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EDITORIAL

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Return of the unexpected: Rural workforce recruitment and retention in the era of COVID-19

We are pleased to introduce this special edition of the *Australian Journal of Rural Health* that focuses on rural health workforce. It is an opportune and timely edition as rural health and the rural health workforce face a precipice borne, in part, by the COVID-19 pandemic. There has never been a more important time to consider appropriately and effectively rural communities to improve health outcomes.

The COVID-19 pandemic has seen many people re-evaluate what is important to them. In an already unpredictable period, the ongoing exodus from Australia's capital cities to the perceived safety of regional areas is a largely unforeseen demographic shift. The March 2021 quarter saw the largest net loss of people from Australia's capital cities (−11 800) and surpassed the previous record set in the September 2020 quarter (−11 200).[1] Regional Australia is where most of these internal migrants now call home. In 2020, 43 000 Australians moved to regional areas from capital cities, the largest inflow since 2001 when tracking this movement began.[2] This is notable as it is counter to the prevailing trend of migration of rural people to metropolitan areas, favouring capital city growth. In year ending June 2019, the last pre-COVID measurement period, the populations of Australia's capital cities rose by over 300 000 residents and accounted for 79% of Australia's total population increase.[3] However, pre-COVID, there had been a continued population decline of rural and remote communities particularly those associated with mining and agriculture, with an accompanying decline in services.[4]

While a population influx to 'the regions'—seen by many as a panacea to arresting rural decline—is broadly marketed in a positive light, the reality is regional Australia is not homogenous, and the benefits (and drawbacks) will not be shared equally. It is unlikely there will be an associated redistribution of funding for services. That is, services will not likely change in metro areas as the population loss is small in percentage terms. However, for rural areas receiving residents where the influx may be significant in percentage terms, there will be a need for more services and support. This could have long-term service implications due to life cycle demands including, but not limited to, maternity and aged care services, education, public transport and housing. This internal migration is yet to be quantified, the 2021 Census may provide a snapshot of this dynamic, and we are unable to predict whether the trend will be sustained or reversed. Recent media reports have suggested that rural, regional and remote areas are 'greying' and experiencing differential population loss or growth, counter to some state-level trends.[5] For example, while the state of Victoria has overall become younger (median age dropping from 37.2 to 37.1 years from 2012 to 2020), the median age in regional communities during the same period is getting older—for example, the region of Orbost experienced a 4% loss of population and a now has a median age of 55.9.[5] While other areas in Victoria have grown in population, they have also aged; in East Gippsland, the population has grown by 8.4% with a median age of 55. Similarly, Paynesville has witnessed a 20% increase in population and the median age is 59.2.[5] While it is important to monitor these demographic trends and their potential impacts, the opportunity exists to further understand these dynamics with the consideration of geographical access socio-economic data and described by Versace et al[6]

The lack of health resources in these regions became a prominent concern as the projected impacts of COVID-19 would overburden rural health care system during the acute phase of the pandemic. That is, while we do not fully understand the long-term health impacts of recent events, we are already noticing an increase in mental and physical health concerns.[7-9] In this issue, Roberts et al[10] investigate the effects of COVID-19 on the mental health of rural paramedics, police, community nursing staff and child protection staff. They reported high levels of depression and anxiety, attributed to the organisational response to COVID-19. But what of the long-term impacts? What will all this mean for rural communities? More people, and possibly more health conditions, could disproportionately affect rural communities, which already experience health access challenges, an ageing population, and social and economic disadvantages. Having appropriately and effectively resourced health services in rural communities, now more than ever, should be one of our highest priorities. Yet we have a long-standing, and well-documented, battle to attract and retain health care

professionals to rural areas, particularly as the location becomes more remote. The most significant investment we could make right now for the betterment of rural health is in people. With increases in populations, increases in mental health concerns,[7] possible decreases in physical activity[8,9] and an already stretched rural health system, the time for action is now. The last thing we need is to take skilled health professionals from the more remote regions, or sectors such as aged care, to fill service gaps. In one of our local areas, we are aware of aged care facilities closing due to staffing shortages, management citing that staff moved to COVID-19 clinics and hospitals for better wages and conditions. Robbing Peta to pay Paula will be of even greater detriment to rural communities. We need to be vigilant of the ramifications internal migration could have on more remote communities and services generally. Will we see a 'reinforcement' of regional capitals at the expense of smaller, outlying communities as the critical mass increases?

Many countries have adopted programs and strategies to attract and retain health workers to non-metropolitan areas. Walsh et al[11] concluded that although Australia and other developed countries have introduced policies to encourage health workers to live and work in rural communities, there was a little evidence at scale that demonstrated more workers living and working in those communities. In Australia, the flagship program is the Rural Health Multidisciplinary Training (RHMT) program. In a recent evaluation of the RHMT program,[12] it was noted that while the program was effective, elements such as rural integrity and research networks needed to be strengthened. In this special edition, Australian academics, policy-makers and clinicians share their work in rural health workforce recruitment and retention. We intertwine these papers in our editorial by raising what we believe are some of the grand challenges in delivering a sustainable health workforce for rural Australians.

1 | THE GRAND CHALLENGES

1.1 | What really works and how will we know when it does

One of the major themes of this special issue is the use and articulation of various data sources to better understand trends and inform policy. Australia has world-class data sources on workforce location. It seems logical to us that, as rural academics, we need to work together to use these data sources to map location and understand what really works to increase attraction and retention of health workforce to rural areas. Gilliam et al[13] argued that academics do not need to invent new ways of collecting data, but rather make better use of these sources. The policy paper by Versace et al[6] on population residency and social disadvantage is a practical example of how to do this and provides a resource to help policy-makers plan future workforce programs. Through the RHMT program, University Departments of Rural Health and Rural Health Clinics are well positioned to monitor practice location data. Not necessarily to demonstrate the effectiveness of the RHMT program, because as Beccaria et al[14] note, exposure to rural practice is only one part of a multidimensional landscape, but the suite of efforts being made to improve recruitment and retention. Efforts such as these will build an evidence base over time as to whether government policies to address workforce maldistribution are having the desired effect. Ivec et al,[15] in a data linkage study, described the employment and demographic characteristics of first-year paramedic graduates to examine the factors which predicted the reasons for their first graduate location. They found that rural origin students had an increased likelihood of working in a rural location after graduating. We look forward to further publications from the Nursing and Allied Health Graduate Outcomes Tracking consortia.[16]

1.2 | It's not just employment, it takes a community to attract a health care professional

There is an African proverb, 'it takes a village to raise a child' it means raising a child is the whole community's responsibility to enable the child to grow in a safe environment. We think developing a sustainable rural health workforce has much to learn from this. Koedyk et al[17] describe a rural program for dental students in which they argue the connections the students make with their community as part of the placement assists the social capital of the communities and supports the student to consider a rural career. In a systematic review, Wieland et al[18] examine the factors required to retain GPs in rural Canada. The factors identified included professional support building the uniqueness of a rural lifestyle. Bailey et al[19] examine the impact of providing child support for rural health workers. They highlight the importance of quality child support for rural health workers. The case study by Brown et al[20] reflects on the experiences of building a sustainable dietetic research team and the importance of continued professional development. They note the importance of gaining a critical mass of same discipline academics that can support each other to improve rural research in that field, and the importance of having multidisciplinary and metropolitan engagement. Further, they recognise that rurally based academics may have different metrics to

their metropolitan counterparts; for example, community engagement may be more highly regarded. Ramsden et al[21] note the benefits of collaboration between health professional also increase accessibility and sustainability of rural health services.

1.3 | Bridging the gap between university, practice and communities

The prevailing opinion appears to be that if students undertake rural placements, they are more likely to practice rurally. While statistically this may be apparent, our own experience tells us that that there is more complexity to be understood. Beccaria et al[14] have suggested that this is one part of the puzzle; however, place-based personal factors, social and community integration, and connection to place with lifestyle aspirations, are also important. While the scoping review by Quillam et al[22] explores the range of factors that are needed to support mature-aged nursing and allied health students. While they note there is a lack of evidence on the topic, they identify several barriers to engaging rural mature-aged nursing and allied health students. Yet they found few studies that detailed the micro- and macro-level supports that would enable a possibly under-tapped resource to fully participate and succeed in higher education, securing a pipeline of rurally based health professionals. McMasters et al[23] report on the evaluation of an Allied Health Rural Generalist Pathway pilot. This was a multifaceted approach to support recruitment, retention and capacity building in a rural area of New South Wales. They note that the additional support and mentoring offered to newly graduated physiotherapists had a positive effect on recruitment and retention, yet without ongoing support for the initiative some of these gains may be short lived.

1.4 | Build economic, social, educational and cultural capital

The COVID-19 pandemic has helped many health service providers realise the potential of telehealth. In this issue, Parks et al[24] discuss some of the successes of delivering virtual health services in the far west of New South Wales. However, we should not be fooled into thinking that telehealth replaces the need for boots on the ground in rural communities. Skilled health professionals do more than just provide an essential service for communities—they contribute to the economic, social, educational and cultural capital. Relying primarily on telehealth to deliver services to rural communities undermines the real opportunity to develop and sustain communities as vibrant spaces that attract more people to the region. While the less congested spaces of rural communities have become more alluring during the pandemic, it is the vibrancy of these spaces that will retain people. Jessup et al[25] explore the pathways new nursing and allied health graduates adopt to gain employment. They conclude it was a time-consuming experience, suggesting well-serviced connected education programs with health services, with diverse and robust economies are the key to sustainability. We are aware that when health services cannot attract a certain profession, they will open the position up to other disciplines. We would suggest that while this is a pragmatic solution, it also does a disservice to rural communities as it is a lost opportunity to attract a different health professional that will contribute to a depth of service.

1.5 | Rural autonomy, rural integrity, rural solutions

Arguably, the most important aspect of the evaluation of the RHMT program[12] was the emphasis on community autonomy. This would require State and Commonwealth partners to place a higher value on community-led solutions, using different approaches where traditional approaches have fallen short. In our experience, communities with a sense of isolation will continue to advocate for conventional answers if they believe this is the only way forward. As rural academics, we are in a privileged position to talk to communities to enhance the social capital they invest in our future health workforce. One of the standouts of the evaluation of the RHMT was about the role of the program in strengthening the social fabric of rural Australia and perhaps how we should view our approach to creating a sustainable rural health workforce. The time of geographical narcissism[26] is over. Metropolitan solutions do not always translate to rural areas, and this is something we must recognise. The only way to make significant progress on health workforce is for rural communities, rural academics included, to come up with the solutions. In this edition, Healy et al[27] demonstrate engagement with rural communities can be applied to the evaluation of visiting services. Using the Delphi method with an expert panel of rural health practitioners, they developed and refined an evaluation framework for visiting services.

Rural background and rural placement experiences have been consistently linked to increased rural practice intention and rural practice post-graduation. We know the longer the experience, the more likely new graduates are to take up rural practice. This is a significant commitment requiring investment not only through the RHMT, but also from universities, placement and employment providers, and the broader community. This commitment

should not end at graduation. It will be needed to ensure sustainable rural careers. The pandemic has demonstrated the relative ease of making education and training online. This continuing effort will be needed to ensure that rural health professionals have ongoing access to specialist training—the specialist generalist is embedded in rural health. Perhaps the most crucial component of the success of any rural health workforce endeavour is rural integrity. Highlighted by the evaluation[11] of the RHMT, rural integrity should permeate rural health workforce initiatives. From planning to quality improvements, rural communities need to be involved and afforded the opportunity to have a sense of ownership and agency in workforce programs. Funding for rural health workforce programs should put more than just boots on the ground; it should contribute to the social, cultural and economic capital of rural communities. Finally, in this edition, Derbie et al[28] describe the distribution of 3 allied health professional disciplines in South Australia according to socio and economic disadvantage. This raises the possibility of replicating this study at both scale and longitudinally to measure changes of workforce distribution over time and assess whether they are practising in communities which experience the most disadvantage.

2 | CONCLUSION

Returning to expecting the unexpected, this is probably the new norm for the foreseeable future and the health sector needs to adapt to this. Rural workforce shortages will only be addressed if holistic strategies are put in place to recruit and retain health care workers, which rural Australian desperately needs. Reflecting on our experience as rural academics and the themes which emerged from this special edition, 'Dropping people in the bush' is not fair on health care workers or the community. Holistic solutions founded on rural autonomy, governance and place-based solutions offer the best chance for attracting and retaining people and will, ultimately, build the capital of rural areas.

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