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SALARIES AND BENEFITS OF ENTRY-LEVEL HOSPITAL DIETITIANS  
AND OTHER SELECTED HEALTH CARE PROFESSIONALS

by

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## INTRODUCTION

The American Dietetic Association (ADA) has suggested that to maintain high standards and achieve the objectives of the dietetic profession competent individuals must be attracted and retained in the field. Recruitment of capable professionals is achieved by sound employment practices, salaries appropriate with education and responsibilities, and good employment conditions (1).

General information on salaries and benefits is provided by the United States Department of Labor in the Occupational Outlook Handbook and the Industry Wage Survey: Hospitals and Nursing Homes (2, 3). The University of Texas Medical Branch at Galveston conducts an annual national survey of wages and salaries offered in hospitals and medical schools (4). Previously, the ADA published nationwide guidelines and salaries and benefits of the dietitian with varying levels of experience (5-11); however, this practice was discontinued after 1981. In 1983, a paper was published on salaries and benefits of dietetic personnel (1). Data from various sources for the period from 1978-1981 were presented. In 1977, a salary and benefit survey of entry level hospital dietitians in the midwest was conducted by Rich (12, 13).

The primary purpose of this study was to provide an update report of the 1977 survey by determining typical salaries and fringe benefits currently offered entry-level dietitians in midwestern hospitals. Specific objectives were to:

- a. analyze changes in salaries and benefits of entry-level dietitians from 1977 to 1981,

- b. determine the level of salaries of dietetic technicians,
- c. compare salaries of entry-level dietitians to those of other health care professionals, and
- d. compare salaries in the midwestern hospitals to those reported in a national survey.

This study was conducted through the use of mailed questionnaires distributed to personnel administrators of all hospitals 200 beds or larger in seven midwestern states. General short-term care hospitals with at least 200 beds were surveyed in accordance with the definition of hospitals surveyed in the Rich study (12, 13). Target states were Kansas and its four contiguous states, Colorado, Missouri, Nebraska, and Oklahoma. Also, Iowa and Illinois were included since these states were in Rich's study. The following definitions were used for this project.

Entry-level Registered Dietitian-

a person who has successfully completed minimum requirements outlined by The American Dietetic Association, successfully completed the examination for registration, and has no more than six months professional work experience.

Entry-level health care professional-

a person who has successfully completed minimum requirements for hospital employment in a selected health-related profession and has less than six months professional work experience.

Salary-

compensation represented by a dollar amount and representing pay for work on an annual basis,

Fringe benefits-

compensation offered other than salary including;

- statutory benefits, payments required by law to insure the worker and family an income in the event of unemployment, injury, or death,
- compensatory benefits, pay for time not worked, and
- supplementary benefits which include any other compensation such as life and health insurance offered by the facility to the employee.

This study should provide current information on salary and benefits to persons preparing to enter the dietetic profession and give counselors

and administrators guidelines on entry-level salaries in the defined geographic area for attracting and retaining competent personnel. Literature topics reviewed for this research include the following: wage and salary determination, wage equity, salary comparisons among health care professionals, fringe benefits, wage and benefit recommendations of the ADA, and cost of living indexes.

## REVIEW OF LITERATURE

### Wage and Salary Determination

#### Criteria for Wage Determination

Money is a complicated motivator and may be related to several basic needs of an individual: material acquisitions, affiliation, status, and self-actualization (14, 15). Lawler (16) found that pay can be an incentive if employees believe that pay and performance are related and believe that they are paid fairly compared to others. Compensation is considered an exchange--labor or services for money. The exchange model is optimum when the parties involved view the inputs and outcomes as relevant. Most organizational objectives toward labor are concerned with recruiting and retaining good employees and obtaining employee performance to achieve company goals. Each employee may have varied objectives, merely a livelihood or rapid career advancement (15).

The employer must choose a position on compensation by deciding where along a continuum the organization will stand: a leader, top pay for the cream of the labor force; minimum pay to keep the jobs filled; or somewhere in between. The decision is influenced by productivity of the economy, collective bargaining, condition of the product and labor markets, profits, and other factors (17).

Wage criteria are used to point out the consequences of the wage-position decision, bases of negotiations, and supplements to judgments. Criteria will vary from organization to organization but these are the most commonly used for rationalizing the positions to arrive at the pay decisions (17).

- Comparable wage. It is determined by surveys to establish the 'going rate' in the area for each occupation. Comparable wage has special value in a tight labor market in which competition is strong for the available labor but timely and accurate information are difficult to obtain.
- Cost of living. This criterion ensures keeping up with changes in the labor market.
- The employer's ability to pay. The organization must compare the projected wage bill with the projected resources. This criterion is usually only noticed in extremes.
- Productivity. The auto industry, for example, has based annual increases of the productivity of the market in the economy. No accurate measures exist and thus, the productivity criterion may contribute to inflation.
- The labor market. Some industries scan the market, especially when certain labor groups are in short supply, to draw the power they need to fill job openings.

### Job Evaluation

Techniques. The first step of compensation is a job evaluation to identify the work content of each job: required responsibilities, education, experience, and the skill necessary for performing the duties combined with consideration to the conditions under which these duties must be performed. The organization must have a valid measurement system so that all employees receive fair and equitable treatment. Procedures for collecting and analyzing job information are worker interviews, observations, questionnaires, employee diaries, or a combination of any of these (17, 18).

Next, a systematic plan for using the data collected must be developed. Techniques used in job evaluation are the job description and job analysis. Henderson (17) contended that the job description is one of the primary tools for coordinating the human and nonhuman resources of the business to achieve individual, group, and organizational goals. Through job analysis, those common elements that are required to perform all jobs in the business

can be identified. Compensable factors are individual parts of a job that when considered together define the job and determine its value. The functions of the variety of jobs in an organization determine the choice of factors to be used (17, 18).

Classifications. Quantitative and non-quantitative methods are the traditional classifications of job evaluation (15, 17). Job ranking and job classification are considered non-quantitative. In job ranking, organizational job descriptions are ranked by an official from most complex to least important. This method is simple and requires little time but is subjected to raters' skill and information (15, 17).

In job classification, a number of classes or grades are defined and the jobs are then "fit." This method is designed to place jobs of the same general value in the same pay grade and provides a smooth progression for advancement. Job classification is flexible and is usually understandable by the employee; however, writing grade descriptions is difficult and subjective judgment is involved (15, 17, 18).

The quantitative methods of wage determination are used more widely. The factor method compares jobs by determining important compensable factors then making judgments on the degree to which each job has these factors. Jobs are compared one at a time to "key jobs." A chart is then designed to rank each job on each factor. This method can be handled by a computer and can be custom fitted to the organization. If an organization uses the factor method the "key jobs" must be reviewed periodically for measurement purposes (15, 17, 18).

The point method breaks down jobs into compensable factors, giving each factor a numerical score than adding the scores for a job total. This method is used widely because it allows less bias by raters, is stable

for a long period of time, and is highly acceptable among the employees; however, it is difficult and timely to develop (15, 17, 18).

#### Wage Surveys

Data from the external labor market of past wage policies are collected in salary and wage surveys and used to validate past decisions and propose new wage administration policies (19). Wage surveys are performed by professional agencies, organizations, universities, and the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor (15, 17). If regularly used, surveys can assure employees that the organization is keeping up with the labor market (18). The majority of managers responsible for salary policy base their decisions on formal or informal survey information (18, 19). To be useful and valid, surveys should compare jobs with the same level of responsibility and job definitions, have an adequate sample size, and include information on benefits in addition to basic salary (19).

Thomsen (20) criticized the statistics used in salary surveys. The mean salary may be misleading if the salary scale is not subject to a normal distribution. He contended that reporting methods have been taken for granted and managers may be using data that is neither valid nor reasonable.

In the health care professions field, several surveys are conducted routinely. In 1978, the BLS completed a national survey of wage and benefits of non-federal hospitals and nursing homes (2). A uniform set of job descriptions was designed to account for variations in duties and job title. The University of Texas Medical Branch at Galveston completed its twenty-first national survey of hospitals and medical school salaries in 1982 (4). Approximately 100 hospitals across all the U.S. census regions

are surveyed annually. Monthly salaries are reported based on a 40 hour week with a conversion table to assist in translating to hourly rates. Cash value of fringe benefits is not included.

### Equity

Henderson (17) described equity theory as the comparison by individuals of inputs and outcomes with those of another individual or group. Inputs include education, intelligence, experience, training, and skill. Outcomes are any relevant rewards. Often the organization and employee define equity quite differently. Organizational equity is full effort by the employee for whatever the business can afford to pay. While the employee defines equity by the perceived contributions and value of the rewards (21).

In a series of equity studies, Belcher (15) found differences in importance of inputs and outcomes to different occupational groups and by demographic areas. The institution will better fulfill its organizational goals by providing each employee group with a reward they consider significant and fair (21).

Ellig (21) purported that internal and external equity are impossible for several reasons. Internal equity is the comparison of inputs and outputs made by the employees within the organization. The comparisons made by individuals toward others in similar job classifications outside the organization are referred to as external equity. If a certain labor group is in short supply the firm strives to achieve external equity to recruit, which may mean higher pay compared to the internal structure. Ellig indicated the cost of living allowance is often tied to the Consumer Price

Index. If the cost of living is negotiated, the non-union positions may not catch up.

Ellig (21) also reported inequities among male and female pay still exist. Newman (22) contended the Equal Pay Act of 1963 has done little to protect against discrimination in the work place, which involves more than just the concept of equal pay for equal work. Job discrimination is only an issue if both sexes are employed in the same occupation. The Equal Pay Act does not affect jobs that are traditionally held by one sex. Therefore, employers may tend to continue segregating jobs to avoid violating the act. Sometimes, women tend to hold the lower evaluated jobs; however, the job evaluations have rated jobs lower because they have typically been held by women or they place too much importance on physical requirements (21, 22).

#### Salary Comparisons Among Health Professionals

The pay differentials among health professionals have remained constant for years (23). With collective bargaining and a tight labor market for such professionals as nurses and respiratory therapists, this trend may be affected. The BLS has developed descriptive phrases for reporting changes in the employment requirements through the 1980's of recognized occupations in the Occupational Outlook Handbook as shown in Table 1 (3). Several health care professionals in a hospital setting have similar education, credentials, and responsibility levels (1-3). The professionals reviewed in this study are dietitians, medical technologists, occupational therapists, pharmacists, physical therapists, respiratory therapists, social workers, and staff nurses.

Table 1: Occupational outlook--potential growth<sup>1</sup>

descriptive phrase	projected 1980-90 change in employment requirements (%)
much faster than average	50+
faster than average	28 to 49
average	15 to 27
more slowly	6 to 14
little change	5 to -5
decline	lower than -6

<sup>1</sup>The average increase projected for occupations over the 1980-90 period.

Source: (3)

#### Dietitian

The professional in dietetics has a Bachelor of Science (B.S.) degree and is registered or registry eligible by the Commission on Dietetic Registration of The American Dietetic Association. The registered dietitian (R.D.) applies principles of nutrition to menu planning, food preparation and service; instructs patients and family in nutrition and special diets; and consults with other health care professionals concerning patients' food needs (1, 2). The dietitian's salary was one of the lowest of the health care professionals according to the 1980 University of Texas survey of hospital and medical school salaries and the 1982 Bureau of Labor Statistics, even though the BLS growth rate for dietitians is predicted to be faster than average (1, 3, 4, 24).

### Medical Technologist

The medical technologist has completed three years of college and one year in a medical technology course and is usually registered (1, 2). The technologist performs approved tests to obtain data used in diagnosis and treatment of patients. The salary increase rates of medical technologists have been faster than those of dietitians (1).

### Occupational Therapist

The occupational therapist (O.T.) has a B.S. degree and is registered by the American Occupational Therapy Association. This therapist plans and directs rehabilitation of the mentally or physically impaired patient (1, 2). The O.T. has had a much faster than average BLS predicted growth rate and the salary has been increasing at about the same rate as that of the dietitian (1, 3).

### Pharmacist

The pharmacist holds a B.S. in pharmacy and is registered by the state Board of Pharmacy. He/she reviews written prescriptions, dispenses medication, and explains directions to the outpatient (1, 2). Pharmacists have been one of the highest paid allied health professionals and traditionally pharmacy has been a male profession with a highly organized retail brotherhood (11). Their earnings have been increasing slower than those of dietitians (1). According to the BLS occupational outlook, potential growth is average in the pharmacy profession (3).

### Physical Therapist

The physical therapist (P.T.) has a B.S. degree and state registration. In accordance with a physician's prescription, the P.T. treats

disabilities and injuries through massage, exercise, and effective properties of air, water, temperature, radiation, and electricity. The physical therapist's salary has been increasing faster than that of the dietitian and the BLS growth projections are for much faster than average growth (1, 3).

#### Respiratory Therapist

The hospital often trains the respiratory therapist who can then become registered or certified by the National Board of Respiratory Therapy. The responsibilities include administering therapeutic and diagnostic procedures to patients with pulmonary disorders (2). Respiratory therapists have a much faster than average predicted BLS growth rate (3).

#### Social Worker

The medical social worker has a Master of Science degree and provides counseling to help a patient resolve personal or environmental difficulties (1, 2). Salary increases of the social worker have been less than salary increases of the dietitian and the BLS growth rate predictions indicate average growth (3).

#### Staff (General Duty) Nurse

A graduate of an accredited nursing school who is state licensed, the staff nurse observes and reports patient conditions, dispenses medication, assists the physician, and may do patient instruction (1, 2). Registered nurses have been in short supply for many years and, although they may have less formal education than a dietitian, their salary has climbed faster so that in 1981 the staff nurse's salary was above that of a registered dietitian (1). The BLS growth projections for registered nurses is the

same as for dietitians, a faster than average increase in employment requirements (3).

### Benefits

Benefits have grown and changed in the last 40 years due to social, economic, and legislative events (25). During the 1930s, the need for economic recovery led to enactment of the social security program and various other aid programs. In 1935, the Wagner Act establishing the National Labor Relations Board was passed permitting labor to organize and bargain collectively for benefits (25).

War economy and the Wage Stabilization Act of the 1940s restricted minimum wage increases so that labor turned to increased benefits. The Taft-Hartley Act governs the management of an employee benefit trust fund which in 1981 covered 20 percent of the private sector employees. During the 1950s union membership increased and benefits became a mandatory subject in collective bargaining (25).

The fields of science and management were increasing rapidly in the 1960s so that organizations increased benefits to attract college graduates. Many fringe benefits such as vacations, holidays, and medical insurance became the norm. As a result of the economic recession of the 1970s, the cost of benefits was a concern in organizations. The Employee Retirement Income Security Act (ERISA) was enacted to protect employees. Predictions are that benefits will continue to grow as employees demand employer paid benefits because of the decrease in net personal income (25). According to Beadle (26), today's employee benefits continue to increase more rapidly than wages.

With unemployment in 1983 the highest since 1940 and the rate of business failures the highest since the depression, major collective bargaining units in private industry have asked for the smallest compensation (wage and benefits) packages since data recordings began in 1967. In 1982, compensation settlements were adjusted only 3.3 percent the first year and 2.5 percent over the contract term (27).

Hospitals often lag behind private firms in bonus and benefit plans (11). In 1980, private employers were offering benefits accounting for 37.1 percent of payroll, while the benefits of 67 surveyed hospitals averaged only 29.6 percent of payroll (1, 28).

Eligibility requirements differ among companies and the benefits vary geographically. Employee benefits fall into three categories: statutory, compensatory, and supplementary (29).

#### Statutory Benefits

The statutory benefits, required by law, include social security, unemployment insurance, and workers' compensation. These payments ensure the worker and family an income in the event of unemployment, injury, or death (29).

Taxes are deducted from the employee's paycheck and matched by the employer for social security. The amount of retirement and other benefits provided by social security depends on the age at which the employee begins retirement and increases depend on the Consumer Price Index and congressional action. Social security also covers medical care of the retired and disabled and provides disability and survivor benefits (17).

### Compensatory Benefits

Compensatory benefits are paid time off: vacation, sick leave, holidays, and personal leave. Leave time has shown a slow but steady increase over the years (1). In 1981, the average medium size organization offered 10 paid holidays and 16 vacation days yearly after 10 years of service (1). Some organizations offer these leave days on a floating basis to be taken as the employee desires (15, 17, 29).

In the 1977 survey of entry-level dietitians' salary, Rich found that hospitals offered an average of 12.3 vacation days, 12 sick days, and 7.7 paid holidays (12, 13). Hospital professionals typically receive three weeks of vacation after five or less years of service (1). Some hospitals and organizations are allowing educational leave with or without pay. Data from a 1981 survey conducted by the Renal Dietitians Dietetic Practice Group indicated that paid time off ranging from 4 to 15 days were offered to a majority of renal dietitians in clinics, outpatient facilities, and hospitals (1).

### Supplementary Benefits

Health insurance, life insurance, retirement plans, profit-sharing or annuity plans, and continuing education payments are commonly included in supplementary benefits (29). According to Henderson (17), insurance plans generally are designed to meet the needs of the employee at the least cost to the organization.

Medical insurance must change to keep up with inflation and is the most costly benefit offered (29). In 1978, most hospitals offered health and major medical insurance but coverage and employee contributions varied (2). In the 1981 survey of employee benefits, 71 percent of private employees provided health insurance plans completely paid by the employer

(30, 31). In 1977, all hospitals in the midwest surveyed by Rich (12, 13) offered health insurance; over 50 percent paid the full premium and the remainder shared costs with the employee. Dental insurance is a relatively new addition to the benefit package. In 1978, only 27 percent of private firms offered dental insurance, while in 1980 the number had grown to 44 percent (1). In 1978, less than one-third of private hospitals had dental benefits (2). Results of the 1981 BLS survey of professional and administrative employees in private industry indicated that 60 percent had dental benefits (30).

If life insurance plans are offered, the employer usually pays the entire premium (31). Eighty percent of professional and technical employees in private industry have life insurance based on their earnings (30). Rich reported that 80 percent of the hospitals surveyed in 1977 paid the full premium of employee life insurance (12, 13).

Pension plans are now governed by the Employee Retirement Income Security Act of 1974. The employer does not have to offer retirement plans but if a plan is offered the employee must be given a written statement of the facts and amounts in the fund. Vesting rights assures the eligible employee a share of the pension fund even if they leave before retirement age (29). Pension plans in the health care field are not extensive. The reasons given are low pay, high turnover, and a large work-force of young female workers (1). According to a 1980 Chamber of Commerce survey, hospitals paid 3.6 percent of payroll to pension plans compared to 5.4 percent of payroll paid by private industries (28). In 1977, 79 percent of the hospitals surveyed by Rich offered some form of retirement benefits (12, 13).

Tuition reimbursement has been a standard employee benefit among many hospitals (32). The cost of private education continues to increase and Frantz (32) stressed the need for hospitals to achieve a benefit mix so that the employee's educational goals relate to the goals of the organization. The BLS showed that three-fifths of all employees have educational assistance available (30).

Other supplementary benefits are being offered to employees in various organizations. Discounts on meals and other services accounted for 98 cents per employee of weekly employee benefit costs in 1981 (28). Two-fifths of all employees surveyed by the BLS reported discount benefits (30). Child care (defrayed nursery cost or a day care facility) was available to only one percent of workers in 1981 (30). Profit-sharing or savings plans was available to only a minority of workers (30).

A new idea in supplementary benefits is the cafeteria plan. The organization has the basic benefits for all employees, then offers a variety of other benefits from which an employee may choose depending on personal needs (17, 29).

#### Position Papers of The ADA

The American Dietetic Association has prepared an official position paper on recommended salaries and employment practices for members since 1971 with six updating papers (5-10). The most recent position paper was published in 1981 (11). These papers were designed to:

- a. document the official position of the ADA in regard to recommended minimum salaries,
- b. assist members in evaluating positions at the time of initial interview, and

- c. provide a reference standard for both members and administrators who must evaluate benefit and compensation levels as a basis for making decisions.

The papers included qualifications of each dietetic position and responsibilities. The recommended minimums for each position are listed in Table 2 and recommended employment practices and benefits are enumerated in Table 3. The ADA also recommended salary increments of 25 percent between the minimum and maximum salary of each position. Minimum salary recommendations were meant to balance goals, trends, factual data, and realistic expectations (11).

According to Baldyga (33), the 1981 paper will be the last official position of the ADA on recommended salaries and employment practices. The position papers were discontinued on the advice of legal counsel.

### Cost of Living

#### Family Budgets

For the last 20 years, the Bureau of Labor Statistics has published a report on an annual consumption budget for the standard family. The statistic is composed of costs such as food, housing, transportation, clothing, personal and medical care, and miscellaneous costs. The report is used to compare three budget levels in urban and non-urban areas of each region of the United States. The 1981 consumption budget was estimated by applying the increases in the Consumer Price Index for Urban Wage Earners from autumn of 1980 to autumn of 1981. The budgets are not intended to represent a minimum level of adequate living. Because of a lack of resources the 1981 report was the last family budget statistic to be developed by the BLS (34, 35). The estimate of the single person,

Table 2: ADA recommended minimum salaries for dietetic positions, 1971-1981<sup>1</sup>

year	dietitian	R.D.	administrative dietitian	clinical dietitian	dietetic technician
1971	8,000	9,000	10,000	10,000	
1974	10,000	11,000	12,000	12,000	
1975	11,000	12,100	13,200	13,200	8,800
1976	11,500	12,500	13,500	13,200	9,200
1977	12,000	13,100	14,600	14,600	10,000
1979	13,000	14,000	15,500	15,500	11,600
1981	15,700	17,000	18,500	18,000	14,500

<sup>1</sup>Source: (5-11).

Table 3: ADA recommended minimum benefits, 1981<sup>1</sup>

1. 12 days sick leave per year
2. 4 weeks vacation per year
3. 10 paid holidays per year
4. Group life insurance equal to individual's annual salary
5. Hospitalization and medical insurance paid by the employer
6. Dental insurance paid in whole or in part by the employer
7. Retirement plan to supplement social security and a tax-sheltered annuity
8. Provisions for professional growth, reasonable time without loss of pay and expenses for continuing education
9. Travel allowance

<sup>1</sup>Source: (11).

under 35, intermediate consumption level as shown in Table 4, is probably the most representative of the entry-level dietitian (13).

Table 4: Average total consumption budget for a single person (under 35), by region, autumn 1981<sup>1</sup>

region	total consumption	% of U.S. average
	\$	
United States	6,380	100
metropolitan	6,508	102
non-metropolitan	5,809	91
North Central		
metropolitan	6,380	100
non-metropolitan	5,809	91
Northeast		
metropolitan	6,827	107
non-metropolitan	6,508	102
South		
metropolitan	6,125	96
non-metropolitan	5,487	86
West		
metropolitan	6,763	106
non-metropolitan	6,125	96

<sup>1</sup>Source: (34, 35).

#### Consumer Price Index

The Consumer Price Index (CPI) is the major economic indicator designed to measure changes in a family's purchasing power (36). The objective is to index accurately the changes in the cost of living. The CPI is used for so many varied programs and organizations that a large percentage of the population has its income affected by the index (37). The CPI-W represents the urban wage earner and the CPI-U covers a wider spectrum of the population including salaried workers, the unemployed,

retired, and self-employed. The CPI measures the change in the total cost to purchase a fixed set of goods and services. This is referred to as the market basket, which is revised every 10 to 12 years; the current base period is 1972 and 1973. An index number of 100 is assigned to represent the average market basket in the base year, currently 1967. The month-to-month change is converted to a percent, adjusted for seasonal factors and compounded over 12 months to compute the annual rate (36). The annual averages and changes of the CPI from 1977 through 1982 are shown in Table 5.

Table 5: Consumer Price Index (CPI-U): National and north central annual averages and changes 1977-1982<sup>1</sup>

year	national <sup>2</sup>		north central <sup>3</sup>	
	average	% change	average	% change
1977	186.1		100.0	
1978	202.9	9.0	110.0	10.0
1979	229.9	13.3	125.1	13.7
1980	258.4	12.4	140.4	12.2
1981	281.5	8.9	150.3	7.1
1982	292.4	3.9	159.7	6.3

<sup>1</sup>Data for December of each year (38).

<sup>2</sup>1967 = 100.

<sup>3</sup>1977 = 100.

## METHODOLOGY

### Development and Distribution of the Survey

The survey instrument was based on a 12-item questionnaire developed by Rich in 1977 (12). Three hospital personnel administrators were interviewed for their comments and suggestions after a review of the original survey. Changes were made to update items on benefits and clarify several questions. For example, salary data were requested as of September 1, 1982, to ensure a common base for comparisons. The personnel administrators commented that in the last few years salaries have changed more often than annually. Dental insurance, tax-sheltered annuities, child care, and laundry services were benefits added to the listing in the 1977 survey.

After additional review of the interview comments and the draft form by a four-member review committee, four questions were added to fulfill the objectives stated in the introduction. A question was added on benefits for part-time personnel. Another was designed to determine if personnel departments used the ADA position papers on recommended salaries and the reasons why the papers were not used in wage administration. Also, a question was designed to ascertain the number of technicians employed by hospitals and their entry-level salaries. A final question on entry-level salaries of other hospital professionals was added to permit comparison with those of dietitians. The finalized instrument was printed on colored paper imprinted with the letterhead of the sponsoring organization (Appendix A).

Hospitals in the seven target states (Colorado, Kansas, Illinois, Iowa, Missouri, Nebraska, and Oklahoma) that met the following criteria

were selected from the American Hospital Association Guide to the Health Care Field (39):

- 200 or more beds/bassinets,
- member of the American Hospital Association and accredited by the Joint Commission on Accreditation of Hospitals,
- provision of short-term general medical and surgical services, and
- classified as government-federal, government-non-federal, non-government-not for profit, osteopathic for profit, osteopathic not for profit, or investor owned.

In the seven state area, 248 hospitals met these criteria. The survey was directed to the personnel administrators of each of these hospitals since this person would have the best access to records about the type of data sought.

Prior to mailing, for follow-up purposes each questionnaire was coded with an identification number assigned to each hospital on the final list. A cover letter (Appendix B) accompanying each questionnaire identified the researchers and the objectives of the project. Anonymity was assured and a self-addressed envelope was enclosed to enhance the return of the questionnaire. Also, the personnel directors were offered a copy of the results as an additional enticement.

In three weeks, a second mailing followed to non-respondents. This mailing included a copy of the original questionnaire and follow-up cover letter with an appeal for assistance (Appendix B).

#### Analysis of Data

Data were coded for analysis by electronic data processing. Programs and routines in the Statistical Analysis System (SAS) were used for analyzing the data (40). Frequency distributions for all items were compiled;

univariate analysis was used to provide mean, median, and range statistics on salary data.

## RESULTS AND DISCUSSION

### General Information on Hospitals

#### Survey Returns

Of the 248 hospitals that met the criteria described in the methodology, 173 responses were received (70 percent). In Table 6, the hospital returns by state are shown. Five of the responses were unusable because hospital policies did not permit responding to questionnaires, or the hospital did not meet the established criteria.

#### Size and Type of Hospitals

Hospitals classified as non-government, not for profit, represented 75 percent of the sample (Table 7). Government affiliated hospitals, both federal and non-federal, comprised the second largest group. The remaining hospitals were classified as not for profit osteopathic and investor owned.

Hospitals ranged in size from 200 to 1,600 combined beds and bassinets (Table 8). About 50 percent of the hospitals were under 400 beds and the others were larger.

#### Control and Professional Staff in Department of Dietetics

All of the reporting hospitals employed at least one full-time dietitian (Table 9). The maximum number of full-time dietitians employed at one facility was 35. In this study, full-time was defined as 30 to 40 hours per week. Most of the hospitals (90 percent) reported the full-time equivalent as 40 hours.

Table 6: Responses to survey questionnaire

state	number of surveys sent	number of hospitals responding	% return
Colorado	20	16	80.0
Illinois	109	66	60.6
Iowa	28	21	75.0
Kansas	13	11	84.6
Missouri	46	33	71.7
Nebraska	15	12	80.0
Oklahoma	17	14	82.3
total	248	173	69.8

Table 7: Classifications of reporting hospitals<sup>1</sup>

classification	number	%
federal government	15	8.9
non-federal government	20	11.9
non-government, not for profit	126	75.0
osteopathic, not for profit	3	1.8
investor owned	4	2.4

<sup>1</sup>All short-term, general medical-surgical hospitals, 200 beds or larger, in seven midwestern states were surveyed.

Table 8: Size of reporting hospitals

state	hospital size, number of beds and bassinets				
	200-299	300-399	400-499	500-599	600+
Colorado	3	6	5	1	--
Illinois	15	11	17	12	9
Iowa	11	4	1	2	2
Kansas	3	1	1	1	5
Missouri	6	12	5	1	8
Nebraska	5	3	--	2	2
Oklahoma	3	3	3	1	4
total	46	40	32	20	30

Table 9: Qualifications of staff dietitians and directors of dietetics in selected midwestern hospitals

qualifications of currently employed staff dietitians	total number of hospitals	qualification of director		
		RD	member of ADA	foodservice director
← no. of hospitals →				
all are R.D.s	130	63	14	53
both R.D.s and non-R.D.s	24	12	5	7

Sixty-two hospitals (35 percent) also reported employing part-time dietitians. Five part-time dietitians were the maximum number employed, while the majority (82 percent) hired only one or two part-time dietitians. Most of the hospitals (84 percent) employed only R.D.s (Table 9).

Almost two-thirds of the directors of dietetics had earned bachelor's degrees and about 30 percent held a master's degree. A few held an associate degree or had not completed college.

Only 22 hospitals (13 percent) indicated that a food management company operated the Department of Dietetics. In half of those with contract-operated foodservice, all of the dietitians were employed by the foodservice company. Seven hospitals reported that only the director of the department was a company employee while the remainder of the staff was employed by the hospital.

#### Entry-level Salaries and Conditions of Employment for Dietetic Personnel in Midwestern Hospitals

##### Entry-level Salaries for Dietitians

Salaries by State. The mean annual salary offered entry-level dietitians eligible for registration was \$16,472 as of September, 1982, ranging from \$12,000 to \$23,652. The mean, median, and range of annual salaries by state are shown in Table 10 for entry-level dietitians eligible for registration and those who were registered (R.D.s). The mean salary offered entry-level R.D.s was \$17,250 annually with a range of \$12,400 to \$23,652.

Hospitals in Colorado and Oklahoma offered the highest entry-level salaries for dietitians awaiting registration, although salaries for entry-level R.D.s were highest in Colorado followed by Illinois and Oklahoma. Mean annual salaries in Nebraska hospitals were the lowest for both groups

Table 10: Entry-level salaries (September 1982) of dietitians eligible for registration and of registered dietitians (R.D.s) in selected midwestern hospitals<sup>1</sup>

state	annual salary		
	mean	median	range
entry-level dietitians eligible for registration			
	← \$ →		
Colorado	17,121	17,035	15,850-18,720
Illinois	16,584	16,640	12,000-23,652
Iowa	16,036	16,575	12,800-18,713
Kansas	16,423	16,000	15,392-17,862
Missouri	16,343	16,505	12,854-18,533
Nebraska	15,935	15,641	12,979-20,737
Oklahoma	17,166	16,652	14,934-20,300
total	16,472	16,587	12,000-23,652
entry-level R.D.s			
	← \$ →		
Colorado	18,443	18,533	16,673-20,256
Illinois	17,416	17,139	12,400-23,652
Iowa	16,656	16,746	13,369-20,946
Kansas	17,279	17,202	15,392-20,762
Missouri	17,108	17,007	14,500-20,259
Nebraska	16,242	16,188	13,369-20,737
Oklahoma	17,294	17,014	14,934-20,300
total	17,250	17,129	12,400-23,652

<sup>1</sup>N = 168.

of entry-level dietitians. The range of salaries was greatest in the Illinois hospitals for both classifications of entry-level dietitians studied.

The mean annual salary offered an entry-level R.D. was \$778 greater than that of a dietitian awaiting registration in the midwestern hospitals. In 34 hospitals (24 percent) the personnel administrator indicated a salary increase was given at the time registration was achieved by an entry-level dietitian on staff.

The registered dietitian has completed academic and experience requirements, successfully completed the registration exam, and has a commitment to maintain continuing education requirements of the Commission on Dietetic Registration. The entry-level R.D. may have a limited amount of work experience during the period between graduation and the registration exam (11).

Salaries by Size of Hospital. Salaries also were studied by size of institutions. In Table 11, the annual mean, median, and range for entry-level salaries of dietitians are listed for the midwestern hospitals in relation to five size classifications. In the smallest (200-299 beds) hospitals, annual mean salaries for R.D.s were lowest and in the largest (600+ beds) salaries were highest. The 600+ bed hospitals are all located in the large metropolitan areas where the cost of living is higher (Table 4).

Interestingly, the minimums were lower and the maximum salaries higher in the two groups of smaller hospitals. Perhaps those reporting salaries at the high end of the range have had difficulty attracting dietitians because most were located in smaller cities.

Table 11: Entry-level salaries (September 1982) of dietitians eligible for registration and of registered dietitians according to size of hospital<sup>1</sup>

number of beds and bassinets	annual salary		
	mean	median	range
entry-level dietitians eligible for registration			
	←————— \$ —————→		
200-299	15,963	15,974	12,000-23,652
300-399	16,698	16,673	12,979-20,737
400-499	16,914	16,661	14,934-19,500
500-599	15,993	15,922	12,085-19,136
600+	16,890	16,950	15,080-19,926
entry-level R.D.'s			
	←————— \$ —————→		
200-299	16,698	16,746	12,400-23,652
300-399	17,316	17,007	13,369-23,587
400-499	17,546	17,366	14,934-20,259
500-599	17,255	16,775	14,508-20,946
600+	17,627	17,472	15,917-20,762

<sup>1</sup>N = 168 hospitals in seven midwestern states.

Trend in Salaries, 1977-1982. Annual salaries of entry-level R.D.s for the years 1977 to 1982 in midwestern hospitals are shown in Table 12, along with the annual percentage increase. The increases from 1978 through 1980 were lower than the North Central CPI (Table 5), especially in 1979 and 1980. In 1981 and 1982, when inflation had declined somewhat, some attempt to "catch up" was reflected in entry-level dietitians' salaries. The entry-level dietitian's salary still lags behind the cost of living increases from 1977 through 1982. The salaries of entry-level R.D.s increased 54 percent, while the CPI, North Central, increased 59.7 percent. Therefore, the entry-level dietitian of 1982 has less real dollar earnings than was true in 1977.

Urban/Non-urban Salaries. The family budget data presented in Table 4 indicate the cost of living differs in metropolitan and non-metropolitan areas. Because this survey was limited to hospitals of 200 beds or more, most of the midwestern hospitals surveyed were located in metropolitan areas. Of the 168 hospitals in the study, 138 were in SMSAs (Standard Metropolitan Statistical Areas) as defined by the U.S. Bureau of Census (41) and 30 were in the non-metropolitan areas.

In Table 13 the annual mean salaries of entry-level R.D.s employed in urban and non-urban hospitals are enumerated. While the non-metropolitan salaries were lower than those in the metropolitan areas each year in the analysis, the difference in 1982 was only 2.8 percent. The family budget data indicated a 9 percent differential in cost of living, however, demonstrating that dietitians in non-urban areas may have greater relative spending power than the urban professional.

Table 12: Annual salaries and percentage increments for entry-level registered dietitians in selected midwestern hospitals, 1977-1982

year	mean	median	range	% increase <sup>1</sup>
	←————— \$ —————→			
1977	11,198	11,523	8,965-14,097	
1978	12,280	12,418	9,900-15,091	9.7
1979	13,275	13,250	10,507-16,152	8.1
1980	14,340	14,446	11,243-18,251	8.0
1981	16,011	15,942	12,260-20,120	11.7
1982	17,250	17,129	12,400-23,652	7.7

<sup>1</sup>% annual increase in mean salary.

Table 13: Annual mean salaries of entry-level R.D.s in midwestern hospitals in metropolitan<sup>1</sup> and non-metropolitan areas, 1977-1982

year	annual mean salaries	
	metropolitan	non-metropolitan
	\$	\$
1977	11,243	11,022
1978	12,376	11,883
1979	13,382	12,748
1980	14,402	14,078
1981	16,109	15,519
1982	17,331	16,851

<sup>1</sup>As defined by Standard Metropolitan Statistical Areas, source: (41).

Comparisons with ADA Recommendations. Comparisons of midwestern R.D. salaries with the ADA recommended minimums (9-11) are shown in Table 14 for the three years covered in this study for which recommendations were published--1977, 1979, and 1981. The annual mean salaries in 1979 and 1981 were closer to the recommendations than was the 1977 figure.

Salary Increments. The midwestern hospitals also were surveyed to determine the frequency of salary increments for entry-level dietitians. The results are shown in Table 15. The most frequent increase plan was an annual cost of living and/or an annual merit raise. Cost of living increases varied ranging in 1982 from 3.5 percent to 10 percent with a 5 percent increase most common. Merit raises ranged from 2 percent to 10 percent, also with a 5 percent increment the most frequent.

Most of the reporting hospitals (97 percent) had a probationary period ranging from one month to two years, with three months indicated by almost 60 percent. A salary increase at the end of probation was not a common practice among the midwestern hospitals. Almost 60 percent reported no raises were given after the probationary period.

#### Salaries of Dietetic Technicians

Eighty hospitals in the seven states surveyed reported hiring dietetic technicians. The dietetic technician is an individual who has an associate degree from a program that meets the educational standards defined by The American Dietetic Association and who has responsibilities in assigned areas under the supervision of an R.D. (11).

The mean, median, and range of annual salaries in 1982 are reported in Tables 16 and 17. The mean salary offered entry-level dietetic technicians was \$12,088 annually, with a range of \$8,105 to \$16,390. The

Table 14: ADA recommended minimum annual salaries for R.D. compared to salaries in midwestern hospitals, 1977-1981

year	ADA recommended minimum annual salaries for R.D. <sup>1</sup>	annual salaries in midwestern hospitals		
		entry-level R.D. salaries		% of recommended salaries <sup>2</sup>
		mean	median	
1977	13,100	11,650	11,731	88.9
1979	14,000	13,574	13,385	97.0
1981	17,000	16,245	15,920	95.6

<sup>1</sup>Sources: (9-11).<sup>2</sup>% based on mean.

Table 15: Frequency of salary increments, cost of living and merit, in selected midwestern hospitals

frequency of salary increments	number of hospitals	% <sup>1</sup>
cost of living		
annually	105	96.3
six months	2	1.8
none	1	.9
varies	1	.9
merit		
annually	136	90.1
six months	13	8.6
none	1	.7
varies	1	.7

<sup>1</sup>N varies because of nonresponse on specific items in survey, % is based on number of respondents.

Table 16: Entry-level salaries (September 1982) of dietetic technicians in selected midwestern hospitals<sup>1</sup>

state	annual range		
	mean	median	range
	← \$ →		
Colorado	12,210	12,481	10,296-13,896
Illinois	12,735	12,659	8,105-16,390
Iowa	11,034	11,294	8,840-12,917
Kansas	11,561	11,533	10,379-13,700
Missouri	12,218	12,500	9,464-13,369
Nebraska	10,998	11,077	9,360-11,949
Oklahoma	11,804	12,194	9,100-12,854
total	12,088	12,179	8,105-16,390

<sup>1</sup>Number of hospitals reporting employment of dietetic technicians (N = 80).

Table 17: Entry-level salaries (September 1982) of dietetic technicians according to size of hospital

number of beds/bassinets	annual salary		
	mean	median	range
	← \$ →		
200-299	11,326	11,496	9,200-14,000
300-399	11,736	12,228	8,105-13,279
400-499	12,857	12,775	10,296-15,267
500-599	12,205	11,861	10,379-16,390
600+	12,206	12,449	9,100-14,200

annual mean salary was lowest in Nebraska hospitals for dietetic technicians; whereas the salary was highest in Illinois hospitals, which also had the widest range of salaries. The mean salary was between \$1700 and \$3500 below the 1981 ADA recommendation for technician salaries (11).

Data for technicians' salaries also were analyzed by size of institution (Table 17). In hospitals of 400-499 beds, the annual mean salary was highest; lowest salaries were in the smallest hospitals.

#### Salaries of Selected Health Care Professionals in Midwestern Hospitals

In Table 18, annual mean salaries (September 1982) for selected health care professionals employed in midwestern hospitals located in metropolitan and non-metropolitan areas are presented. Salaries among the various states are listed in Table 28 in Appendix C.

Most of the non-metropolitan salaries were lower than those in urban areas, but the differential was less than the 9 percent in the urban/non-urban cost of living for the North Central region of the U.S. The salaries in urban hospitals were from approximately \$500 to \$1250 higher with one exception. The physical therapist's mean and median salary was slightly higher in the non-urban areas, which suggests that premium salaries may be offered because of possible shortages of P.T.s in the non-metropolitan sections of the midwest.

Table 18 shows that the annual salaries are ordered similarly among the various professionals in metropolitan and non-metropolitan hospitals. The only difference was the staff nurse who was paid a slightly lower salary than the social worker and dietitian in the non-metropolitan areas but a somewhat higher salary in the urban areas.

Table 18: Comparison of salaries of selected health care professionals in midwestern hospitals in metropolitan<sup>1</sup> and non-metropolitan areas (September 1982)

occupation	annual salary		
	mean	median	range
<hr/>			
←————— \$ —————→			
non-metropolitan <sup>2</sup>			
dietitian	16,851	16,037	13,369-23,652
medical technologist	16,046	16,037	11,490-20,737
occupational therapist	16,945	16,973	14,328-18,782
pharmacist	21,011	21,258	16,931-27,320
physical therapist	18,411	18,679	14,324-21,840
respiratory therapist	15,130	14,789	11,490-19,407
social worker	16,942	16,994	12,600-21,632
staff nurse	16,453	16,500	13,900-20,737
dietetic technician	11,252	11,502	8,840-12,854
metropolitan <sup>3</sup>			
dietitian	17,331	17,160	12,400-23,587
medical technologist	16,854	17,066	10,420-20,259
occupational therapist	17,611	17,507	12,854-22,972
pharmacist	22,261	22,025	11,960-27,860
physical therapist	18,151	18,221	10,531-23,702
respiratory therapist	15,753	15,930	11,490-20,000
social worker	17,548	17,368	12,646-22,774
staff nurse	17,584	17,708	14,934-21,424
dietetic technician	12,281	12,397	8,105-16,390

<sup>1</sup>As defined by Standard Metropolitan Statistical Areas, source: (41).

<sup>2</sup>N = 30 hospitals.

<sup>3</sup>N = 138 hospitals.

In both urban and non-urban areas, the pharmacist, physical therapist, and the occupational therapist had the highest salaries and the medical technologist, respiratory therapist, and the dietetic technician the lowest. The nurse, social worker, and dietitian had salaries intermediate between these two extremes.

Interestingly, the dietetic technician and respiratory therapist have a similar level of training, but the annual mean for the respiratory therapist was almost 30 percent higher than that of the dietetic technician. This trend may result from a higher demand than supply ratio of the respiratory therapist, whereas the role of dietetic technician on the dietetic team has not been established in many areas.

Since the primary objective in this study was an analysis of salaries in dietetics, annual salaries for other health professionals also were analyzed as a percentage of those for dietitians to facilitate comparisons (Table 19). Data indicate that dietitians, occupational therapists, social workers, and staff nurses earned similar salaries in the midwestern hospitals surveyed. Medical technologists had slightly lower, and physical therapists slightly higher annual mean salaries; pharmacists, however, were paid significantly higher salaries, even though their level of education is similar.

#### Comparison of Hospital Salary Data from Midwestern and National Surveys

To provide a basis for further analyzing the salaries of health care professionals in the midwest, data from the national surveys conducted annually by the University of Texas at Galveston were examined. The mean, median, and range of annual salaries in 1982 for the selected health care professionals in the midwestern survey are shown in Table 20, along with

Table 19: Entry-level salaries of selected health care professionals as percentage of entry-level R.D. salaries in midwestern hospitals (September 1982)

occupation	annual entry-level mean salary	% of entry-level R.D. salary
	\$	
dietitian	17,250	100.0
medical technologist	16,710	96.9
occupational therapist	17,533	101.6
pharmacist	22,095	128.1
physical therapist	18,191	105.5
respiratory therapist	15,666	90.8
social worker	17,461	101.2
staff nurse	17,385	100.8

Table 20: Entry-level salaries of health care professionals in selected midwestern hospitals<sup>1</sup> compared to salary data from a national survey<sup>2</sup>

occupation	annual salary		
	mean	median	range
<div>←————— \$ —————→</div>			
midwestern hospitals			
dietitian	17,250	17,129	12,400-23,652
medical technologist	16,710	16,973	10,420-20,737
occupational therapist	17,533	17,500	12,854-22,972
pharmacist	22,095	21,840	11,960-27,860
physical therapist	18,191	18,242	10,531-23,702
respiratory therapist	15,666	15,809	11,490-20,000
social worker	17,461	17,264	12,600-22,774
staff nurse	17,385	17,500	13,900-21,424
hospitals in national survey			
dietitian	17,880	17,820	14,184-28,584
medical technologist	17,580	17,100	12,972-24,684
occupational therapist	18,312	18,204	14,184-24,972
pharmacist	22,848	22,272	17,088-32,844
physical therapist	18,612	18,456	14,184-24,972
respiratory therapist	16,044	15,768	11,484-23,220
social worker	18,960	19,152	13,644-26,964
staff nurse	17,772	17,676	14,184-23,220

<sup>1</sup>Data for September 1, 1982.

<sup>2</sup>Data for August 1, 1982 (4).

those from the national survey. Job descriptions used in the national survey of the selected health care professionals are included in Appendix C (Table 29).

Salaries were higher for all of the professions in the national survey than in the midwest, with the differential being lowest for respiratory therapists and the highest for medical social workers. Differences also were reflected in the rank order of salaries among the eight health professions surveyed in the midwest compared to the national means. In both surveys, respiratory therapists were paid the lowest and pharmacists the highest salaries. Nationally, dietitians were offered slightly higher salaries than staff nurses, while the pattern was reversed in the midwest. The difference in the annual mean salaries in the midwestern and the national survey varied from \$378 to \$1499:

<u>occupation</u>	<u>difference in national and midwest salaries</u>
	\$ annually
dietitian	630
medical technologist	870
occupational therapist	779
pharmacist	753
physical therapist	421
respiratory therapist	378
social worker	1499
staff nurse	387

Data for 1977 to 1982 were available from the midwestern survey for dietitians, but were not requested for the other professions. Similar data were secured from the University of Texas surveys (4, 42). These annual salary statistics are shown in Table 21. Each year, except in 1981, the salaries of dietitians were higher in the national surveys than in the midwest.

Table 21: Entry-level salaries of dietitians in midwestern hospitals compared to those of selected health care professionals from national surveys, 1977-1982<sup>1</sup>

occupation	annual mean salary					
	1977	1978	1979	1980	1981	1982
	←————— \$ —————→					
midwestern survey						
dietitians (R.D.'s)	11,198	12,280	13,275	14,340	16,011	17,250
national survey <sup>1</sup>						
dietitian	12,072	12,588	13,392	14,520	15,804	17,880
medical tech- nologist	11,628	12,372	12,960	14,364	16,200	17,580
occupational therapist	11,904	12,636	13,500	15,024	16,740	18,312
pharmacist	16,116	16,944	17,880	19,836	21,696	22,848
physical therapist	12,012	12,888	13,752	15,144	16,932	18,612
respiratory therapist	10,812	11,388	11,832	13,260	14,664	16,044
social worker	13,032	13,800	14,640	16,056	17,352	18,960
staff nurse	11,172	12,000	12,816	14,508	16,308	17,772

<sup>1</sup>Source: (4, 42).

The annual increase for each profession was computed and these statistics are listed in Table 22. In general, salaries in the health care industry have not kept up with inflation. The increase in the national CPI from 1977 to 1982 was 57.1 percent. The only health care profession examined in this study in which the salary increases have matched the cost of living is that of staff nurse. Nurses' salaries rose 59.1 percent since 1977 according to the national survey, exceeding the rate of inflation by 2 percent. The dietitian's salary increased 54 percent in the midwest during this period and 48.1 percent nationally.

For all the occupations, increments lagged considerably behind the inflation rates in 1978 and 1979. In 1980 and 1981, salary adjustments were closer to the inflation percentage. Inflation slowed from 1981 to 1982, while salary adjustments in the health occupations surveyed exceeded this rate. These adjustments would appear to be merited, however, because of the differentials in 1978 and 1979. The overall percentage increase in annual salaries for the eight professions studied for the five years from 1977 to 1982 are as follows:

<u>occupation</u>	<u>% increase in salaries 1977 to 1982</u>
dietitian	48.1
medical technologist	50.6
occupational therapist	53.8
pharmacist	41.8
physical therapist	54.9
respiratory therapist	48.4
social worker	45.5
staff nurse	59.1

Entry-level salaries of selected health care professionals as a percentage of the entry-level salaries of dietitians from 1977 through 1982 are listed in Table 23. Interestingly, the dietitian was one of the

Table 22: Percentage increase in annual mean salaries of selected health professionals, 1977-1982, based on data from midwestern and national surveys

occupation	% increase				
	1977-78	1978-79	1979-80	1980-81	1981-82
midwestern survey					
dietitian	9.7	8.1	8.0	11.7	7.7
national survey <sup>1</sup>					
dietitian	4.3	6.4	8.4	8.8	13.1
medical technician	6.4	4.7	10.8	12.8	8.5
occupational therapist	6.1	6.8	11.3	11.4	9.4
pharmacist	5.1	5.5	10.9	9.4	5.3
physical therapist	7.3	6.7	10.1	11.8	9.9
respiratory therapist	5.3	3.9	12.1	10.6	9.4
social worker	5.9	6.1	9.7	8.1	9.3
staff nurse	7.4	6.8	13.2	12.4	9.0

<sup>1</sup>Source: (4, 42).

Table 23: Entry-level salaries of selected health care professionals as percentage of entry-level salaries of dietitians, 1977-1982<sup>1</sup>

occupation	% of entry-level dietitian salary					
	1977	1978	1979	1980	1981	1982
dietitian	100.0	100.0	100.0	100.0	100.0	100.0
medical technologist	96.3	98.3	96.8	98.9	102.5	98.3
occupational therapist	98.6	100.4	100.8	103.5	105.9	102.4
pharmacist	133.5	134.6	133.5	136.6	137.3	127.8
physical therapist	99.5	102.4	102.7	104.3	107.1	104.1
respiratory therapist	89.6	90.5	88.4	91.3	92.8	89.7
social worker	107.9	109.6	109.3	110.6	109.8	106.0
staff nurse	92.5	95.3	95.7	99.9	103.2	99.4

<sup>1</sup>Based on data from national surveys conducted by University of Texas Medical Branch at Galveston (4, 41).

highest paid professionals in 1977 but in 1981 was offered the second lowest salary of the occupations reported in this study. In 1982, however, the dietitian gained some ground and was in the middle of the pay scale.

### Fringe Benefits

#### Leave Time

A review of the literature on fringe benefits revealed that some facilities are pooling all leave time for the employee to take at his/her discretion rather than segmenting it into vacation, etc. Only 20 hospitals (12 percent) in this midwestern survey reported having a leave pool.

The total number of days offered annually is enumerated in Table 24. Annual sick days ranged from three to 30 days with 60 percent of the reporting hospitals offering 12, or one day per month. Vacation time varied from 10 days to 22 days per year; almost 60 percent of the hospitals allowed 10 working days annually. Holidays ranged from six to 14 days, with six holidays being the most prevalent policy. About half of the medical facilities reported giving personal holidays with three personal days per year being the most common practice. The personnel administrators also were asked to list other leave days in addition to the categories above. The other types of leave reported in only a few hospitals were days for bereavement, family illness, bonus, and a Red Cross Blood Donor holiday.

#### Insurance Benefits

Relative contributions of employer and employee to insurance costs in selected midwestern hospitals are presented in Table 25. Health, dental, and life insurance benefits were surveyed.

Table 24: Total days leave time granted annually including sick leave, vacation, holiday, personal, and other

all leave time, total number of days annually	% of hospitals
20 or fewer	3.1
21 to 30	48.5
31 to 40	44.2
41 or more	4.3

N = 163.

Table 25: Relative contributions of employer and employee to insurance costs in selected midwestern hospitals

contribution		hospitals reporting benefit	
employer %	employee %	number	% <sup>1</sup>
health			
100	0	84	57.2
75 or more	25 or less	38	25.8
less than 75	more than 25	25	17.0
dental			
100	0	59	69.4
75 or more	25 or less	13	15.3
less than 75	more than 25	13	15.3
life			
100	0	131	91.0
75 or more	25 or less	3	2.1
less than 75	more than 25	10	6.9

<sup>1</sup>N varies because of nonresponse; % is based on number reporting level of benefit offered.

Life Insurance. Full employer payment of employee life insurance was reported by 91 percent of the 146 hospitals which responded to this question. In 1977, full employer payment of life insurance was reported in 80 percent of the hospitals (12).

Health Insurance. Not all hospitals indicated the availability of health insurance. Of the reporting hospitals, 57 percent paid the full premium and 26 percent paid more than three-quarters of the insurance cost; statistics in 1977 were 56 percent and 15 percent respectively (12). Family coverage was indicated in 15 responses; however, data on dependent coverage was not specifically solicited.

Dental Insurance. The response to dental insurance coverage was encouraging. Eighty-five hospitals (51 percent) reported offering dental coverage.

#### Retirement Benefits

Only four hospitals indicated a retirement plan was not available, although 10 declined to answer. Retirement formulae varied widely; many of the formulae were complex but some of the facilities enclosed employee instruction sheets to figure the retirement benefit. Thirty hospitals based returns on a percentage of the average salary earned by the employee. The next most common formula reported was based on a percentage of the highest five or highest three annual salaries. Ten hospitals subtract the social security allowance from the final earnings. A few facilities contributed to the employee's savings plan.

The time an individual had to be employed before having the opportunity to join the retirement fund varied. One year was the most common (67

percent) time frame mentioned. Although vesting rights were not specifically requested, a few hospitals indicated 10 years.

#### Other Benefits

Several supplementary benefits were examined in the survey, including discounts for hospital services, payment of dues, and support for education. Although the amounts of discounts varied widely, many hospitals reported reductions for employees on several of their services. The type of employee discounts offered by midwestern hospitals are listed in Table 26.

The most widely offered discount was on pharmaceuticals, with 64 percent of the hospitals reporting reductions ranging from 5 to 100 percent. In 19 hospitals, medicinals were offered at cost and in 31, at cost plus 10 percent.

In 50 percent of the hospitals, meal discounts of five to 100 percent were indicated. Four hospitals reported free employee meals; the most frequent discount was 25 percent.

Emergency room, laboratory, and X-ray services were discounted in about 40 percent of the reporting hospitals. A 50 percent reduction was the most common although ten hospitals reported that these services were provided free of charge to their employees.

In approximately one-third of the health care facilities inpatient discounts of 10 to 100 percent were reported. Sixteen hospitals offered 25 percent reductions and 17 hospitals gave a 50 percent reduction of the inpatient bill.

Other supplementary benefits offered by reporting hospitals are summarized in Table 27. Payment of professional dues was reported in only 16 percent of the hospitals. Uniform services were provided in 43

Table 26: Employee discounts offered by selected midwestern hospitals

service	hospitals reporting discounts	
	number	%
meals	84	50.0
pharmacy	107	63.7
emergency room	72	42.9
laboratory	70	41.7
X-ray	68	40.5
inpatient room	57	33.9

N = 168.

Table 27: Other supplementary benefits offered by reporting hospitals

supplementary benefit	hospitals reporting benefits	
	number	%
payment of professional dues	27	16.1
uniform service	43	25.6
tax sheltered annuity	126	75.0
reimbursement for continuing education	137	81.5
child care	32	19.0
educational leave of absence	125	74.4

N = 168.

hospitals. One-half of these hospitals provided the uniform while the remainder provided a laundry service.

Tax sheltered annuities were a frequently offered fringe benefit. Three-fourths of the surveyed hospitals were offering annuities to their employees.

Child care, either a facility or reimbursement, was offered in only 32 hospitals. This statistic is higher than the one percent of employers reportedly providing child care in the 1980 BLS survey (30). Child care benefits is an area that health care facilities may need to increase with more working mothers and the large percentage of female employees in hospitals. Perhaps retention rate would improve with the security of a reliable day care center.

The response to continuing education reimbursement and educational leave of absence was encouraging. More than 80 percent of the hospitals surveyed provided reimbursement for continuing education, well above the 60 percent of employers in the private sector in 1980 (30). Continuing education is of vital importance to the dietitian in order to maintain professional standards and keep abreast of an ever-changing field. A specific limitation on reimbursement was not reported in nine hospitals. The cap varied from \$50 to \$2000 in the hospitals surveyed. The most common limits were \$500, \$1000, or \$1500. Several hospitals (13) reported allowing assistance for three to 18 university credits per year.

## SUMMARY

The American Dietetic Association has stated that competent individuals must be attracted to the dietetic profession to maintain high standards. Sound employment practices, salary appropriate with education and responsibilities, and good employment conditions are necessary for recruitment of capable professionals.

The objective of this study was to provide current data on salaries and fringe benefits of entry-level dietitians employed in hospitals of 200 beds or more in seven midwestern states. Trends in salaries for dietitians from 1977 to 1981, a comparison of salaries among selected health care professionals, and a comparison of salaries in midwestern hospitals to those in a national survey were examined.

Survey instruments were mailed to personnel directors of 248 hospitals offering general short-term care. As a result of initial and follow-up mailings, 173 questionnaires or 70 percent were returned.

The annual mean salary as of September 1982 offered to dietitians awaiting registration was \$16,472, ranging from \$12,000 to \$23,652; whereas that for entry-level R.D.s was \$17,250 with a range of \$12,400 to \$23,652. About one-fourth of the hospitals indicated a salary increase at the time of registration. Hospitals in Colorado offered the highest entry-level R.D. salaries and Oklahoma reported the highest salaries for dietitians awaiting registration. In the smallest (200-299 beds) hospitals, annual mean salaries for R.D.s were lowest and in the largest (600+ beds) salaries were highest. The non-metropolitan salaries were

2.8 percent lower than the metropolitan salaries, however, family budget data indicated a 9 percent differential in the cost of living.

An annual cost of living and/or annual merit raise was reported by most hospitals. Entry-level dietitians were most frequently subject to a three-month probation period, but a pay increase after probation was not a common practice. Annual midwestern salary increments from 1977 through 1982 lagged behind the cost of living increases in the North Central United States. The salaries of entry-level R.D.s increased 54 percent, while the CPI, North Central, increased 59.7 percent.

Eighty hospitals reported hiring dietetic technicians. The mean entry-level salary for a technician was \$12,088, ranging from \$8,105 to \$16,390.

The entry-level R.D.'s salary was compared to those of other entry-level health care professionals in the hospitals surveyed in the seven midwestern states. Salaries for these entry-level professionals ranked in decreasing order were as follows: pharmacist, physical therapist, occupational therapist, social worker, staff nurse, dietitian, medical technologist, and respiratory therapist.

A national survey of hospitals and medical school salaries is conducted annually by the University of Texas Medical Branch at Galveston. The findings of the national study were compared to the results of the midwest survey. Nationally, the entry-level dietitian's mean annual salary was \$630 higher than that of the midwest dietitian. The increase in the national CPI from 1977 to 1982 was 57 percent while the increase in the dietitian's salary was only 48 percent. The staff nurse was the only health care professional whose salary increased at a faster rate than the national cost of living.

This study also included a survey of employee fringe benefits provided by midwestern hospitals. Only 20 hospitals reported a pool of leave time for the employees to take at their discretion. The predominant pattern of leave time was 12 sick days, two weeks vacation, six holidays, and three personal days per year.

Life, health, and dental insurance were common employee benefits but relative contributions of employer and employee to the insurance costs varied among hospitals. Most hospitals (92 percent) offered retirement plans with various returns. Discounts often were permitted on meals, pharmaceuticals, and emergency room, laboratory, X-ray, and inpatient services. Child care benefits were reported in only 19 percent of the hospitals. More than 80 percent of the hospitals surveyed provided reimbursement for continuing education, and 74 percent permitted educational leaves of absence.

This study examined several areas of concern for the entry-level dietitian including salary, increments, fringe benefits, and salary comparisons with other health care professionals. Periodic surveys on salaries and fringe benefits are needed to provide current, valid data because of the fluctuations in economic conditions, the number of dietitians entering practice, and the changes in the health care field.

Current information on salary and benefits was provided from this study that will be helpful to persons preparing to enter the dietetic profession. Also, these data will assist administrators in the defined geographic area to set realistic salaries for attracting and retaining competent personnel. An in-depth study of dietitians' salaries and benefits in private practice, school and university foodservice, and industry also would be valuable to practitioners for career planning.

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## APPENDIXES

APPENDIX A  
QUESTIONNAIRE

## SALARY STUDY: THE ENTRY-LEVEL DIETITIAN

Please answer each question so that data will be complete. Do not sign or indicate the name of your hospital: simply place the completed questionnaire in the enclosed postage paid envelope and return it to me. Prompt return will be greatly appreciated. Thank you.

1. In what state is your hospital located? \_\_\_\_\_
2. Size of hospital:                      beds \_\_\_\_\_  
   bassinets \_\_\_\_\_
3. Classification of hospital:
  - (1) gov't., federal \_\_\_\_\_
  - (2) gov't., non-federal \_\_\_\_\_
  - (3) non gov't., not for profit \_\_\_\_\_
  - (4) osteopathic, for profit \_\_\_\_\_
  - (5) osteopathic, not for profit \_\_\_\_\_
  - (6) investor owned \_\_\_\_\_
4. a. Does your hospital operate the Department of Dietetics?
  - (1) Yes \_\_\_\_\_
  - (2) No, operated by a food contract company \_\_\_\_\_
 b. If a food management company operates the department, who employs the dietitians?
  - (1) Number employed by the hospital \_\_\_\_\_
  - (2) Number employed by the food management company \_\_\_\_\_
5. a. Qualifications of the present Director of Dietetics:
  - (1) Food Service Director \_\_\_\_\_
  - (2) Administrative Dietitian, R.D. \_\_\_\_\_
  - (3) Administrative Dietitian, ADA member \_\_\_\_\_
 b. Educational background of Director (indicate highest degree):
  - (1) Ph.D. \_\_\_\_\_
  - (2) Master's Degree \_\_\_\_\_
  - (3) Bachelor's Degree \_\_\_\_\_
  - (4) Associate Degree \_\_\_\_\_
  - (5) High School Diploma \_\_\_\_\_
6. a. How many dietitians are on your staff?
  - (1) Full time \_\_\_\_\_
  - (2) Part time \_\_\_\_\_
 b. How many hours constitute full time employment? \_\_\_\_\_
- c. How many are Registered Dietitians (R.D.)? \_\_\_\_\_
7. Indicate the current salary as of Sept. 1, 1982 offered to entry level dietitians awaiting registration who are seeking full time employment. An entry-level dietitian is defined as a person with six months or less professional work experience. \$ \_\_\_\_\_/yr.
8. a. Is there a salary increase upon achieving an R.D. status?
  - (1) Yes \_\_\_\_\_
  - (2) No \_\_\_\_\_
 b. If the answer to 8.a. is Yes, in what amount? \$ \_\_\_\_\_/yr. or \_\_\_\_\_%
9. Please indicate the typical salary offered entry-level Registered Dietitians (R.D.) seeking full time employment. \$ \_\_\_\_\_/yr.
10. a. Is there a probationary period for newly employed entry-level dietitians?
  - (1) Yes \_\_\_\_\_
  - (2) No \_\_\_\_\_
 b. If yes, state length of time in months \_\_\_\_\_ months
- c. Is there a salary increment after the probationary period?
  - (1) Yes \_\_\_\_\_
  - (2) No \_\_\_\_\_
- d. If yes, how much \$ \_\_\_\_\_/yr. or \_\_\_\_\_%
- e. After the probationary period, how frequent are salary increments for entry-level dietitians?
  - (1) Cost of living \_\_\_\_\_ times/yr.
  - (2) Merit \_\_\_\_\_ times/yr.
- f. In what amounts?
  - (1) Cost of living \_\_\_\_\_%
  - (2) Merit \_\_\_\_\_%
11. If the data are available, please indicate minimum annual salary, excluding all fringe benefits, offered to entry level dietitians seeking full time employment within the past five years.
 

<u>Minimum annual salary as of Sept. 1</u>	
(1) 1977	\$ _____
(2) 1978	\$ _____
(3) 1979	\$ _____
(4) 1980	\$ _____
(5) 1981	\$ _____

12. If data are available, please indicate compensation in the form of fringe benefits offered entry-level Registered Dietitians:

a. Total paid leave days per year \_\_\_\_\_  
If specified by categories, please indicate breakdown:

	days per year
* sick	_____
vacation	_____
holidays	_____
personal	_____
other, specify type	_____

b. Health insurance  
employer contribution \_\_\_\_\_ \$  
individual contribution \_\_\_\_\_ \$

c. Dental insurance  
employer contribution \_\_\_\_\_ \$  
individual contribution \_\_\_\_\_ \$

d. Life insurance  
employer contribution \_\_\_\_\_ \$  
individual contribution \_\_\_\_\_ \$

e. Retirement formula \_\_\_\_\_  
After how many months can an employee participate in the plan? \_\_\_\_\_ mos.

f. Payment of professional dues?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

If yes, what is the maximum amount?  
\$ \_\_\_\_\_/yr.

g. Discount for hospital services  
meals \_\_\_\_\_ \$  
pharmacy \_\_\_\_\_ \$  
emergency room \_\_\_\_\_ \$  
lab \_\_\_\_\_ \$  
X-ray \_\_\_\_\_ \$  
hospital room rates \_\_\_\_\_ \$

h. Uniforms provided?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

Uniform laundry?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

i. Tax Sheltered Annuity?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

j. Educational leave of absence?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

If yes, indicate annual time limit \_\_\_\_\_

k. Reimbursement for continuing education?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

If yes, indicate \$ \_\_\_\_\_/yr.

l. Child care:  
Facility available on premises?  
(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_  
Reimbursement \$ \_\_\_\_\_/mo.

13. a. Are fringe benefits offered to part time employees?

(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

b. If yes, how many hours per week must an employee work to receive fringe benefits?

\_\_\_\_\_ hrs./wk.

14. a. Does your healthcare facility use The American Dietetic Association position paper on salaries as a basis for salary offers?

(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

b. If no, why? (check one)

(1) Did not know about position paper \_\_\_\_\_  
(2) Recommendation too high for this region \_\_\_\_\_  
(3) Recommendation too low for this region \_\_\_\_\_

15. a. Do you employ Dietetic Technicians?

(1) Yes \_\_\_\_\_  
(2) No \_\_\_\_\_

b. If yes, how many? \_\_\_\_\_

c. If yes, indicate entry-level salary for technicians as of Sept. 1, 1982.

\$ \_\_\_\_\_/yr.

16. Indicate the current annual salary offered the following entry-level professionals as of Sept. 1, 1982. Entry-level is defined as a person with six months or less professional work experience.

Entry-level salary (annual) as of Sept. 1, 1982:

Staff nurse	\$ _____
Pharmacist	\$ _____
Medical Tech	\$ _____
Social Worker	\$ _____
Physical Therapist	\$ _____
Occupational Therapist	\$ _____
Respiratory Therapist	\$ _____

APPENDIX B  
CORRESPONDENCE

October 7, 1982

Dear Hospital Personnel Director:

In the Department of Dietetics, Restaurant and Institutional Management at Kansas State University, we are currently seeking information regarding salary and fringe benefits offered to entry-level Registered Dietitians and salaries of other entry-level health professionals.

We believe this information will help us in counseling students in the dietetics program at K-State and other midwestern universities by providing current data to formulate reasonable salary expectations. The salary comparisons will provide knowledge of the prevailing rate in the labor market. Also we plan to share a complete report of the results with all participating hospitals to assist you in evaluating salary policies.

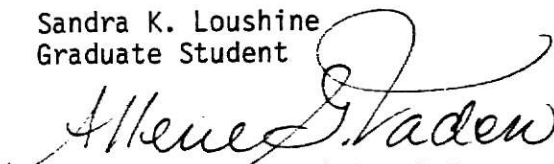
The enclosed questionnaire is being mailed to personnel directors of hospitals accredited by the JCAH and holding AHA membership. We are surveying hospitals offering general, short term care, with 200 beds or more. The project includes hospitals meeting these criteria in Kansas, Missouri, Oklahoma, Nebraska, Iowa, Illinois, and Colorado. We hope you, as a hospital personnel director, or your staff will provide input into this project.

Please complete the questionnaire and return it in the enclosed, stamped envelope. We hope to receive your response within the next two weeks. Be assured that individual hospital anonymity will be maintained. Results will be reported only in aggregate form for each state and the seven state area. However, as indicated above, we will share a complete copy of the results with you.

Thank you for your assistance.

Sincerely,

Sandra K. Loushine  
Graduate Student



Allene G. Vaden, Ph.D., R.D.  
Professor

ns  
Enclosures

October 29, 1982

Dear Hospital Personnel Director:

We need your help! The Department of Dietetics, Restaurant, and Institutional Management at Kansas State University is compiling data regarding salaries for the entry-level dietitian. On October 7, we mailed you a questionnaire and in reviewing returns we noticed that your response has not been received. We need your assistance in order to have complete data in reporting results.

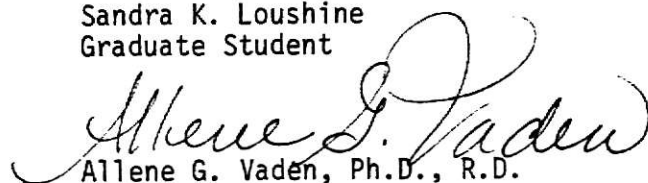
In the event you did not receive the first mailing, let me briefly restate the objectives. We are seeking information regarding salaries and fringe benefits offered to entry-level Registered Dietitians and salaries of other entry-level health professionals. We are surveying Midwestern hospitals offering general, short term care, with 200 beds or more in a seven state area. This information will offer students seeking employment in the Midwest realistic data on which to base expectations.

Please complete the questionnaire enclosed and return it in the enclosed envelope as soon as possible. Be assured that individual hospital anonymity will be maintained. Results will be reported only in aggregate form for each state. We will share a complete report of results with all participating hospitals to assist you in evaluating salary policies.

Thank you for your assistance.

Sincerely,

Sandra K. Loushine  
Graduate Student



Allene G. Vaden, Ph.D., R.D.  
Professor

ns  
Enclosures

APPENDIX C  
SUPPLEMENTARY TABLES

Table 28: Annual mean salaries for entry-level health care professionals in selected midwestern hospitals (September 1982)							
occupation	state						
	Colorado	Illinois	Iowa	Kansas	Missouri	Nebraska	Oklahoma
	← annual mean salaries (\$) →						
dietitian	18,443	17,416	16,656	17,279	17,108	16,242	17,294
medical technologist	18,186	16,497	16,122	16,870	16,715	15,691	17,325
occupational therapist	18,289	17,709	16,992	17,095	17,130	16,769	18,058
pharmacist	24,897	22,126	21,326	21,840	21,566	20,222	22,456
physical therapist	18,289	18,502	17,890	15,755	17,491	18,267	18,649
respiratory therapist	16,932	15,731	15,527	15,035	15,768	14,679	15,460
social worker	19,293	17,679	16,553	17,502	16,698	16,386	18,253
staff nurse	18,552	17,560	16,393	17,132	17,232	16,451	18,043

Table 29: Brief job descriptions for selected health professions used in national surveys of hospital salaries<sup>1</sup>

title	job description
dietitian	Responsible for calculating and writing special diets and supervising foodservice to patients. <u>Bachelor's Degree</u> with major in food and nutrition. Must qualify for ADA Registration and have some experience as professional dietitian.
medical technologist	Performs various chemical, microscopic and bacteriologic tests to obtain data for use in diagnosis and treatment of diseases. May specialize in bacteriology, chemistry, hematology or serology. Must be a high school graduate or equivalent, with <u>3 years of college and completion of 1 year course in medical technology from an approved school</u> . American Society of Clinical Pathologist registration required (ASCP).
occupational therapist	Plans and implements projects of therapeutic value in a rehabilitation program for patients with physical and mental disabilities. Evaluates projects that are tailored to fit the individual patient. Prefer a <u>Bachelor's Degree</u> with specialization in Occupational Therapy from an approved School of Occupational Therapy. Must be eligible for registration.
pharmacist	Performs professional duties involving the manufacture, compounding and dispensing of drugs, medicines, and other pharmaceutical preparations as prescribed by physicians of a hospital or clinic. Maintains records and makes reports as required by regulations. Must have a <u>Bachelor's Degree</u> in pharmacy. Registration is required.
physical therapist	Evaluates and treats patients with physical disabilities in accordance with the physician's orders through the use of heat, massage, exercise, hydrotherapy, diathermy, ultrasonics and other methods as may be prescribed. Must have a <u>Bachelor's Degree</u> with specialization in Physical Therapy from an approved School of Physical Therapy. Registration required.
respiratory therapist (inhalation therapist)	Administers prescribed respiratory therapy, including emergency care to the patient, under the direction of a physician. Must have ability to modify respiratory therapy, including ventilatory techniques to deal with

<sup>1</sup>Source: (4).

Table 29: (cont.)

title	job description
respiratory therapist (cont.)	adverse patient response. Is capable of providing in-service training. Must be eligible for registration by the National Board of Respiratory Therapy as a Registered Respiratory Therapist (RRT).
social worker	Provides social case work services to hospital and clinic patients. This involves interpreting the social and environmental factors of patients to the medical staff and explaining the medical requirements to the patient and his family. This is a full professional level. Must have a <u>Master's Degree</u> in social work and 1 year of related experience. Do not include Case Aides, Case Workers and others unless they meet the educational requirements.
staff nurse (R.N.)	Responsible for providing professional patient care according to established standards and institutional policy and procedures. Includes registered nurses assigned to operating rooms, general floor duty, emergency room, out-patient clinic, intensive care and others. Must be a graduate of a School of Nursing and registered by the state.

SALARIES AND BENEFITS OF ENTRY-LEVEL HOSPITAL DIETITIANS  
AND OTHER SELECTED HEALTH CARE PROFESSIONALS

by

SANDRA KAY LOUSHINE

B.S., University of Minnesota, 1974

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AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

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## ABSTRACT

The objective of this study was to provide current data on salaries and fringe benefits of entry-level dietitians employed in hospitals of 200 beds or more in seven midwestern states. Trends in salaries for dietitians from 1977 to 1981, a comparison of salaries among selected health care professionals, and a comparison of salaries in midwestern hospitals to those in a national survey were examined.

Survey instruments were mailed to personnel directors of 248 hospitals offering general short-term care. As a result of initial and follow-up mailings, 173 questionnaires or 70 percent were returned.

The annual mean salary as of September 1982 offered to dietitians awaiting registration was \$16,472, ranging from \$12,000 to \$23,652; whereas that for entry-level R.D.s was \$17,250 with a range of \$12,400 to \$23,652. About one-fourth of the hospitals indicated a salary increase at the time of registration. Hospitals in Colorado offered the highest entry-level R.D. salaries and Oklahoma reported the highest salaries for dietitians awaiting registration. In the smallest (200-299 beds) hospitals, annual mean salaries for R.D.s were lowest and in the largest (600+ beds) salaries were highest. The non-metropolitan salaries were 2.8 percent lower than the metropolitan salaries.

An annual cost of living and/or annual merit raise was reported by most hospitals. Entry-level dietitians were most frequently subject to a three-month probation period, but a pay increase after probation was not a common practice. The salaries of entry-level R.D.s increased only 54

percent from 1977 to 1982, while the CPI, North Central, increased 59.7 percent.

Eighty hospitals reported hiring dietetic technicians. The mean entry-level salary for a technician was \$12,088, ranging from \$8,105 to \$16,390.

The entry-level R.D.'s salary was compared to those of other entry-level health care professionals in the hospitals surveyed in the seven midwestern states. Salaries for these entry-level professionals ranked in decreasing order as follows: pharmacist, physical therapist, occupational therapist, social worker, staff nurse, dietitian, medical technologist, and respiratory therapist.

The findings of a national survey conducted by the University of Texas Medical Branch at Galveston were compared to the results of the midwest study. Nationally, the entry-level dietitian's mean annual salary was \$630 higher than that of the midwest dietitian. The increase in the national CPI from 1977 to 1982 was 57 percent while the increase in the dietitian's salary was only 48 percent. The staff nurse was the only health care professional whose salary increased at a faster rate than the national cost of living.

This study also included a survey of employee fringe benefits provided by midwestern hospitals. The predominant pattern of leave time was 12 sick days, two weeks vacation, six holidays, and three personal days per year.

Relative contributions of employer and employee to life, health, and dental insurance costs varied among hospitals. Most hospitals offered retirement plans with various returns. Discounts often were permitted on meals, pharmaceuticals, and emergency room, laboratory, X-ray, and

inpatient services. Child care benefits were reported in only 19 percent of the hospitals. More than 80 percent of the hospitals surveyed provided reimbursement for continuing education, and 74 percent permitted educational leaves of absence.