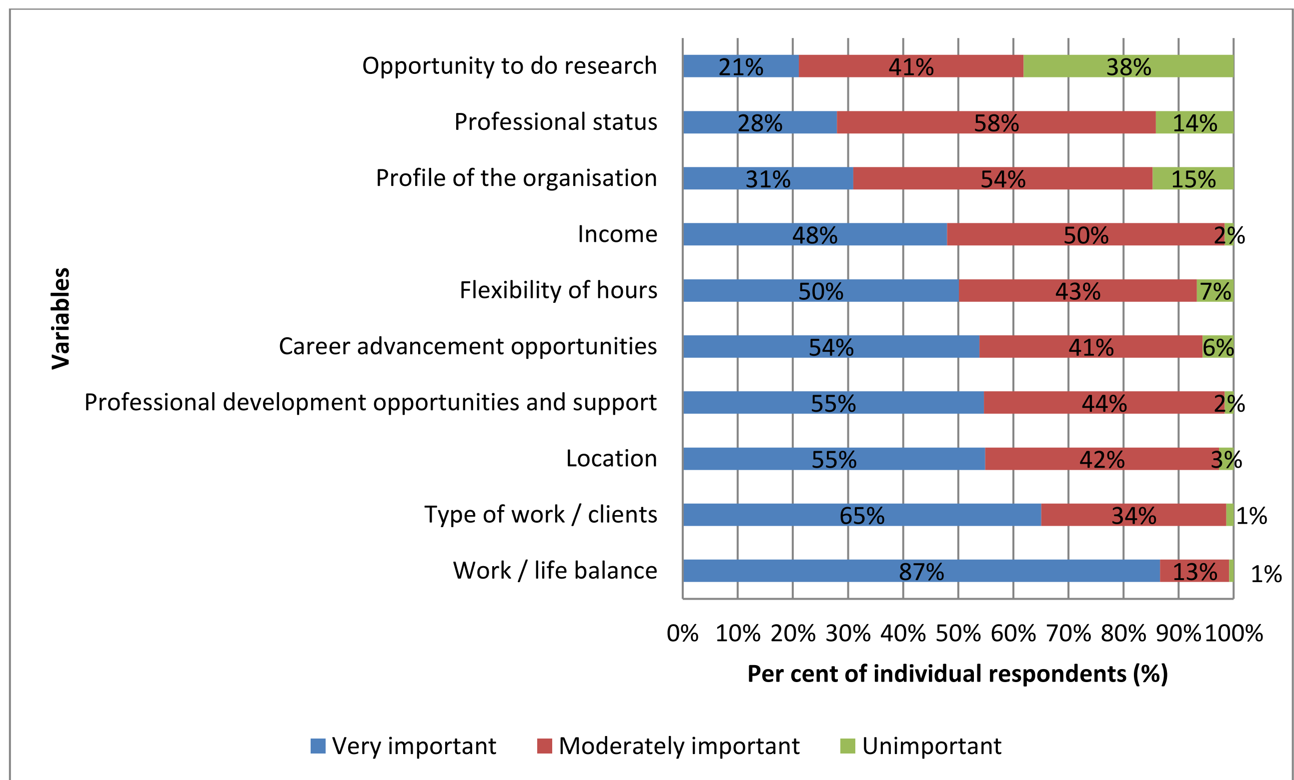
Figure 44: Overall satisfaction (n=387)



Participants were asked about the relative importance of different features of their employment. Five features were identified as being important to the greatest proportion of respondents:

- work-life balance (87%, n=325)
- type of work / clients (65%, n=244)
- location (55%, n=206)
- professional development opportunities and support (55%, n=205), and
- career advancement (54%, n=202) (Figure 45).

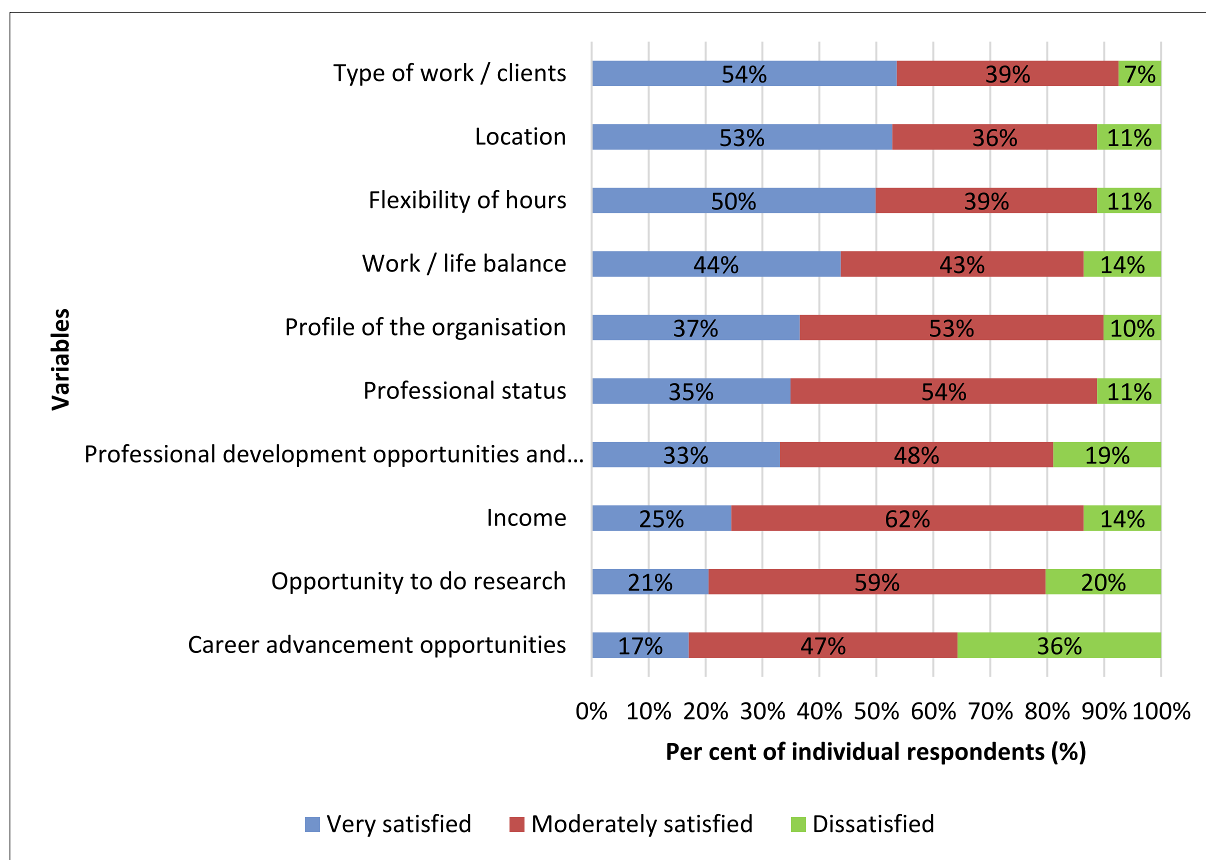
Figure 45: Importance of factors in employment choices (n=375)



However, the proportion of those who indicated they were currently very satisfied with these features was markedly lower. Fifty four per cent (54%) rated career development opportunities as very important but only 17%, (n=64) were very satisfied with their current situation. The same applied to professional development opportunities and support, only 33% (n=124) very satisfied, and work life balance with 44% very satisfied.

The variable that had the highest proportion of respondents very satisfied with was type of work/clients (54%, n=201). Career advancement opportunities was the factor where the highest proportion of respondents (36%, n=134) reported dissatisfaction in their current working life (Figure 46).

Figure 46: Current satisfaction with factors affecting employment choices (n=375)



"I felt much more positive prior to starting a family. I definitely feel my career progression is now limited by my part time hours."

"I feel there is a good variety of areas of work you can choose from if you work in the public health system and there are opportunities."

"We are often a minority profession and for any senior positions like team leaders, it is very rare for dietitians to be listed as one of the desired professions…I have been in this role for six years and I feel very trapped."

I'm really satisfied in my career in private practice so far to me it means flexibility, having a good work life balance and being valued and supported in the AH team which looks different depending which clinic I am in, and earning a good income."

"At my previous job there was more career satisfaction, there was a lot less pressure, there was a lot more health professionals to patient ratios, you were able to give patients the time they needed and see most of the patients that needed to be seen. At this site the pressure is a lot harder, the patients are a lot more unwell, you don't really get to do your best work."

The issue of workplace satisfaction was explored in more detail in the focus groups; participants spoke about the importance of:

- career progression,
- job security,
- being a valued team member,
- having the opportunity to work across different areas of practice, client groups and locations,

- being able to pair flexible work arrangements to maintain work-life balance, meet family obligations and meet other working commitments,
- location of work being a reasonable distance from home,
- achieving good outcomes for clients,
- feeling well supported,
- being able to advance clinically and receive pay that reflects clinical skill and experience,
- having good relationships with colleagues,
- being supported and encouraged to participate in ongoing learning that is embedded in your work and also that is available through formal means,
- experiencing diversity in workload, and
- having opportunities to progress in levels of responsibility and leadership.

Dietitians reported that although their skill set is diverse they were often overlooked for senior AH managerial positions because professionals who are the same profession as most of the team members are often preferred.

"AH management professions are often challenging to get because they are often given to the person that has the professional background that most of the staff have… so it physios or OTs or social workers and they tend to get the more general allied health managers positions ahead of dietitians.""

Although the majority of AHWQ2 respondents indicated they were in full time work, many qualitative responses to the survey indicated that job security was an issue. This concern was consistently expressed by those working in the community sector. The reasons for concern were not entirely clear. It could be speculated that this was an anticipatory response to the introduction of an increasingly market-based system through funding mechanisms such as My Aged Care and the NDIS. In addition the absence of dietitians as a registered therapist in the NDIS is a barrier to providing employment opportunities. Additionally, it is possible that although the respondent cohort was predominantly comprised of individuals in permanent employment, their responses might reflect observations of others in the profession who may not have been reached by the AHWQ2 survey.

Intra-professional engagement

In addition to respondents' relationships with their dietetic profession colleagues through their employment, feedback from the research participants reflected that DAA (the national association representing dietetic profession in Australia) is recognised as a key facilitator and reference point for intra-professional engagement and discipline-specific change at a systems level within and beyond the profession. Issues individuals referred to included:

- Mentoring program for the first year of employment for APDs
- interest groups
- professional development events and conferences

"Networking through involvement in my professional association helped my career progression."

However, a number of respondents commented there is a need for the DAA to provide innovative and stronger leadership to support the development of the profession.

"There is limited leadership from the professional body, DAA to support the development of the profession."

"The workforce has changed substantially in recent years but the professional association [DAA] and council [DCC] and the accreditation requirements and processes are holding back the profession."

“I think there is also a serious conflict of interest with our professional body being associated with the food industry and this really needs to change for our profession to be taken seriously.”

Issues respondents identified as being important for enhanced intra-professional engagement in the future included:

- breaking down silos between community and clinical (hospital) dietetic practitioners
- developing training pathways for dietetic specialties and extended scope of practice
- advocating for evidence-based practice that enables the development of innovative practice and ensures achievement of client outcomes.

““I have been in the profession for 35 years and there is a divide between the clinical and those who work in the community, health promotion, health prevention and a sense that those who work in clinical are somehow are better dietitians…that is driven by dietitians and that is something we need to work on in the profession.”

“Recognition that a public health dietitian is just as 'worthy' of being called a 'dietitian' as a clinical dietitian. I have never worked clinically; my work is concerned with creating more sustainable, fair, nutritious food systems for local communities when people can access the food they need for a healthy diet. I feel like a fraud when I call myself a dietitian because I'm not interested in the medical side of things, or prescribing 'diets'. I think there's a real disconnect between the two ends of the spectrum within our profession, even though we recognise the importance of prevention.”

At the individual level, challenges to intra-professional engagement were reported to include:

- the cost of professional development
- lack of support and funding from employers to attend professional development and training

Professional isolation was reported as an issue for 17% (n=64) of respondents and 16% (n=58) were neutral on this issue. By sector those who were most likely to be isolated were private practice employees and not surprisingly, dietitians working in rural and outer-regional areas (33%, n=9 and 27% n= 6 respectively).

“Workplace has minimal funding to support attendance at professional development events.”

Inter-professional engagement

Dietitians wanted greater awareness by their professional colleagues of the role and contributions of the dietetics profession. Other professionals’ lack of understanding of the function and value of dietitians results in poor dietetic care, clients being referred in later stages of disease progression than is desirable or clients not being referred at all

Focus groups reported a need for greater strategic planning and leadership across professions as a whole. Areas which would benefit from greater dietetics involvement included aged care and malnutrition. Dietitians reported their experience within the aged care sector as frustrating, observing a need for dietetic input but funding mechanisms did not support their work. Dietitians wanted greater awareness by their professional colleagues of how and where to access services.

“In general I believe dietitians and clients are poorly referred by GPs and other health professionals (nursing, hospitals, other AH) when they are at risk / have chronic health conditions that can be assisted by dietary modification. In addition those that are referred often are reluctant to attend, as there can be a feeling of "I know what I should eat" by clients.”

Overall I think we are missing opportunities for earlier intervention in chronic disease, both because of health professional and client inertia.”

"I work in two settings. One of my settings has a head of unit [who is] very pro dietetics and patients get excellent nutritional care. In the other setting the medical director does not think dietitians have a role. As a result patients get suboptimal nutritional care."

"Improved recognition by other health professionals and general public about what we can provide."

"Despite working in an area of great need, in community health, we don't have a waiting list and I don't think we are our best advocates. We need to get in that space of GP's and specialists and we need to be getting the referrals."

A strong strategic lead was required at all levels including the government. One respondent highlighted the aggressive public health strategic direction on obesity in the United Kingdom and in particular the referral of patients for weight loss before surgery. The respondent was concerned that the evidence-base in Australia has not been well developed regarding dietetic input, however those practising bariatric surgery have advocated strongly for bariatric surgery.

"We need to do more research and develop more guidelines…so what we are doing is evidence-based, justifiable to the organisation, and understood by our medical colleagues."

"The bariatric surgeons have been pretty aggressive to lobby for bariatric surgery to be publicly listed and they have developed a lot of research looking at the health economies and argue that it is much more cost-effective to have weight loss surgery…..I would like to see some more outcome measures in AH developed."

Engagement with the community and society

As was the case for many of their professional colleagues, many dietitians reinforced the importance of improving community and the public understanding of the role of the profession. They identified the need to build greater understanding of the role of dietetic profession in occupational performance and delivery outcomes this brings for individual quality of life as well as health service efficiency and sustainability.

When asked what was the single most important issue for the dietetic profession to address a common response was improving awareness of the dietetic profession as the leading expert in area of nutrition and dietetics 13% (n=55). Dietetics as a career choice was acknowledged to be increasingly popular.

Dietitians consistently reported the need for the dietetics profession to advocate strongly the importance of their role to the public. Although advocacy was needed at all levels and was perceived as the responsibility of all dietitians, ensuring that there is a strong social media presence was considered particularly important. Nutrition and food-related issues generate high publicity and some messages that are given high media coverage are not evidence-based.

The causes of poor community awareness of dietetics profession included limited awareness on the part of other referring professionals, challenges delivering comprehensive and evidence-based services in the context of current funding models and models of care, and a need for greater evidence about dietetics profession interventions and outcomes. They wanted increased advocacy for funding rebates that more accurately reflect the full cost of service provision.

In the area of weight-loss management, the dietetics profession was competing with a strong private industry which often focused on interventions which provided immediate results but had little long lasting effects. Many evidence-based dietetic weight loss interventions work at a slower pace, and therefore may not be as appealing to clients.

Some dietitians were concerned with the role of corporate sponsorship to the dietetic profession. They felt the view of the profession by the public is discredited when it is tied with business interests in the food industry.

“I think there has been some fantastic work done…when I trained no-one knew what a dietitian was and now everyone wants to be one. I think that is incredible and fantastic and a huge innovation from where we were.”

It needs to modernise and recognise the advances in technology etc. that impact the public's knowledge and understanding of food and nutrition.”

“More dietitian representation in the media and review of corporate sponsorship. I think we need to improve our image and help people understand what we do.”

“I think one of the profession’s weaknesses as a whole is advocacy on behalf of what they can do.”

“Establishing the reputation of dietitians amongst the public (including ending corporate sponsorship of professional organisations).”

”Concerning the obesity crisis I think it is going to take a multi-level approach – various levels of government, the food industry, the health system, cultural norms that it is acceptable to have a large girth.”

For some AHWRQ2 respondents (8%, n=25), the single most important issue to be addressed by the profession was becoming a registered profession under AHPRA. Focus group discussions also highlighted the importance of this issue. It was felt that the professional status, understanding by other health professionals and opportunities to move forward in implementing their extended scope of practice and career progression would be enhanced by being regulated. A number of respondents thought that the lack of career progression opportunities was because they were not an AHPRA recognised profession. In addition AHPRA registration would bring them in line with some other AH professions.

“We need to be on AHPRA, to have recognised standard, advanced and extended scope of practice so that we can have a wider breadth of career progression in hospital healthcare settings.”

“Dietetics should be regulated by a government body and not a privately owned company (DAA), this way we could ensure more transparency, aiming to appear more credible in the public eye”

“I am keen for dietitians to be registered via APHRA, in line with most other allied health.”

Conclusion

The dietetics profession is a young and predominately female workforce. Supply of junior professionals is strong with a 95% increase in graduates over the last seven years. There is great concern that there is an oversupply of practitioners causing difficulties in new graduates finding positions and inhibiting movement for existing employees. Despite strong growth in the workforce, dietitians expressed concern that there is limited capacity within existing resources to meet the growing dietetic and nutritional needs of the ageing population.

Dietitians are highly qualified, however it was identified there were limited dietetics specific post-graduate study opportunities as well as gaps in business and professional skills. In addition, there was a desire to innovate and strengthen current evidence-based practice. This could be supported through the integration of clinical and research roles, increased use of technology and dietetic input into research funding bodies.

Within the professional community and across the broader community in general, there is a need for greater understanding of the role and contribution of dietetic profession. Contributors felt this would be enhanced by improved communication and advocacy about existing evidence for dietetics profession interventions, APHRA registration and transparent relationships with the food industry.

Overall, the dietitians contributing to this research were satisfied with their careers and had a strong commitment to practising as skilled clinicians working directly with clients. They expressed aspirations to develop their skills and knowledge to deliver the best possible clinical services across their careers. However, career structures to support these aspirations require considerable attention particularly in the area of clinically focused career pathways. Without this the opportunities arising from this commitment are not likely to be realised within the health and human service system.

References

Australian Bureau of Statistics. (2011). *Census of Population and Dwellings 2011*. Provided to Southern Cross University by Department of Health and Human Services.

Dietitians Association of Australia. (2015). *Definition of a dietitian*. Retrieved from https://daa.asn.au/what-dietitans-do/definition-of-a-dietitian.

Dietitians Association of Australia. (2017). *DAA membership data*. Unpublished

Victorian Public Service Commission. (2016). Public health services (hospital) workforce dataset. Provided by Department of Health and Human Services

Appendix

The following section contains additional data, figures and tables referred to in the main report relating to the data collected through the AHWQ2 dietetics survey.

Responses and respondents

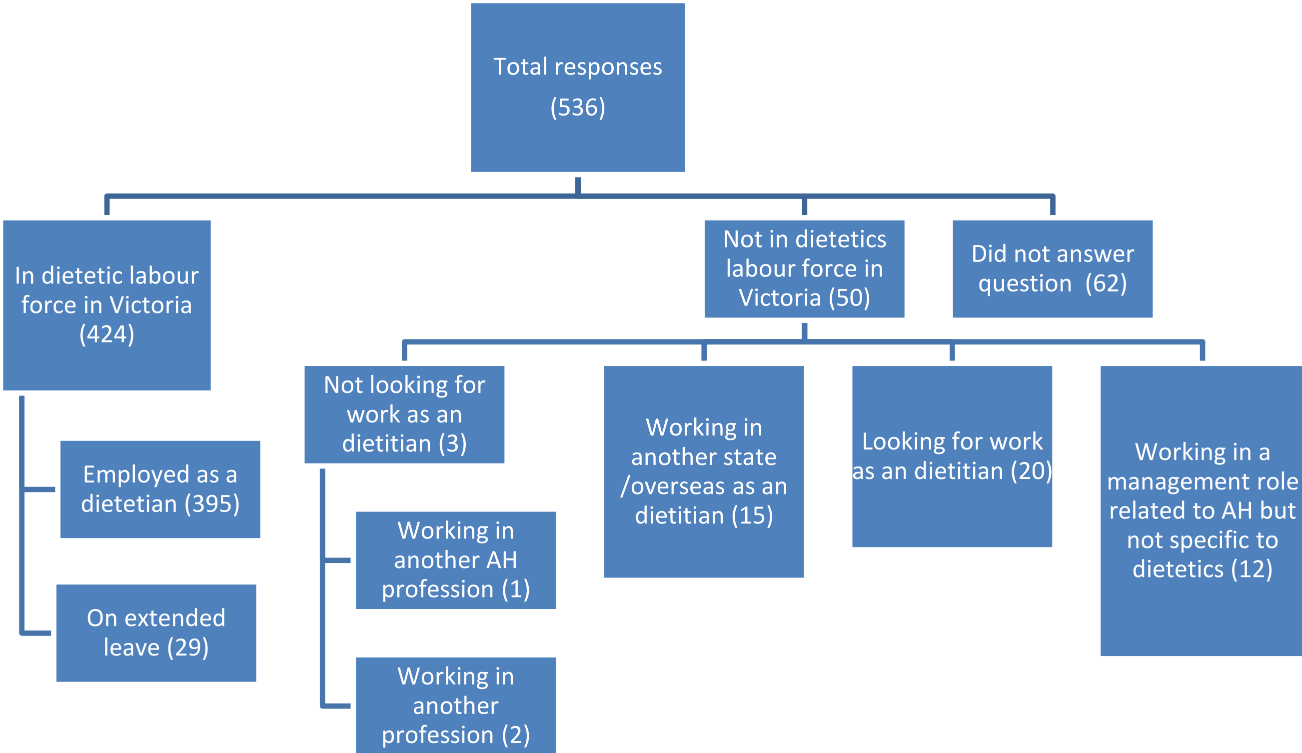
The AHWQ2 survey was completed at both the organisational and individual practitioner level. The respondents to the organisational / managerial level questions were presented with 12 questions, plus four questions that were conditional on answers to previous questions; the individual clinicians were presented with 66 questions plus seven questions that were conditional on the answers from previous questions. Completion of the survey was voluntary and respondents, both organisational and individual, had the opportunity to choose if they wished to answer a question or not. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 536 dietitians completed at least one question on the survey and submitted their survey. The range of respondents to an individual question ranged from 50 to 2,732. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

A total of 195 respondents (36%) provided their email address and agreed to be followed up for further research.

Most respondents (89%) were employed in the dietetics workforce in Victoria at the time of completing the survey. Twenty of the 50 respondents who indicated they were not currently employed as a dietitian in Victoria reported they were actively seeking dietetics work.

Figure 1: Current employment status[5]



[5] All data in Figure 1 and Tables 1 – 14 comes from AHWQ2 survey

Table 1: Reason for not currently working as dietitian (n=20)

Reason for not working	%	Count
No dietetic profession jobs available in my area	45	9
No dietetic profession jobs available that interest me	15	3
No dietetic profession jobs available that I feel qualified to do	0	0
No dietetic profession jobs available at the appropriate level/pay rate	15	3
Illness	0	0
Maternity leave	0	0
Family reasons	0	0
Other	20	5

Table 2: Principal area of practice and all other areas of practice [a]

Areas of practice	Principal area of practice	All other areas of practice
	Count	Count
Chronic disease management (including arthritis, cardiovascular disease including CVA and metabolic disorders)	87	254
Nutritional support (including malnutrition, HIV, enteral /parental, palliative care, swallowing difficulties)	87	251
Diabetes	32	237
Paediatrics	30	124
Other	28	38
Age related conditions	23	197
Overweight and obesity	22	225
Cancer (oncology)	16	139
Gastrointestinal disorders and surgery (including coeliac)	14	276
Public health (including health promotion, community development, community engagement, cooking classes, demonstrations, food literacy, community education, refugee health)	14	93
Renal	14	98
General nutrition (including men and women's health and vegetarian)	10	206
Mental health (including eating disorders)	8	92
Reproductive health (including fertility, pregnancy, gestational diabetes, breastfeeding, lactation and polycystic ovarian syndrome)	7	80
Food services activities (including menu reviews)	6	101
Sports nutrition	4	22
Disability	3	76
Aboriginal health	1	22

Areas of practice	Principal area of practice	All other areas of practice
	Count	Count
Allergy and food sensitivity	0	123
Sports nutrition	0	22
Communication and marketing	0	20

[a] *Respondents could select more than one response to signify 'all other areas of practice'.*

Table 3: Employment location – first position, position prior to current position, current main position (n=382 - 428)

Location	First position		Position prior to current position		Location	Current main position	
	%	Count	%	Count		%	Count
Victoria - Metropolitan	46	175	52	208	Metropolitan	68	293
Victoria - Regional	16	62	19	78	Regional	22	93
Victoria - Rural / remote	12	44	10	39	Rural / remote	9	40
Australia - Metropolitan	10	38	5	22			
Australia - Regional	7	26	5	20			
Australia - Rural / remote	5	19	2	8			
Overseas	5	18	7	26			
Total	**100**	**428**	**100**	**401**		**100**	**426**

Table 4: Employment sector – first position, position prior to current position, current main position, current second position (n=377-428)

Sector	First position		Position prior to current position		Current main position		Current second position	
	%	Count	%	Count	%	Count	%	Count
State Public Sector	59	224	55	221	60	256	36	33
Commonwealth Public Sector	12	43	12	46	12	51	5	5
Not for profit	4	14	4	17	7	29	5	5
Large private provider	5	17	6	23	3	11	7	6
Private practice (owner or employee)	14	54	11	42	10	41	16	15
Local government/ council	1	3	2	9	1	3	0	0
University / higher education	2	7	4	16	6	26	8	7
Other	4	15	7	26	3	11	3	3
Total	**100**	**377**	**100**	**400**	**100**	**428**	**100**	**91**

Table 5: Employment setting – first position, position prior to current position, current main position, current second position (n=376- 428)

(Client’s own home not included as n=<5)

Setting	First position		Position prior to current position		Current main position		Current second position	
	%	Count	%	Count	%	Count	%	Count
Administrative centre or office (e.g. government, not-for-profit, for-profit organisation, etc.)	7	27	7	28	10	44	2	2
Client's workplace including office, industrial setting, defence force	1	4	1	3	<1	1	0	0
Community locations (e.g. within daily activities - shopping centres, parks, etc.)	4	14	6	23	3	14	1	1
Hospital (inpatient or outpatient)	63	237	56	222	58	246	30	27
Private or community clinic, laboratory or medical centre	18	69	17	67	15	66	23	21
Residential facility (e.g. residential aged care, disability accommodation, rehabilitation centre, correctional facility)	2	8	4	14	3	12	4	4
Schools, preschools or childcare centres	1	2	,<1	1	<1	2	0	0
Telehealth / online	0	0	1	5	<1	2	2	2
Tertiary education facility / research institute	2	7	5	18	7	28	4	4
Other	2	8	6	22	3	12	3	3
Total	**100**	**376**	**100**	**399**	**100**	**428**	**100**	**91**

Table 6: Years worked in current main role by sector (n=371)

	1 – 5 years	6 – 10 years	11 – 15 years	16 – 20 years	> 20 years
State public sector	165	49	18	13	11
Commonwealth public sector	22	0	1	0	0
Local government / council	2	4	3	1	
Private practice (employee / subcontractor)	6	1	0	0	0
Private practice (business owner)	2	0	1	0	0
Large private provider	9	1	0	0	1
Not for profit	17	9	1	2	0
University / higher education	15	3	2	0	0
Aboriginal Controlled Community Health Service	0	0	0	0	
Other	5	1	1	1	0

Table 7:Qualifications held or currently studying (n=475)

Qualification	Current qualifications	Currently studying	First qualification enabling practice as a dietitian (n=475)
Certificate III	22	0	0
Certificate IV	35	2	0
Diploma	30	5	7
Advanced diploma	5	0	5
Associate degree	0	0	0
Bachelor degree - directly related to prof entry	315	3	199
Bachelor degree - not specific to profession	110	1	1
Honours degree	83	1	16
Graduate certificate	73	10	3
Graduate diploma	71	4	54
Master's degree - prof practice (e.g. grad entry)	195	3	192
Master's degree - management / research / other	36	12	1
Professional Doctorate	1	0	0
PhD	16	16	0

Table 8: Location where respondents gained their first qualification as an dietitian (n=475)

Country	%	Count
Victoria, Australia	72	342
Other Australian state or territory (not Victoria)	25	117
New Zealand	<1	2
United Kingdom	1	5
Canada	<1	2
India	<1	2
Other overseas country	1	5
Total	**100**	**475**

Table 9: Location where respondents gained their first qualification as a dietitian, for those who did not qualify in Victoria (n=117)

Location	%	Count
New South Wales	50	59
Queensland	18	21
South Australia	19	22
Australian Capital Territory	8	9
Western Australia	4	5
Tasmania	1	1
Northern Territory	<1	0
Total	**100**	**117**

Table 10: Proportion of respondents indicating they 'agree' with statements about their current clinical knowledge and skills

For each of the sub-questions the number of responses varied, therefore the number of individuals who agreed with each statement is included and the per cent of the respondents this represents.

If there were 5 or fewer respondents in any category data is not included to maintain anonymity (e.g. private practice business owners, or individual statements with too few responses)

	State public sector (n=230)	Cwlth public sector (n=29)	Private practice (employee / subcontractor) (n=7)	Large private provider (n=11)	Not for profit (n=22)	University / higher education (n=10)
I have the skills necessary to do my current job	94% (n=228)	90% (n=26)	Data withheld (n=<5)	100% (n=11)	100% (n=28)	Data withheld (n=<5)
I have all the tools I need to perform my job safely	85% (n=205)	71% (n=5)	71% (n=5)	73% (n=8)	96% (n=27)	81% (n=17)

Table 11: Proportion of respondents indicating they 'agree' with statements about their current experiences of professional support and development opportunities

For each of the sub-questions the number of responses varied, therefore the number of individuals who agreed with each statement is included and the per cent of the respondents this represents.

If there were 5 or fewer respondents in any category data is not included to maintain anonymity (e.g. private practice business owners, or individual statements with too few responses)

	State public sector (n=230)	Cwlth public sector (n=29)	Private practice (employee / subcontractor) (n=7)	Large private provider (n=11)	Not for profit (n=22)	University / higher education (n=10)
I have access to clinical supervision	70% (n=160)	52% (n=15)	Data withheld (n=<5)	64% (n=7)	45% (n=10)	50% (n=5)
If I am uncertain about an aspect of my work, I can always access someone who can help me	80% (n=193)	79% (n=23)	Data withheld (n=<5)	82% (n=9)	75% (n=21)	80% (n=16)
I am professionally isolated	10% (n=24)	25% (n=7)	Data withheld (n=<5)	Data withheld (n=<5)	21% (n=6)	Data withheld (n=<5)
I have formal management support from a member of my own team	70% (n=166)	68% (n=19)	Data withheld (n=<5)	91% (n=10)	75% (n=21)	81% (n=17)
I have access to peer support from members of my own profession	86% (n=207)	76% (n=22)	100% (n=7)	91% (n=10)	82% (n=23)	90% (n=19)
My grade and / or salary is appropriate for the work I do	54% (n=130)	55% (n=16)	Data withheld (n=<5)	55% (n=6)	54% (n=15)	71% (n=15)

Table 12: Overall job satisfaction by sector

For each of the sub-questions the number of responses varied, therefore the number of individuals who agreed with each statement is included and the per cent of the respondents this represents.

If there were 5 or fewer respondents in any category data is not included to maintain anonymity (e.g. private practice business owners & employees / contractors, or individual statements with too few responses)

	State Public Sector (n=247)	Commonwealth public sector (n=31)	Large private provider (n=11)	Not for profit (n=28)	University (n=21)
Extremely satisfied	22% (n=54)	23% (n=7)	Data withheld (n=<5)	29% (n=8)	24% (n=5)
Somewhat satisfied	51% (n=125)	61% (n=19)	55% (n=6)	46% (n=13)	62% (n=13)
Neither satisfied nor dissatisfied	14% (n=35)	Data withheld (n=<5)	Data withheld (n=<5)	Data withheld (n=<5)	Data withheld (n=<5)
Somewhat dissatisfied	9% (n=22)	Data withheld (n=<5)	Data withheld (n=<5)	Data withheld (n=<5)	Data withheld (n=<5)
Extremely dissatisfied	4% (n=11)	Data withheld (n=<5)	Data withheld (n=<5)	Data withheld (n=<5)	Data withheld (n=<5)