Dietitians Association of Australia (DAA) Response to "The Health Workforce" Issues Paper

About DAA

The Dietitians Association of Australia is the largest nutrition focussed organisation in Australia representing a membership of over 2800 Dietitians, dietetic students and a small number of Associate members. Its mission is to support members and to advocate for 'Better food, better health, better living for all'.

Introduction

DAA welcomes the opportunity to contribute to this important examination of health workforce issues in Australia. This response was developed by a reference group of Accredited Practicing Dietitians from a range of backgrounds including dietetic education, clinical management, acute care, public health nutrition, primary care, rural and remote practice, indigenous nutrition and health service management.

This submission addresses the issues under the headings nominated in 'Questions Identified from the Commission's first circular' but is referenced to the discussion in the Issues Paper.

Submission

Workforce Planning

DAA believes that current arrangements for workforce planning could be greatly improved especially for Allied Health Professionals (AHPs).

DAA advocates strongly for Service Planning as opposed to workforce planning. Proper assessment of community needs (as opposed to planning based on wish lists from vested interests including public lobby groups) will better demonstrate the requirements for professional mix and how those professions deliver services either by themselves or by collaborating with others.

As the issues paper points out, workforce planning is often profession specific or even speciality specific in given settings rather than multi-disciplinary and across the continuum of care.

Dietitians and other AHPs need to be involved in planning/decision making processes at all levels of the health system (ie local, State and National). Dietitians are often not factored into the planning at all even when their key role in that particular area is well

known. If they are factored in initially, as soon as the budget is short, the first positions to be removed are more likely to be allied health.

The planning short falls are often not just in personnel. It is not unknown to find a dietitian consulting in a waiting room or storeroom because no one thought to allow for resources for the position such as room, furniture and IT support.

No Standard currently exists to describe the ideal dietetic workforce in Australia and it is doubtful if one exists for any Allied Health profession. Staffing levels are often dependent on whim, random pots of money and which departmental manager is the best advocate.

Dietetics is not identified as an area of workforce shortage in general but this can be misleading. Workforce shortage appears to be measured by whether or not existing positions can be filled. It gives no indication as to whether the number of positions was adequate in the first place.

Growth in private sector and non-traditional areas of practice (often with far greater rewards) is draining the available pool. Whilst on the surface there may appear to be sufficient graduates to fill public sector positions it is not necessarily reflected in the workforce with significant variations of numbers per 100,000 population depending on the area. [1] There are regional shortages especially in Tasmania and in rural areas with relative shortages emerging in Queensland and WA where rapid population growth is occurring. Only one jurisdiction, the ACT, meets even the raw and outdated benchmark of 14 dietitians per 100,000 population.

"The uneven distribution of dietitians across the country and, in particular in rural areas, suggests that planners of health services need to reconsider the distribution and future allocation of services across the country and within states and territories. Distribution of dietitians cannot however, be based simply on number of dietitians per head of population, as this does not take into account other factors that affect service provision. These factors may include: the range of services provided in specialist hospitals, the outreach services provided beyond the main hospital or community health service, the distances travelled by rural and remote dietitians and/or the time involved in counselling clients from indigenous and culturally and linguistically diverse communities. Future workforce planning for dietetics also needs to consider the adequate provision of primary, secondary and tertiary level services to the population." [2]

For too long there has been an almost exclusive focus on medical and nursing with little recognition of the contribution of, or need for, allied health workers including dietitians.

There has also been an apparent bias towards the acute care end of the spectrum with primary and preventative care receiving less focus and limited funding, yet this is where Dietitians and other allied health professionals can make a significant impact on the health of the population whilst maintaining their important role in acute care. Emphasis needs to be placed on the continuum of care and a more holistic approach rather than on brief disconnected episodes of care. This should not be interpreted as implying that less Dietitians are needed in the acute services.

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[1] ABS Census data

[2] Brown, L and Capra, S - Paper submitted for publication to *Nutrition & Dietetics*

Much of the data collected on Allied health workforce is poor to say the least. It is inconsistent across the professions and varies from one jurisdiction to another. '*The currently available sources of data have used different methodologies making comparisons difficult. While some conclusions can be drawn from existing data, a coordinated approach to workforce data collection and reporting is lacking. Ongoing inadequacies in workforce data hinders future professional workforce planning.*'[3]

DAA believes that funding should be applied to uniform national data collection for Dietitians and allied health professionals. If adequately funded the Professional Associations could undertake the work against strict guidelines.

Improved data collection would include both public and private health care settings Private hospital patients are often disadvantaged in that they have less access to allied health services. It mostly depends on whether the consultant medical practitioner has a holistic approach to patient care, and whether the senior nursing staff are sufficiently well informed to advocate for patient needs in the allied health area. The argument of lack of access to the decision making process and advocacy for patient services from allied health is even stronger in the private sector which is strongly driven by costs. There appears to be much less understanding of the role of AHP's in the private hospital sector.

Because there is often poor coordination between jurisdictions under different sources of funding, artificial barriers to care can occur. As the level of inpatient acuity increases the opportunity to perform traditional roles of counselling and education in the acute setting is diminished. The dietitian is still required to provide the acute care but unable to follow the client to the ambulatory setting where the next steps are required. Either there is no follow up or follow up by another practitioner with little or no knowledge of the early care provided. This can lead to readmissions, conflicting information, wheel reinvention and, subsequently, to increased costs (and not just financial).

Aged care is addressed as separate area of planning. DAA believes that this will contribute to poor workforce planning and coordination across the board. Planning of the aged care workforce must be integrated with health workforce planning in general to allow continuity of care and good outcomes. At present allied health participation in the aged care sector is patchy at best and not based on planning related to assessed needs.
General health care services do not have the capacity to service aged care and if those multidisciplinary services are not available in aged care the risk of admission and re-admission to acute facilities increases.

If allied health professions command a low profile in the workforce planning, their technical assistants are all but invisible. These support staff provide an invaluable service in the acute setting managing lower level tasks which can allow the more highly qualified professional to use their time more effectively. Unfortunately data collection regarding these staff is probably less well developed than that of the professional and must be included in any workforce planning.

[3] Brown, L and Capra, S - Paper submitted for publication to *Nutrition & Dietetics*

There appears to be some suggestion that there could be a category of 'general' allied health support staff. This would seem somewhat naïve. Some professional areas may allow reasonably easy transition between duties for technical aides such as in Occupational Therapy and Physiotherapy. It would not, however, be reasonable to expect that a therapy technician could easily switch to the role of Diet Technician with full knowledge of the food service and an ability to interpret dozens of different diet prescriptions. One size does not fit all.

The assumption that administrative support can always be sacrificed to provide more 'clinical' positions is entirely self defeating. The reality is that administrative work must be done. If there is no administrative assistance the highly qualified, and relatively highly paid, professional has to do the typing, filing and management of appointments. i.e. no more clinical time, just expensive clerical work. The collection of data on how much time professionals spend on administration better done by someone else would be very instructive.

Education and Training

DAA is closely involved in the Education and Training of the Dietetic workforce in Australia and the assessment of overseas graduates through accreditation of all entry level courses in Australia and assessment and examination of overseas dietitians.

DAA believes that good quality graduates are being produced.

DAA has a commitment to generalist nutrition and dietetic training which is competency based. Dietitians graduate with strong grounding in three main streams of clinical dietetics, community/public health nutrition and food service management. Dietitians are first and foremost scientists who apply their knowledge to the nutritional health of the community. This provides a very flexible workforce equipped to take on a range of roles often not traditionally associated with 'health care' as such.

DAA believes it is vital that this diversity is not stifled by an over emphasis on the 'clinical' role.

Dietitians undertake three types of professional placement; clinical, community/public health and food service. All these are vital but the greatest pressure is on clinical placement. Unlike nursing and medical, allied health receives little or no funding for clinical placement supervision. Supervision is undertaken by already over stretched clinicians who continue to shoulder the burden out of a sense of duty to the profession. This is becoming increasing difficult to sustain. It is exacerbated by uneven demand. In some areas the number of students outweighs the number of placements available or even the physical space to take them.

DAA believes adequate funding for all practice placements should be made available to Allied Health disciplines including the employment of clinical educators to relieve the burden on clinicians. There needs to be innovation in the way professional practice placements are structured and some sense of a benchmark as to what is

generally appropriate rather than some professions placing disproportionate demands on the system at the expense of others.

DAA believe that the funding of all allied health education needs to be allocated at the same level of at least nursing and ideally the same as medical.

DAA believes that whilst there are examples of good coordination in the area of health professional education such as between the profession and most of the educational institutions, this is not necessarily repeated elsewhere and improved coordination would be a great advantage. The funding of professional practice placement is everyone's responsibility and there needs to be shared funding between the states and commonwealth and across the Public and Private sectors. Health professional education is the responsibility of both the education and health sectors for all the professions and this is currently applied selectively and inequitably.

At present there is little or no capacity to train students in the private sector. Dietitians are rarely salaried in this area. Working on a fee for service basis means taking students threatens their income. Private practitioners could be paid to take students, providing income security. An alternative model is to fund University based clinics where private practitioners could be contracted to provide clinics and practical experience for students.

Now that universities are required, due to budget constraints, to take a larger percentage of fee paying overseas students this increases the burden on clinical supervisors. Many of these students have poor English language skills and, even more importantly in the dietetics field, little cultural context or understanding of local food behaviours. This makes their professional practice placements much more difficult and time consuming. Australian dietitians do not object to training overseas students per se – but they should not be expected to bear the burden of unforseen consequences of policy changes in the area of university funding.

DAA supports the development of cost effective models of student education and professional practice placement and encourages innovation. A number of different models are emerging in the DAA accredited courses and the Association is flexible in its application of accreditation requirements.

There is clear evidence that graduates are more likely to work in areas where they have studied or experienced placements. DAA believes there need to be incentives for students to accept placements in areas where there either is no course such as Tasmania and the Northern Territory or rural and remote areas. Rural health placement accommodation is funded by universities but, with rare exceptions, only Medical students can access it. This should be made routinely available to allied health students as well.

Students who do choose to go away from their base for placement are often placed at a major disadvantage. Not only do they have to pay for transport, and accommodation, they are unable to earn income from their part-time and casual jobs. Some may lose their jobs. This is a major disincentive.

DAA strongly believes that undergraduate education is the most effective means of producing specialised allied health graduates.

The suggestion that all allied health could do a 'generic' undergraduate degree then specialize at postgraduate level would be prohibitively expensive for many students. This 'generic' degree also poses another problem with which dietetics has already been obliged to grapple. There is a similar situation with students who have undergraduate degrees in 'nutrition' who struggle to find employment as they are unable to undertake clinical practice and lack the knowledge of health care and health promotion across the spectrum. Having done a 'generic' degree, graduates are actually qualified for nothing in particular.

That said, there is no reason why there cannot be more common programs in undergraduate courses. There would be considerable advantage in fostering the multidisciplinary approach by having common subjects and lectures in the first two years for allied health, medicine and nursing. There may also be some advantage in some professional practice placements occurring in a team setting to enhance common skill development and team interaction.

Re-entry to allied health professions requires attention also. Whilst DAA has its Accredited Practicing Dietitian (APD) program which includes 26 weeks mentoring by an experienced practitioner for new graduates and those re-entering the profession after a period of time this again is voluntary on the part of the mentor and can be a burden. Funding should be considered for universities to provide re-entry refresher courses and for mentors to provide the necessary support.

Regulation in the health workforce

DAA agrees that regulation should only be employed where other less intrusive means are not available.

Dietetics is an unregistered profession and DAA does not believe this is detrimental either to the profession or to public safety especially if existing professional accreditation becomes the requirement for employment.

DAA has a system of accreditation which it has had in place for 11 years. Whilst the system is always open to improvement DAA believe it makes an excellent model which could be applied to other professions.

Firstly, it is a national system which removes the irritating and potentially costly problems of different registration requirements for different jurisdictions. A dietitian can work anywhere in Australia once accredited. This makes it very much easier to register with DVA, HIC, and private health funds who then only need to talk to one peak body rather than eight different ones. The APD program is based on more than just qualifications. It is predicated on a commitment to lifelong learning, where meeting minimum requirements of continuing professional development (CPD) is mandatory.

The APD program has a built in compulsory mentoring requirement for all provisional members of the program who must register a mentoring relationship and pursue it for 26 weeks and provide evidence to that effect.

In keeping with the requirements of the Trade Practice Act Dietitians who are not members of the DAA can join the APD program.

DAA has effectively administered this national system at nil cost to the tax payer and could continue to do so if the government chose to make such national accreditation compulsory for practitioners. DAA does not apply any quotas nor attempt to restrict entry to the profession through this system. The program is now being extended to recognise advanced practice.

Workforce Participation

The issues paper appears to be primarily focussed on the clinical workforce. It should be noted at the outset that whilst all Dietitians are qualified and able to be clinicians, their broad generalist training means that a percentage of them, estimated to be around 10-15 per cent, will choose not to take the clinical option but will move into other areas. Experienced clinicians can and do leave the clinical area but not the profession as they pursue evolving interests. This is seen as one of the profession's great strengths.

However, there are pressures and issues which can lead to dissatisfaction with clinical roles. Job satisfaction is crucial to retention. Like most allied health professions there are often few opportunities to pursue a career path. Improved levels of remuneration or career advancement are largely dependent on moving into management roles yet many Dietitians do not wish to pursue this path and it is often difficult to recruit to the higher graded positions. There is little reward for high level specialized clinical skills and experience.

Dietitians are constantly frustrated at being unable to achieve best practice due to time and resource constraints. It becomes very demoralising when all one can do is the best that time allows rather than what is going to provide the best outcome for the patient/client.

Lack of profession specific clinical supervision and lack of access to continuing professional development are major factors in work dissatisfaction. Dietetics is one of the professions where access to resources, especially in the public health system, is very poor. Whilst significant amounts of funding are allocated to the purchase of expensive medical equipment, it can be a struggle to get a desk, a computer or even an office to counsel in. This can lead to extreme resentment and / or loss of professional self worth.
The constant battle for resources can also lead to ill-feeling between members of the 'multidisciplinary team' who, rather than working together to generate outcomes, are constantly 'robbing Peter to pay Paul' and are in competition with each other.

DAA is concerned about the hierarchical structures in multidisciplinary teams. There should be no requirement that a team is lead by one particular discipline. In service delivery and in management dietitians should have equal access to opportunities and appointments should be made on the basis of skills, knowledge and experience required rather than just discipline. There are still anti-competitive rules in some situations e.g. nurses can only be managed by nurses.

DAA believes that the 'Nurse Practitioner Model' could be extended into allied health professions where AHP's working at hight levels in specialised areas could be accredited to take on other roles. This already occurs in Diabetes Education where a dietitian can achieve accreditation and undertake the educator role. Considering the shortages in nursing there are a number of areas in which allied health could fulfil such education roles and free up scarce nursing resources.

Financial and practical support for re-entry program for dietitians who have not been engaged in clinical work for sometime would be valuable. Provision of short refresher courses and mentoring are envisaged as ideal options. As a predominantly female profession dietetics suffers from high attrition rates during child bearing years. Even if dietitians do return to work relatively early they are likely to choose part-time positions. The current structure does not support them well. They are likely to be in base grade positions only despite high levels of expertise and experience. This is not good for morale nor does it utilize skills effectively. If salaries were based on skill set and ability to produce results rather than the number of staff managed, this would vastly increase job satisfaction and retention rates.

Adequate access to continuing professional development opportunities is a major factor in retention. These opportunities should allow for at least some general education and networking rather than a total focus on narrow areas related only to the immediate area of practice. There appears to be inequity within the system with some groups getting full support whilst others struggle to get even a small amount of study leave, let alone any financial or locum support.

Rural/remote practice has very specific issues around participation and this will be addressed under that section.

Productivity

Productivity measures can be highly problematic for allied health services. Productivity tends to be measured as number of procedures, length of stay, 'bums on seats' or 'backs on beds' as opposed to outcomes. Results of dietetic interventions can take many months, even years to be measurable. This does not mean they are not valuable just that conventional measures of outcomes and productivity do not necessarily apply. Unfortunately the use of inappropriate measures can put unnecessary pressure on allied health professionals. Appropriate benchmarking practices should be used to improve planning and service delivery rather than being the tool of consultants with unfriendly agendas.

Dietetics is not procedure driven but DAA supports the use of technological advances where appropriate. The use of e-health methods such as e-mail or video consultation can certainly use scarce resources more effectively but are unlikely to fully replace

face to face interventions. The development of suitable electronic group education models could be used to advantage. As dietetics uses interviewing, counselling and demonstration for the majority of its interventions there is not much application for other technological advances.

As a profession which is educated on a strong generalist base, dietitians are better able than most to move across boundaries. This is particularly valuable in rural and remote areas but can be used to good effect anywhere.

DAA supports opportunities to work across settings and to take on roles which are aligned with dietetics and can be easily incorporated with extra training. E.g. There is no reason why dietitians could not undertake all areas of Diabetes Education thus freeing scarce nursing resources. Dietitians can be trained and certified to manage enteral feeding in the home again freeing up scare nursing resources. Both these areas require high level skills in medical nutrition therapy which are not as easily transferred to the other professions currently involved.

Dietitians do not have to be managed by Dietitians. They do, however, need access to professional mentoring supervision and opportunities for career progression. The risk with removing delineations is to enshrine the role of a base grade 'jack of all trades' who will never progress. If professionals gain broader skills then they need to be rewarded for it, not penalised. The advanced generalist should command just as much respect, and indeed reward, as the specialist. This is enshrined in DAA's advanced practice recognition.

Demand

Nutrition is high on the agenda. Malnutrition is recognised as being a major factor in indigenous health especially amongst the more isolated communities and in children. Malnutrition is also a significant and well documented problem in inpatient populations. On the other hand obesity, chronic diseases and the ageing population will place even greater demands for dietetic services. Should awareness of these problems ever be matched with appropriate funding to address them, the demand for dietitians, already strong, would increase markedly.

Until recently private practice has not been seen as a particularly attractive option for dietitians and the numbers moving into the area have been small. Now, however, with the advent of the Strengthening Medicare allied health initiative and other opportunities this is the fastest growing segment of the profession.[4] Dietitians are not yet at the private practice levels of professions such as physiotherapy, podiatry and pharmacy but if the trend continues it is likely that shortages will begin to occur in public practice. This is not inherently bad as long as public practice does not continue to be seen as something to get out of due to poor morale, poor advancement opportunities and unreasonable demands.

[4] Dietetic workforce area statistics
http://www.daa.asn.au/_util/download.asp?id=60&doc_id=802&view=directory&type=file

Regional, remote and indigenous issues

Dietitians undoubtedly have similar concerns to other health professionals in relation to rural and remote positions and working with indigenous communities.

Professional isolation is a major issue. Whilst it is not necessary to have direct face to face contact with another dietitian, formal mechanisms to facilitate professional support should be incorporated. It is not sufficient to expect that the professional (often a new graduate) has the necessary links or knows how to develop them.

Because most rural/remote positions are base grade they tend to attract new or recent graduates. Not only do these positions offer little career progression, in situ, the skills required are often at a higher level than the inexperienced practitioners have developed.

Paying a higher salary or allowance to rural practitioners is not just a recruitment or retention issue. It acknowledges the extra skills and commitment required. Even though dietitians have a good generalist qualification it takes great skill to juggle the demands of acute clinical, outpatients, community education, public health nutrition, food service and general management competencies on a daily basis with no support. The most common outcome is burn out. Constant turnover of staff results in gaps in service provision, poor continuity of service and is detrimental to team building.

This is compounded by the lack of locum support. There is no funding for backfill for much needed holidays – the amount of stress associated with returning from leave is not worth going in the first place. Rural practitioners also need locum support to allow opportunities for blocks of Continuing Professional Development in larger centres. One model could be to organise formal exchanges of staff.

Despite the difficulties, properly supported rural practice can provide invaluable experience and open broader career opportunities for the practitioner. It can also provide an instructive model as to how to develop multidisciplinary care. Away from the traditional pressures and 'silos' encountered in larger centres, groups of practitioners naturally form teams utilising each others strengths, understanding complimentary roles and moving across the continuum of care.

Practitioners working in indigenous communities need special skills, whether remote or in the cities and funding should be available for some form of intensive training in this area of practice.

A key value a dietitian can add to indigenous health is to work with and provide adequate training to indigenous health workers who are much more likely to positively influence the health of their communities than some 'white fella' who wanders in from time to time.

Workforce planning which incorporates the training and creation of positions for indigenous health workers is vital. At present levels of training and qualifications are highly variable which serves the neither the communities nor the more highly specialised AHP well. Dietitians need to be confident that their message is conveyed in the most culturally appropriate and effective way.

From a dietitian's point of view, no amount of training and workforce planning is of much value for indigenous communities whilst environments remain hostile to good health. As in all other areas of the health system – more emphasis on prevention and supportive environments rather than waiting until there is something to cure would be an advantage.

Migration Issues

DAA does not know of any overseas recruiting for dietitians, although a significant number choose to migrate to Australia of their own volition. DAA does not envisage that overseas recruitment is either likely or necessary in the foreseeable future. However, DAA administers a rigorous process of assessment of qualifications and examination of overseas graduates under it Dietetic Standards Recognition process for those who do choose to move here.

After Hours GP Service Adjacent to Hospitals

DAA supports this concept although any after hours clinic, to be effective, needs to be linked to multidisciplinary services. If the purpose is to reduce waiting times in emergency, reduce unnecessary admissions and allow hospitals to concentrate on core business then at least some of those who attend the GP clinic will need immediate organisation of community follow up such as the elderly person who is a falls risk and afraid to stay at home alone. Linkages are vitally important – again the importance of planning services rather than workforce.

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