Chapter 8
Rural health workforce: planning and development for recruitment and retention

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Learning objectives

- Describe the challenges to building and maintaining a rural health workforce.
- List the key professional and personal factors contributing to workforce recruitment and retention.
- Appreciate that workforce recruitment and retention require different strategies.
- Describe the important role played by community in workforce recruitment and retention.
- Describe the association between sustainable service delivery models, training, community capacity and workforce recruitment and retention.

Introduction

In Australia, as elsewhere in the world, recruiting, training, supporting and retaining a rural health workforce is a longstanding and continuing problem (AMWAC 1996, Brooks et al 2003, AIHW 2005b, Gregory et al 2006).

Training for rural practice is a core element in redressing the problem (Wise et al 1994), along with appropriate support and skills maintenance opportunities for rural health professionals (Hays et al 1997, 2003; Strasser et al 1997; Battye and McTaggart 2003; Joyce et al 2003; Schoo et al 2005; Glazebrook and Harrison 2006). Preparation for rural life before arrival in a rural community, and support structures for spouses and family, are recognised as important elements of recruitment and retention (Wise et al 1996, Veitch and Crossland 2005).

Increasing recognition of the important differences between recruitment (attracting health professionals to rural areas) and retention (keeping them there) has led to the

development of specific strategies for each issue (Cutchin 1997ab, DHAC 2001b, Veitch and Crossland 2002).

The important role that rural communities can play in workforce support and retention is also beginning to be recognised as an important workforce strategy (Veitch et al 1999, Battye and McTaggart 2003, Veitch and Grant 2004, HWQ 2006), although many rural communities are yet to recognise their potential to positively contribute to ameliorating the rural health workforce problem (Veitch and Grant 2004).

Changes are occurring in the workforce and structure of rural health in Australia (Wainer et al 2004), including the increasing proportion of female medical practitioners in the workforce and the standing and numbers of allied health professionals and models of service (Wilkinson 2000b, Veitch and Mudge 2001, Battye and McTaggart 2003, Osolins et al 2004, AIHW 2005b). Perceptions and expectations of rural health professionals and rural health services are also changing. In the case of the former, there has been a gradual move away from solo practices and all-of-career residence in one community. For the latter, there has been movement away from the 'shrunken urban model' towards services that are more sustainable and that match the needs of rural communities. Community involvement in service planning has also increased. These broad changes have occurred, somewhat against the trend of increasing centralisation of state-based services, increasing legislative and indemnity constraints (leading to diminishing procedural capabilities), and a general withdrawal of services and support in rural and remote areas (Kamien and Cameron 2006). This chapter demonstrates through a series of case studies how rural workforce recruitment and retention issues can be addressed.

Recruitment often involves promotion of rural practice as an exciting, challenging and rewarding career option. It is generally accepted that this process should begin at an undergraduate level or earlier, through programs such as the Rural Undergraduate Support and Coordination (RUSC) program for medical students. Individual rural communities have also attempted to recruit health professionals through inducements and incentives such as housing and travel support.

Retention is the successful outcome of recruitment when health professionals are recruited into rural practice and remain for extended periods. There is increasing recognition that retention involves a different set of issues from recruitment (Cutchin et al 1994, Pathman et al 1994, Hays et al 1997, Humphreys et al 2002b). This is because decisions to take up rural practice (recruitment) are made outside of the contextual setting of rural practice, whereas decisions to remain (retention) occur within that setting and are based on experience there (Cutchin 1997ab; Hays et al 1997, 2003; Kamien 1998).

The decision to remain in rural practice appears to be a dynamic equilibrium of positive and negative factors; issues such as overwork and poor adaptation to role changes can easily upset this equilibrium (Hays et al 1997, 2003; Veitch and Crossland 2002). Table 8.1 sets out 26 factors that influence retention, grouped into three broad dimensions: security, freedom and identity (Cutchin 1997ab).

Security factors may have the greatest influence on retention (Veitch and Crossland 2002), so strategies to boost retention need to be continuous (increasing security), rather than one-off. Although retention is often thought of as long-term residence in a single rural location, it is also appropriate to include health professionals who move between rural communities (Hays et al 1997).

Table 8.1 Factors that influence retention in rural practice

Security	Freedom	Identity
Confidence in clinical abilities	Challenge and diversity in clinical work	Loss of anonymity
Commitment to aspirations and goals	Ability to consult more with clients	Like-minded practice group
Ability to meet family needs (eg spouse happiness, education)	Cooperation within medical and at-large community	Roles played and responsibilities taken
Comfort with clinical community and institutions	Respect of the practitioners and at-large community	Respect of practitioners and at-large community
Degree of on-call coverage	Power in medical relations	Fulfilling aspirations in place
Practice group environment and anchor person	Ability to develop health care resources	Seeing self as belonging to the community
Community and medical institution development	Diversity in social interactions	Awareness of self in time and place
Available social and cultural networks	Involvement in community affairs	Creation of future goals in place
Respect of health practitioners and community at-large	Personal and family activities	

Source: after Cutchin (1997a)

Support for rural health professionals is a key element of recruitment, re-entry and retention. Support can take many forms, including financial, material, social, professional and personal (DHAC 2001a, Hays et al 2003, Joyce et al 2003, DoHA 2004, Osolins et al 2004, Veitch and Grant 2004, HWQ 2005, Veitch and Crossland 2005). It can come from a variety of sources, such as government, specialist support agencies, professional bodies and organisations, and the community. Support can be both formal (ie policy-based) or informal (which is common at the community level).

Sustainability is a complex, multifaceted concept. Sustainability as a rural workforce issue has been considered from many perspectives, including financial, workforce, skills and community. For example, sustainable general practice might be defined as self-sustaining maintenance of GPs, associated skills and services within a specific town or area. Alternatively, it may be defined as ‘the provision of a specified range of services

to a community in an appropriate way for a guaranteed period of time' (Togno et al 1998).

Two major studies of rural general practice sustainability have been done in Australia. Many of the key issues found are equally important to the retention of other rural health professionals (Fitzgerald et al 2000, Battye and McTaggart 2003, HWQ 2005). The first, in 1997 (Togno et al 1998), found that key elements of rural practice sustainability included issues associated with:

- practitioners
- administration, funding and financial arrangements of the service
- population and community characteristics and infrastructure
- nature of the service and health service environment
- policy environment.

The second study, done in 2002, reported similar findings (Humphreys et al 2002b, Jones et al 2004).

It is important to realise that there is a fundamental link between models of service delivery based on principles to enable sustainability, and the retention of health professionals. Thus, health service and workforce sustainability is best achieved when a holistic approach is taken. This is demonstrated in the case studies below.

The development of a sustainable rural and remote health workforce requires the following three elements:

- The attraction of people to health careers in rural locations through exposure to opportunities in rural health during school and tertiary training. This is the rationale behind the establishment of career expos, rural health clubs, rural and remote student placements and training pipelines.
- Recruitment and selection of appropriate personnel with the skills mix and aptitude for rural and remote practice.
- Retention of health professionals in rural and remote services to enable provision of health care, continuity of patient care and local capacity building.

Health Workforce Queensland (formerly known as Queensland Rural Medical Support Agency) has developed a set of principles to support sustainable service delivery (QRMSA 2004). These principles relate to:

- a critical mass of health professionals for communities, benchmarked on population, geographical location and remoteness from other health services
- interprofessional primary health care
- community participation in service planning and monitoring

- quality in terms of appropriately skilled health professionals, with access to ongoing professional development, and accredited health facilities
- culturally appropriate service provision
- remuneration packages that consider quality accommodation, vocational development, safe hours and financial reward that recognises isolated practice.

The following case studies demonstrate different approaches to workforce recruitment, retention and support. Case study 8.1 involves the development of an entirely new interprofessional service, encompassing practical evidence of many of the issues outlined in this chapter. As a result, Case study 8.1 is considered in some detail. The remaining case studies are covered in less detail, partly to avoid repetition and partly because they focus on changing or enhancing existing services. Case studies 8.2 and 8.3 demonstrate changes within existing health services and so focus on certain aspects of workforce and health service planning, particularly community involvement.

Case study 8.1 Outville Primary Health Care — a new allied health service from scratch

Development of the model

Outville Primary Health Care (formerly Outville Rural Division of General Practice) in Queensland established an outreach service in Outville in 2001 to provide regular allied health services to 12 remote communities in the area. The model was developed outside the existing local public health system, but in consultation with both local and head office representatives. Previously, allied health services in the area relied on infrequent visits by staff who were poorly prepared for remote area practice, and poorly supported professionally and personally. This in turn resulted in little corporate knowledge being maintained which placed the additional burden on new staff members of having to learn their way in and around the local system. Sometimes, that process itself led to staff leaving the service.

In the case of the outreach service to northwest Queensland, an informed approach to the situation was required in order to develop a service model that met the needs of the population and addressed the known retention issues. Community consultation sought to engage with the Indigenous population (approximately 16% of the catchment population for the service) and their needs, and respond to factors known to contribute to the poor retention of allied health professionals in rural and remote locations.

Operation of the Outville Primary Health Care service to respond to community and professional needs

The allied health service operates within a primary health care framework. The key features of the service are set out in Table 8.2, along with examples of the issues that these features address.

Table 8.2 Service features that address community and professional needs at Outville Primary Health Care

Service feature	Community/professional issue
The same allied health teams visit a cluster of communities in regular and reliable rotations.	Continuity of care is ensured.
Transport by charter aircraft to more distant locations (>2h drive) minimises clinical time lost.	Clinical time is increased, and travel time and the impact of long-distance driving are reduced.
The duration of visits is 2–3 days, depending on the size of the community, to enable community development activities and adequate clinical time.	Extended visits mean that all clients receive more comprehensive attention.
Allied health professionals travel and work in functional teams (ie Team 1: physiotherapy, dietetics, podiatry; Team 2: occupational therapy, speech pathology, psychology).	Greater interprofessional communication enhances the comprehensiveness and continuity of care. Professional (peer) support is provided and feelings of isolation are reduced.
The roster of visits requires that allied health professionals are not away from their base for more than half their working time. This enables client-related follow-up, resource development and professional development back at base, as well as an opportunity to establish a social network.	The roster addresses key retention issue of travel and time away from home and family. By building this into employment contracts, health professionals are provided with certainty and recognition of the importance of time-out from practice, resulting in increased retention.
The calendar is planned six months in advance so that communities and local health professionals can refer to and access the service. This minimises overloading the community with visiting health professionals from other services.	The calendar provides certainty to communities and professionals, ensuring continuity of care and increased compliance.
A centralised booking system.	The booking system ensures continuity of care and appropriate workloads.
Community-based workers in some communities are trained, to build local skills and support clients between visits.	Valuable inter-visit support for clients and professionals is provided and capacity within local community is developed.
Videoconference follow-up between visits is available.	Videoconferencing provides continuity of care and support for community-based workers.
Case conferencing can occur with resident health professionals and other agencies.	This enhances the level of care provided to clients, and reduces the need for clients to travel for care, which leads to greater compliance.
To promote access by clients, there are a range of locations for service provision: home visits, work in schools, child care centres, aged hostels, etc.	Multiple access points enhance continuity of care and compliance, and recognise cultural sensitivity and client mobility issues.
There is an orientation to the Indigenous and remote context, with the establishment of a buddy system.	This orientation recognises cultural sensitivity and service provision is seen as locally appropriate.

Recruitment and retention of allied health professionals at Outville

Building on the recommendations from the literature and interviews with incumbent allied health professionals, the main aspects of the strategy to recruit and retain allied health professionals include:

- professional
  - an experienced allied health professional as team leader/manager
  - mentoring/professional support by a same-discipline professional, if not the team leader
  - access to professional development opportunities, including paid conference leave and travel twice a year
  - negotiated study-leave for postgraduate training
  - access to library resources and academic support for postgraduate studies through the local University Department of Rural Health, with opportunities for research
- opportunities for academic adjunct appointments
- financial
  - remuneration that recognises responsibility for working in isolated practice
  - housing or rent subsidy
  - relocation costs
- time-out from work and community
  - six weeks annual leave
  - airfare to state capital/'home' once a year or equivalent value
- personal and family
  - child care support to a specified amount
  - assistance in finding employment for spouse/partner
- preparation for rural/remote practice and life
  - orientation, including Indigenous cultural awareness and rural practice, through a Graduate Diploma in Rural and Remote Health
  - four-wheel drive driving course/dirt road training, car maintenance and safety in the bush.

In addition, Outville Primary Health Care has developed a selection process that promotes applicants who are suited to working in a team, in remote locations and in a cross-cultural environment.

Discussion

Community input was sought from the beginning of the planning process to ensure that the service best met the needs and expectations of community. It also ensured that the community was informed about the process which in turn built a sense of ownership and commitment to the service. Allied health professional input was also sought to ensure that key recruitment and retention issues were addressed appropriately.

If a service reflects the needs, expectations and experiences of communities and allied health professionals, issues which could threaten service sustainability and workforce retention are resolved. Rural health service planning needs to involve health professionals and clients, and needs to be conducted within the environment for which the service is being planned. All elements of rural and remote health professional retention, not just professional, should be recognised and satisfactorily addressed.

Case study 8.2 Establishing sustainable rural medical services in Milan — a multi-agency interface approach

This case study describes a solution to difficulties with medical and procedural services provision in a rural regional centre. In Milan, an effective interface across the public and private health sectors has been established, driven by local government.

Milan is a regional health service hub located in southwest Queensland, approximately 500 km west of Brisbane. Milan Hospital provides emergency and acute services to the town, and procedural services to the surrounding shires (total population 12 650). Milan Hospital has historically been staffed by a medical superintendent and two medical officers, who provide their own internal relief and cover each other for on-call, leave, etc. The flying obstetrician, flying surgeon and two flying anaesthetists are based in Milan, and there are six private GPs working from four general practices in the town.

Milan Health Service District had a longstanding difficulty in maintaining medical staffing at the Milan Hospital. This had a negative impact on the provision of procedural and outpatient services, and raised considerable concern within the local and wider community. The Milan Town Council and the local chapter of the Division of General Practice collaborated with Health Workforce Queensland and Queensland Health to develop an across-agency solution to the workforce problem. A series of meetings using systems-based methodology were conducted, to develop a workable framework for the group, underpinned by the development and implementation of a training hub for medical and nursing services.

Core components of the revised Milan model include:

- a joint advertising and recruitment strategy by the Milan Town Council and the District Health Service, including the development of a DVD to market the Milan region
- the establishment of clinical leadership within the region
- the establishment of an effective interface across private and public sectors to facilitate training in general practice and procedural medicine (obstetrics, surgery and anaesthetics), and as a pilot site for rural generalist training
- an increase in the critical mass of procedural medical practitioners, enabling the implementation of a sustainable after-hours and on-call roster (across the public and private sector) and providing relief to medical practitioners working in solo practice within the region
- provision of appropriate, quality accommodation as a result of lobbying by local government, and assistance in sourcing accommodation.

Discussion

Multiagency cooperation incorporating community and professional needs can produce solutions not possible for single agencies working independently in small settings. Multiagency cooperation is often best facilitated by an individual or organisation that is not actively involved in local health care provision, with:

- broader experience and focused on improving the local service provision
- no local loyalties or links (real or perceived)
- mutual respect from all parties.

All local agencies should be actively involved in developing a solution, with the health service developing monitoring systems that ensure appropriate data are collected regularly and maintained for the purposes of tracking sustainability, retention and utilisation.

Case study 8.3 Creating a sustainable primary health care workforce environment — the role of local government as a health service fund-holder

This case study is an example of a local government organisation becoming the fund-holder for the delivery of primary health care services within its jurisdiction, so that the needs of all residents of the shire (within the two main townships and outside the towns) were met. The Diamond Shire is the auspicing body of the Diamond Health Service, and has contracted North and West Queensland Primary Health Care to provide remote area nursing services.

In early 2004, it was uncertain whether the non-government organisation (NGO) running remote nursing clinics in the Diamond Shire would continue. Regional health planning work in 2002–03 had identified staffing and operational issues that were having an impact on the sustainability of nursing services in the shire. Therefore, the Diamond Shire Council investigated alternative models of service provision and staffing, and the council Chief Executive Officer approached Health Workforce Queensland for assistance.

The key issues for Diamond Shire Council were:

- the development of a model for sustainable delivery of primary health care nursing services and emergency care
- the identification of a governance model.

The following key factors contributed to the development and implementation of the re-engineered model in the shire:

- An interface between local government, the Australian Government and an NGO was established, which resulted in additional funding for the employment of more nursing staff. The number of nurses in the shire increased so that internal relief, and covering each other for leave and emergencies across the two clinic sites was possible, on-call burden was reduced, and services to properties out of the townships could be provided.
- A contract was drawn up between the funder and the shire, and between the shire and North and West Queensland Primary Health Care, as the foundation for implementation of the model, and as a mechanism to monitor and evaluate implementation.
- The local government was progressive and experienced in meeting challenges.
- The Chief Executive Officer of the shire acted as the local driver for health service reform.

Local government can take the lead in local health services planning, provision and support, but it requires vision, willingness and sound organisational experience. Other levels of government (federal, state and territory governments) assist and facilitate planning to develop services that meet local needs.

Discussion

While not all towns can expect the same service delivery profile, the case studies demonstrate the inextricable link between health service planning and workforce recruitment and retention. Without addressing these elements, workforce and service sustainability will not be achieved. There is, for example, little point in putting effort into

training and recruiting health professionals for rural and remote practice, and then placing them in dysfunctional service models. Equally, the sustainability of a well planned and organised service will be threatened if staff are not appropriately trained and prepared for rural practice.

The case studies also demonstrate that local solutions — locally instigated and developed — best meet the needs and expectations of rural communities and health professionals, with respect to service sustainability and workforce retention. This does not mean that external organisations and agencies do not have a role to play but that their role should be supportive instead of directive. The roles that various agencies can play range from facilitation (eg rural workforce agencies, health service planning consultants), through collaboration (existing local services), and enabling (existing services, government), to funding support (government).

The importance of community involvement in health services planning and workforce retention is demonstrated in each case study, although at different levels. Communities are the repositories of knowledge and experience relating to local health needs, expectations and use, and should be involved in service and workforce planning from the outset. It is important to recognise that 'community involvement' can and will occur in different ways and will achieve different outcomes (Veitch et al 1999, Veitch and Grant 2004). In addition, identification and linkage with key local people supports the orientation of the visiting health professionals in the communities. Community involvement leads to commitment and a sense of ownership, which in turn can lead to the appropriate use and support of the service.

To enable service development and provision, health professionals, service providers and all levels of government need to be involved in the planning process, ideally with local government taking a lead role (they have the best knowledge of local resources and expectations). Core to the success of each service described in the case studies is recognition of the fact that workforce retention involves more than purely professional considerations. Personal and family issues can be major challenges to retention; therefore, they need also to be addressed and effective strategies developed (Hays et al 1997, Wilkinson 2000b, Joyce et al 2003, Veitch and Crossland 2005). The following elements are key considerations in workforce recruitment and retention.

Critical mass of health professionals

The case studies highlight the importance of having a critical mass of health professionals for sustainable service delivery. An adequate number of health professionals within each of the service delivery models described has enabled internal backfill for relief and professional development, safe after-hours and on-call rosters and has provided the foundation for peer-support networks.

Professional development

Relief to attend professional development is an element of the models described in the case studies. Financial assistance allowing access to professional development and

postgraduate training with attainment of postgraduate qualifications while working in remote practice is an element of all of the case studies presented.

Accommodation

Appropriate and affordable accommodation is important. In the case studies presented, examples included an accommodation subsidy as part of the remuneration package to assist in rental or purchase of homes and purpose-built accommodation.

Team-based approach to care

Team-based care is not only good for the patient but an important component in the retention of health professionals. Team-based care enables shared workload, referral to other health professionals with appropriate skills, and provides professional and peer support. In the case studies presented, team-based care can exist within the agency or more broadly through the interface with other agencies and providers.

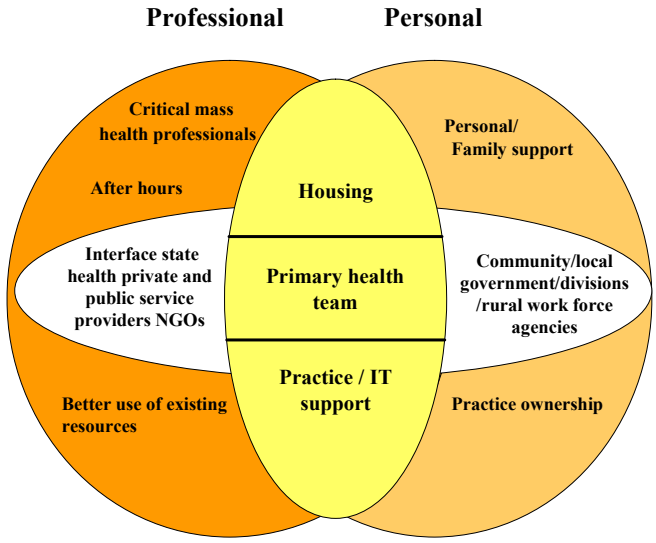
The sustainability of a health service hinges on the retention of health practitioners, so how is a sustainable health service planned?

In some situations 'greenfield' services can be planned de novo, particularly where there is new or specified funding. However, more often health services or systems need to be re-engineered to enhance service delivery sustainability, as illustrated in case studies 8.2 and 8.3.

The most effective approach to planning sustainable health services and the retention of rural and remote health professionals is systems-based, which involves:

- assessment of the situation/problem
- linkage with local stakeholders
- development of an agreed implementation strategy with defined stakeholder roles and responsibilities, and resource requirements identified (HWQ 2006).

The outcome of planning is the development of a service model that supports the professional and personal needs of the health professionals and matches the health needs of the community. Figure 8.1 depicts many of the core factors that influence sustainability.



Source: HWQ (2006)

Figure 8.1 Diagrammatic representation of the interplay of various sustainability factors

The provision of sustainable rural and remote primary health care services depends upon the establishment of an interface between the (local) public, private and NGO sectors, including Indigenous community-controlled health services. This professional, organisational and community interface promotes and presents opportunities to establish a critical mass of health professionals for the provision of health care across a clinical services network, and at a local level. An effective interface enables the development of systems to reduce after-hours burden, manage on-call and back-fill/internal relief requirements, and uses key local resources – including GPs, nurses, allied health professionals, other local health professionals, Aboriginal and Torres Strait Islander Health Workers, ambulance officers, police, community and consumer groups – to promote service delivery across the continuum.

Key points

- Service development and delivery are inextricably linked to workforce retention.
- Services need to reflect benchmarked community needs and morbidity.
- Communities should be involved in service development and monitoring.
- The workforce must have a critical mass to ensure sustainability and retention.

- The workforce should be well-trained in skills and knowledge appropriate to the service and population needs.
- Workforce professional and personal needs must be addressed appropriately as part of service development.

Recommended readings and resources

- Hays RB, Veitch C, Cheers B and Crossland L (1997). Why doctors leave rural practice. *Australian Journal of Rural Health* 5:198–203.

This paper reports a study that explored the reasons why medical practitioners left their practices, with the objective of identifying specific issues to be targeted to improve retention.

- Health Workforce Queensland (2005). *Solutions to the Provision of Primary Care to Rural and Remote Communities in Queensland*, Queensland Rural Medical Support Agency, Brisbane.
  http://www.healthworkforce.com.au (Accessed June 2007)

The key objectives of this policy paper were to:

  - identify the historical and current factors contributing to the rural medical workforce shortage, and scope the impact of the shortage on community wellbeing and service provision
  - review workforce recruitment and retention strategies employed by the medical and other professions
  - review current models of primary care and identify strategies to improve sustainable service delivery
  - develop principles for sustainable primary care to develop models to support sustainable health service delivery in rural and remote areas.

- Health Workforce Queensland (2006). *Methodology to Support the Development and Implementation of Solutions to Queensland's Health Workforce Crisis: Factors Contributing to Success (and Failure)*. Health Workforce Queensland, Brisbane.
  http://www.healthworkforce.com.au (Accessed June 2007)

This paper describes a systems-based methodology to support the re-modelling of primary health care services based on principles to support sustainable health service delivery and address the identified professional and personal factors contributing to the retention of health professionals in rural and remote locations.

- Fitzgerald K, Hornsby D and Hudson L (2000). *A Study of Allied Health Professionals in Rural and Remote Australia*, Commonwealth of Australia, Canberra.

Over 1500 rural and remote allied health professionals responded to this national survey of their support, education and training needs in rural and remote Australia. The study provides a description of the rural and remote allied health workforce, demonstrating the high proportion of women (84%) and relative youth (40% under 29 years) of respondents. About the same proportion (40%) was in the 35–54 year age group. The majority trained in Australia, and nearly half had completed, or were completing postgraduate studies. Nearly one-third of the respondents resided in a regional centre, with more than half providing services across multiple geographical locations.

- Cutchin MP (1997). Physician retention in rural communities: the perspective of experiential place integration. *Health and Place* 3:25–41.

This paper explores physician retention through a series of in-depth qualitative interviews with longstanding rural physicians in Kentucky. It includes a review of theoretical concepts of retention. The author argues that retention occurs when the physician 'integrates' into a community; this often includes elements beyond clinical practice.

Learning activities

1. Describe the potential benefits of workforce retention to rural and remote health services and to rural and remote communities.
2. What factors (positive and negative) influence rural and remote health workforce recruitment and retention? Which of these factors is potentially amenable to intervention by:
    - rural health professionals themselves
    - health professional training programs (undergraduate and postgraduate)
    - rural communities
    - rural health services?
3. Using the case studies and your own rural health experiences, what strategies would you suggest for improving workforce recruitment and retention in a rural community known to you?
4. Using a rural community or region known to you, consider how workforce retention and local health services might be enhanced. Do not just consider the existing service arrangements but think about how to better integrate existing services and new services that complement or enhance existing services in ways that meet community needs and expectations.