Working profile of Australian private practice Accredited Practising Dietitians

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Abstract

Aim: To describe the demographic, operational and financial working profile of private practice dietitians in Australia.

Methods: A cross-sectional online survey examined the demographics, business structure, key services and fees, marketing strategies, financial welfare, professional support and motivation for dietitians working in the private practice sector in Australia. A link to the survey was posted on the Dietitians Association of Australia, Dietitians In the Private Sector Interest Group national list-serve, from September to October 2011 (potential reach of 1222 members). Reminder emails were posted every seven days; data collection ceased after 28 days.

Results: A total of 156 dietitians completed the online survey, representing a response rate of 13%. The majority were female, aged 20-30 years. 74% of dietitians identified themselves as the proprietor of the business in which they worked. 84% of respondents had prior dietetic experience before entering private practice; mainly in the hospital/clinical setting. Most dietitians conducted <20 consultations per week, with the main source of referrals being general practitioners. Initial consultations were on average 52±13 minutes in length (range 30-120 minutes), and incurred a fee of $99±22 (range $60-$195). For dietitians renumerated on a 'per hour' basis (41%), the gross hourly rate was $71±35 (range $20-$135). For those renumerated on a 'percentage of income generated' basis (44%), the rate was 52±23% (range 15-89%).

Conclusions: This study provides valuable data on the working profile of private practice dietitians in Australia, which will inform support and advocacy for this working group.

Keywords: allied health, dietetic practice, dietitian workforce, private practice.

Introduction

Accredited Practising Dietitians (APDs) who work in the private sector, or 'private practice', represent an increasing proportion of Australian allied health professionals, and a growing proportion of the Dietitians Association of Australia (DAA) membership base. Between 2004 and 2007, the number of APDs working in private practice increased by 51%, taking the total to 772.[1] At October 2011, this number increased by a further 29%, taking the total number of APDs working full-time or part-time in private practice to 868. This group currently represents 29% of the total DAA membership (DAA statistics retrieved in October, 2011).

The 'Dietitians In the Private Sector Interest Group' (DIPSIG) was established in 1999, and is designed to support APDs in their interests, resources, continuing professional development and advocacy related to private practice. DIPSIG members include those who work in the sector, as well as those who have an interest in private practice. The current membership base of DIPSIG is 1222 members.

Dietitians play an integral role in the prevention and management of chronic disease and illness in the community.[2] The introduction of the Federal Government's 'Strengthening Medicare' package in 2004 resulted in the development of the *Medicare Australia* Chronic Disease Management Program; allowing individuals with a chronic disease to access rebates from *Medicare Australia* for services provided by registered allied health professionals, including APDs.[3] This policy incentive may have contributed to the considerable increase in dietitians working in the private practice setting since 2004 due to the rebates available for individuals consulting private practice dietitians.[1] Furthermore, from 2002 to 2011, there has been a 56% growth in graduate dietitians from Australian universities (DAA statistics retrieved in October, 2011). The fixed employment opportunities in the hospital and public

health sectors may also be contributing to growth in private practice. Notably, private practice activities have been identified as a core component of dietetic practice [4].

Despite the significant contribution that private practice dietitians make to the Australian primary care sector, limited data exists on the working profile of this group. Establishing a detailed working profile of Australian private practice dietitians is an important first step in promoting effective advocacy for this sector of the dietetic workforce. In particular, it will assist with identifying some of the key issues and challenges faced by this group. In addition, a comprehensive working profile will help inform the work of DAA, government bodies, and DAA members, with regards to addressing areas for improvements in policy, industry structure, practice guidelines, working conditions, continuing education, health professional support and communication. This will ultimately lead to quality improvement, and increased advocacy capacity within the dietetic profession. The aim of this study is therefore to describe the current demographic, operational and financial working profile of private practice dietitians in Australia.

Methods

A cross-sectional online survey was developed using *LimeSurvey™* version 1.82.[5] DIPSIG co-convenors identified ten areas of enquiry deemed as important in describing the working profile of Australian private practice dietitians, and these were addressed in survey questions. Questions for each area of enquiry were developed through a process of brainstorming by the DIPSIG co-convenors. One hundred and eight questions were included in the ten survey sections, each with a distinct rationale for investigation (See Table 1). A variety of response modes were utilised within the survey, including categorical, 5-point Likert scales and open text responses.

INSERT TABLE ONE ABOUT HERE

Initial piloting of the survey consisted of an individual review of the survey questions by each of the DIPSIG co-convenors. Each convenor provided feedback regarding the survey structure, wording, grammar and layout. Recommendations of survey changes were completed prior to secondary survey piloting. Secondary survey piloting consisted of the online completion of the survey by three dietitians working in the private practice setting. These dietitians were asked to comment on their interpretation of each survey question, as well as the clarity of question wording and survey layout. Minor editing of wording was recommended, and these changes were made prior to data collection. The finalised survey was intended to take approximately thirty minutes to complete, and was available in the English language only. Ethics approval was obtained through <removed for blind peer review> Research Ethics Committee (Reference Number PBH/27/11/HREC).

Participant recruitment was conducted through the DIPSIG list serve, with a potential reach of 1222 members. An introductory email was posted on the list serve in October, 2011. The introductory email included a brief description of the study, assurance of confidentiality, a link to complete the survey online, and contact details of the research team. Confidentiality of survey responses was ensured through the certified anonymous *LimeSurvey™* program. Three reminder emails were posted on the list serve; one, two and three weeks after the initial email. Data collection ceased 28 days after the initial email was posted.

Quantitative data analysis was conducted using the SPSS statistical software package version 19.[6] Descriptive statistics were calculated for each survey item including frequency distributions for Likert responses, and mean, standard deviation and ranges for open-ended numerical responses. Pearson's chi-square tests were used to compare main demographic variables (age, years since graduation and geographical location) to reported consultation lengths, fees and remuneration. Gender, age and highest education level were compared between survey respondents and total DIPSIG membership[7] using Chi-square Goodness of Fit analyses as an indicator for representation of the survey sample. When chi-square analyses were conducted, categories were collapsed to ensure that fewer than 20% of cells remained below minimum counts. Statistical significance level was set at $P<0.05$. Dietitians' hourly payment rates were compared to their perceived adequacy of payment using a One-way Analysis of Variance (ANOVA). Post-hoc analysis was conducted using a Bonferroni correction factor. Open ended questions were grouped according to common responses, and placed in order of frequency. Open-ended results were displayed with example text excerpts from responding dietitians.

Results

A total of 156 dietitians completed the online survey, resulting in a response rate of 13%. An accurate response rate is difficult to determine because it was not possible to account for the number of dietitians that were sent the email, but did not read it. The demographics of those dietitians that did respond are listed in Table 2.

INSERT TABLE TWO ABOUT HERE

No significant differences were observed between the survey respondents and overall DIPSIG membership in terms of gender (p=0.38), age (p=0.11) or highest level of education (p=0.19).[7]

Nearly all respondents were female (94%) and the majority (61%) were aged between 20 and 40 years. Approximately half of the respondents completed their university education less than 10 years ago. A small proportion (16%) of respondents started working in the private sector immediately after finishing University. However, the majority (84%) indicated they had experience in the dietetic workforce before working in the private sector, with the main source of prior experience being in a hospital/clinical setting. The average number of years of experience in the private practice setting was 6±4.2 years (mean±SD, range 1-34 years). Most dietitians worked on a part-time basis, with 68% of respondents working less than 20 hours per week. The number of hours worked per week did not differ between those who worked solely in the private practice setting and those who also worked outside of private practice (P>0.05). More than half (57%) of those who worked solely in the private practice setting worked less than 20 hours per week.

INSERT TABLE THREE ABOUT HERE

The operational characteristics of responding dietitians are presented in Table 3, including information relating to business structure, key services and fees. The majority of dietitians (74%) identified themselves as being the proprietor of the business in which they worked, and were registered with Medicare (94%) and Department of Veterans Affairs (82%). Most dietitians (85%) provided at least three quarters of their services as 'one-on-one', 'face-to-face' services and commonly (54%) operated in the general practice setting.

Initial consultations were on average 52±13 minutes in length (mean±SD, range 30-120), and incurred a $99±22 fee (mean±SD, range $60-195). This length dropped to 46±12 minutes (mean±SD, range 25-75) for consultations with patients under the Medicare Chronic Disease Management program. Similarly, the fee for an initial consultation for patients under the Chronic Disease Management program dropped to $84±30 (mean±SD, range $50-$150).

No significant associations were found between initial consultation length and age (p=0.423), years since graduation (P=0.754) or geographical location of practice (p=0.502). No significant associations were found between initial consultation fee and age (p=0.055) or years since graduation (P=0.643). However, a significant association was found between initial consultation fees and the geographical location of dietitians (P=0.026). From visual inspection of the data, it appears that dietitians living in rural or remote areas charge lower fees for their services, compared with dietitians living in regional and metropolitan areas.

Review consultations were on average 28±9 minutes in length (mean±SD range 15-90), and were priced at $61±15 (mean±SD, range $30-$150). No significant associations were found between review consultation length and age (P=0.440), years since graduation (P=0.776) or geographical location of practice (P=0.558). No significant associations were found between

review consultation fee and age (*P*=0.196), years since graduation (*P*=0.659) or geographical location of practice (*P*=0.442).

The three health conditions most regularly managed by responding dietitians were type 2 diabetes mellitus (79%), overweight/obesity (78%) and hyperlipidaemia (78%). Most dietitians (65%) conducted <20 consultations per week, with general practitioners being the main source of referrals.

INSERT TABLE FOUR ABOUT HERE

The financial characteristics of responding dietitians are presented in Table 4, including business marketing strategies, and financial welfare. Dietitians reported mixed usual gross incomes from their dietetic services. Approximately one third of respondents (28%) reported earning less than $30,000 per year, 40% of respondents reported earning $30,000-$60,000 per year and one third (32%) of respondents reported earning greater than $60,000 per year. No statistical associations were found between the geographical region of the dietitian and the gross incomes (*P*=0.093). Nearly half of respondents (43%) incur expenditures relating to their dietetic business of more than 40% gross income.

Those who were employed and renumerated on a 'per hour' basis (41%) earned a gross hourly rate of $71±35 (mean ±SD, range $20-$135). No significant differences were found between remuneration hourly rate and age (*P*=0.485), years since graduation (*P*=0.730) or geographical location of practice (*P*=0.567). Those who were renumerated on a 'percentage of income generated' basis (44%) received a rate of 52±23% (mean±SD, range 15-89). No significant differences were found between remuneration percentage and age (*p*=0.332), years since graduation (*P*=0.283) or geographical location of practice (*P*=0.145). More than

40% of dietitians, regardless of employment structure, perceived themselves as not receiving adequate remuneration for their services, however two thirds of dietitians (68%) anticipated that they will continue to work in the private practice setting for the long-term. No association was found between dietitians' gross hourly wage and perceived adequacy of payment ($P>0.05$).

Numerous factors were reported by dietitians regarding their motivation to work in the private practice setting. Common responses included: enjoyment, a sense of flexibility, self-directed work, independence, and positive job satisfaction. Motivating factors that were less common included: financial income, and private practice work being the only work available. Some examples of these motivating factors include the following:

"I like my patients and enjoy the work that I do. I enjoy the flexibility and only work part-time now."

"I love being my own boss, and job satisfaction keeps me here."

"It's nice to have my own practice, help people, educate people. I have a passion to be independent."

Dietitians reported considerable challenges regarding their work in the private practice setting. Commonly reported challenges included: low referral rates, low patient attendance rates, lack of a support team, lack of remuneration for administration tasks, diminished leave, professional development and a lack of time during business hours to complete necessary work. Some examples of these challenges include the following:

"I am only paid for face to face client time. All admin, marketing, advertising, staff training, holidays etc is for the love of it."

"As I am bulk billing and hence do not ask people for credit card details when they book, some people seem to think that the service is for free and hence that it doesn't matter if they show up or not... This of course affects my income from the clinic in relation to the time I spend there!"

"I am a sole practitioner and miss relating to other dietitians I have no back up dietitian to call on in case of illness or holidays arising."

Many suggestions for further support from DAA were provided by dietitians. The most prevalent suggestions included increased marketing to the general public regarding the dietetic workforce, continued lobbying to *Medicare Australia* for increased Chronic Disease Management consultation rebates, and continuing professional development on business management and communication skills. Some examples of these suggestions include the following:

"Please explain to the general public what a dietitian actually does, and that they are not free, and can't see you in 20 minutes like other health professionals!"

"I think DAA needs to lobby more with GPs [sic] and Medicare. We need higher rebates for CDM [sic] consultations to cover our admin time as well as patient time."

"More CPD [sic] events on contract negotiation and business skills. They didn't teach us this when I was at university, so it needs to come from somewhere."

Discussion

The aim of this study was to describe the demographic, operational and financial working characteristics of private practice dietitians in Australia. This is the first study to compile a working profile of Australian private practice dietitians, and is fundamental to the continued advocacy of APDs working in the private practice setting. Currently, there is limited published evidence describing the working profile of private practice dietitians, despite the increasing workforce size in Australia. This study provides valuable information for organisations such as the DAA and other health professional bodies, as well as private practice dietitians themselves.

Most dietitians reported to operate on a part- time basis, which may be a consequence of the flexible nature of the private practice setting, and may also explain the low income levels reported by dietitians. Interestingly, 83% of dietitians worked less than 30 hours in private practice each week, and this number also encompassed time spent outside of client contact. Furthermore, nearly half of the dietitians reported to also work in other areas of dietetic practice. It is possible that private practice dietitians are supplementing their work to offset low incomes generated through private practice activities. Furthermore, more than half of the dietitians who worked solely in private practice worked less than 20 hours per week, indicating that full-time, private practice dietetic operations are not common in Australia.

The reported incomes and remuneration models for private practice dietitians varied considerably, and no relationship was found between dietitians' remuneration models and annual income. As a result, it may be difficult for private practice dietitians to predict personal incomes based on other dietitians' remuneration models. Of interest, 41% of

dietitians perceived themselves as not receiving adequate remuneration for their work in private practice, and no association was found between gross hourly rate and perceived adequacy of remuneration. Approximately a third of dietitians reported earning a gross income of less than $30 000 per year from their work in the private practice setting; and is below the current minimum wage in Australia.[8] In addition, more than half of the dietitians reported to also work in areas outside of private practice. Challenges such as lack of remuneration for administration tasks, low referral rates and low patient attendance rates may be preventing private practice from being a sole source of income for some dietitians. Furthermore, it is concerning that there may be a subset of private practice dietitians that do not work in areas outside of private practice, and also earn less than $30 000 per year.

There are currently no published benchmarks for Dietitian expenses in Australia, however, 42% of dietitians reported expense rates over 40% of total income. An expense rate of 40% is less than benchmark expenses for chiropractors (53%)[9] and physiotherapists (51%),[10] and may reflect the differences in equipment requirements. Ensuring that all expenses are incorporated in dietetic business plans may improve the financial welfare of private practice dietitians. Despite these financial concerns, two thirds (68%) of dietitians ~~surveyed~~ anticipated continuing their work in the private practice setting on a long-term basis. This confirms that the determinants of working in this setting extend beyond financial factors.

Dietitians providing consultations to patients under the *Medicare Australia* funded Chronic Disease Management scheme charged lower consultation fees, and allocated less time to these consultations. This modification in service delivery may have implications on the effectiveness of dietetic services provided to patients under this scheme.[11] The relationship between consultation length and patient health outcomes, or satisfaction levels, requires

further exploration. Most dietitians reported that more than half of individuals that attended an initial consultation returned for a follow-up consultation. This business operation may positively influence the health outcomes, and satisfaction of returning individuals, and also reflects current business practice recommendations for retaining existing clients.[12, 13]

The reported suggestions for further support from DAA are similar to the 2010 DAA membership survey[14], which ~~outlines~~ outlined requests for marketing and advocacy, as well as continuing professional development in management and business operations. Therefore, the perceived needs of private practice dietitians may ~~not differ~~ be similar to ~~from~~ dietitians in other dietetic sectors. This information should be used to inform future activities by DAA in order to support dietitians across Australia. For example, the responding dietitians reported that most business referrals come from general practitioners. Therefore, future advocacy for referrals may be appropriately aimed at alternative targets, such as allied health professionals.

This study experienced a lower response rate (13%) when compared to expected response rates for online surveys (24-31%)[15]. However, similar response rates were observed in a recent survey of Australian private practice dietitians (12%),[16] and the 2010 DAA membership survey (16%).[14] ~~.~~ The online survey was reasonably long, which has been shown to negatively influence the response rate of surveys.[15] ~~.~~ Furthermore, it is possible that some potential participants did not read the emails that invited participation in the survey, which may have reduced the response rate further. It should also be acknowledged that response rates assume that all potential participants read the relevant email that invites participation, and 13% is therefore likely to be an underestimation of the true response rate of this study.

Two limitations to the current study are noted. Firstly, it is possible that participants' responses were variable due to differences in their interpretation and estimations of business factors such as income, expenses, employment arrangements, and time spent on non-paid tasks. Secondly, the opportunity to identify differences between demographic attributes of participants, such as age and time since graduation, and business structures, such as fees and income, was diminished because the majority of dietitians reported similar demographic attributes. The data may have provided more information if the questionnaire was designed using continuous rather than categorical responses, and should be considered in future work. Additionally, ~~F~~further investigation of all dietitians working in private practice may provide insight regarding these potential relationships.

In summary, this working profile provides up-to-date information on the demographics, business structure, key services and fees, marketing strategies, financial welfare, professional support and motivation for dietitians working in the private practice sector. Ongoing monitoring of this data is important, and it is anticipated that this survey be redistributed by the DIPSIG convening team on an annual basis.

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Table 1: Survey Structure, Area of Enquiry and Response Modes.

Section	Area of Enquiry	No. of Questions	Response Format
General Demographics	Gender	1	Categorical
	Age Group	1	Categorical
	Education Level	1	Categorical
	Time since Graduation	1	Categorical
	Country of Education	2	Categorical
	Employment Arrangements	7	Categorical
	Geographical Location	1	Categorical
	Supplementary Dietetic Work Arrangements	5	Categorical
Business Structure and Operations	Professional Title	1	Open
	Description of Colleagues	6	Categorical
	Service Setting	2	Categorical/Open
	Service Description	2	Categorical/Open
	Registration, Indemnity Insurance	3	Categorical
Key Services and Fees	Registration Status (Medicare, DVA, Private Health)	3	Categorical
	Client Payment Arrangements	2	Categorical
	Description of Services	3	Categorical
	Schedule of Fees	6	Categorical/Open
Demographics of Clientele	Weekly Consultation Load	1	Categorical
	Initial and Review Consultation Ratio	2	Categorical
	Consultation Mode	1	Categorical
	Client Demographics	7	Categorical/Open
	Specialisation	2	Categorical/Open
	Client Information Records	2	Categorical
Marketing and Referrals	Marketing Strategy	3	Categorical/Open
	Need for Support	2	Open
	Public Perception of Dietetic Services	3	5-pt Likert/Open
Financial Welfare	Personal and Business Incomes	8	Categorical/Open
	Remuneration Arrangement	3	Categorical/Open
Professional Challenges	Professional Communication Pathway	2	5-pt Likert
	Professional Resources	2	5-pt Likert
	Professional Challenges	2	Categorical/Open
Motivation for Working in Private Practice	Rationale for Working in PP Setting	3	5-pt Likert/Open
	Perceived Personal Competence	4	Categorical/Open
	Setting Specific Career Satisfaction	4	Categorical/Open
Professional Development	Future Career Goals	2	Categorical/Open
	CPD Activities Undertaken	1	Categorical/Open
	Perceived CPD Needs	1	Categorical/Open
Professional Support	Support Strategies	2	5-pt Likert/Open
	Advocacy Areas	2	Categorical
	Perceived Role of Professional Supporting Bodies	2	Open

CPD=Continuing Professional Development
DVA=Department of Veterans Affairs
Pt=Point
PP=Private Practice

Table 2: Demographic Characteristics of Survey Respondents.

Profile Characteristic	Number of Respondents (n)	Percentage of Respondents (%)
Gender[a]		
Female	147	94
Male	9	6
Age[b]		
21-30 years	53	34
31-40 years	39	25
41-50 years	31	20
41-60 years	19	12
>60 years	11	7
No Response	3	2
Highest Education Level[b]		
Bachelor Degree	66	42
Graduate Diploma or Certificate	32	21
Masters Degree	54	34
Doctor of Philosophy (PhD)	4	3
Time since Graduation[a]		
<5 years	46	29
5-10 years	31	20
11-20 years	38	24
21-30 years	26	17
31-40 years	10	7
>40 years	3	2
No Response	2	1
Country of Dietetic Training[b]		
Australia	146	94
Overseas	10	6
Geographical Location		
Rural or isolated	18	12
Suburban or Regional	80	51
Metropolitan	54	35
No Response	4	3
Previous Areas of Dietetic Work (Not including Private Practice)		
Yes	127	81
No	24	15
No Response	5	3
Setting of previous work (may have been more than one):	104	67
- Hospital (Clinical)	45	30
- Nursing Home	28	18
- University Education	27	17
- Government Agency	20	13
- Public Health Agencies	18	12
- Research	14	9
- Food Service	13	8
- Community Health		
Current Areas of Dietetic Work (Not including Private Practice)		
Yes	78	50

No	73	47
No Response	5	3
Setting of current work (may have been more than one):	38	24
- Hospital (Clinical)	13	8
- University Education	12	8
- Nursing Home	9	6
- Government Agency	8	5
- Community Health	6	4
- Public Health Agencies	5	3
- Research	4	3
- Food Service		
Hours of Private Practice work per week		
<10 hours	42	27
10-20 hours	54	35
21-30 hours	27	17
31-40 hours	18	12
>40 hours	7	4
No Response	8	5
Days of Private Practice work per week		
1 day	36	23
2 days	29	19
3 days	37	24
4 days	16	10
5 or more days	17	11
No Response	21	13
Indemnity Insurance Provider		
'Guild'	98	63
'AON insurance'	39	25
Other	10	6
No Response	9	6

(a) No significant difference was observed between the survey respondents and reference population data with regards to gender (P=0.16), time since graduation (P=0.10),

(b) No reference data was available to test for representation of the survey sample with regards to age, highest education level, or country of dietetic training.

Table 3: Operational Characteristics of Private Practice Dietitians.

Profile Characteristic	Number of Respondents (n)	Percentage of Respondents (%)
Business Ownership		
Proprietor of Business	111	71
Employee/Sub-contractor	39	25
No Response	6	4
Registered Medicare Provider		
Yes	146	94
No	10	6
Registered DVA Provider		
Yes	122	78
No	27	17
No Response	7	5
Setting of Service *(may have chosen more than one)*		
General Practice Clinic	80	54
Private practice with other allied health services	43	29
Private practice offering dietetic services only	37	25
Medical Specialist Practice	9	6
Gym or Health Club	9	6
Community or Health Centre	4	3
Weight loss Clinic	2	1
Other	9	6
Paid Administration Assistants within Business		
Yes	48	31
No	60	38
No Response	48	31
Number of Dietitian Co-Workers in Same Practice		
0	93	60
1	28	18
2	6	4
3-4	9	6
5-6	6	4
7 or more	6	4
No Response	8	5
Percentage of Services Conducted 'One on one', 'Face to face'		
<50%	15	10
50-75%	5	3
75-90%	20	13
>90%	93	60
No Response	22	14
Other Services Offered *(may have chosen more than one)*		
Phone Consultations	46	29
Email Consultations	25	16
Home Visits	49	31
Aged Care Facility Consultancy	57	37
Group Programs (Non-Medicare Australia Scheme)	10	6
Group Programs (Type 2 Diabetes Medicare Australia Scheme)	11	7

Total number of patients seen each week by the respondent		
<10	48	30
10-20	44	28
21-30	23	15
31-40	7	4
>40	14	9
No Response	20	13
Number of new patients seen each week by the respondent		
<10	99	63
10-20	33	23
>20	11	7
No Response	13	8
Percentage of patients returning after initial consultation		
<25%	9	6
25-50%	14	9
50-75%	48	31
75-90%	38	24
>90%	21	13
No Response	26	17
Regularly Managed Health Conditions		
Type 2 Diabetes	122	79
Overweight or Obesity	121	78
Hyperlipidaemia	121	78
General Healthy Eating	119	76
Irritable Bowel Syndrome	116	74
Hypertension	115	74
Heart Disease	113	72
Food Intolerances	106	68
Method of Consultation Record Keeping		
Paper medical record, accessible to other health professionals	17	11
Electronic medical record, accessible to other health professionals	34	22
Paper based client file accessible only by dietitian	63	40
Electronic client file accessible only by dietitian	21	13
No Response	21	13
Use of Business Website		
Yes	59	38
No	55	35
In Progress	10	6
No Response	32	21
Main Source of Business Referrals		
General Practitioners	76	49
Word of Mouth	25	16
Business Website	13	10
Other	7	4
DAA Listing	3	2
No Response	32	21
Anticipation to Continue Private Practice Work Long Term		
Yes	81	52
No	12	7

Unsure	26	17
No Response	37	24

DAA=Dietitians Association of Australia
DVA=Department of Veterans Affairs

Table 4 - Financial Characteristics of Private Practice Dietitians

Profile Characteristic	Number of Respondents (n)	Percentage of Respondents (%)
Usual Gross Income from Private Dietetic Work (per year)		
<$30,000	33	21
$30,000-$40,000	18	12
$40,000-$50,000	17	11
$50,000-$60,000	20	13
$60,000-$70,000	7	4
$70,000-$80,000	9	6
$80,000-$90,000	9	6
$90,000-$100,000	6	4
>$100,000	10	6
No Response	27	17
Percentage of Gross Income Used for Expenditures		
<20%	27	17
20-40%	33	21
40-60%	28	18
60-80%	12	7
>80%	6	4
No Response	50	32
Sale of Products Within Business		
Yes	46	29
No	103	66
No Response	8	5
Commonly Sold Products(may have chosen more than one)		
-Recipe Books	26	17
- Calorie Countering Books	24	16
- Blood Glucose Monitors	22	15
- Exercise Equipment	16	11
- Portion Control Tools	11	7
Personal Payment Arrangement		
Salary	1	1
Set amount per hour	44	28
Set percentage of income generated	47	30
Total business income after costs	15	10
No Response	49	31
Personal Sense of Adequacy of Remuneration		
Definitely Adequate	7	4
Adequate	39	25
Somewhat Adequate	19	12
Not Adequate	29	19
Definitely not Adequate	17	11
No Response	45	29