

Leaving the bush: why did they do it?

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Introduction

The demand for allied health professionals (AHPs) in rural areas is increasing due to changes in lifestyle, disease and disability of the population. Recruitment and retention of AHPs in rural Australia is an issue that continues to challenge policy makers. However, recent initiatives from the Commonwealth Government have focused on boosting the rural health workforce through grants that support education and training, expand health services and increase the number of rural and remote clinical placements.¹ In addition to this funding, suggested restructure of the current allied health service delivery model is gaining much attention. Although this funding and organisational reform is much needed and welcomed, the changing nature of allied health work, increasing demand, and shortages across most rural areas highlight the need for research to address the complexities associated with recruitment and retention of these professionals.²

Gaining insight into the experiences of rural AHPs can assist with enhancing government funded recruitment and retention programs and developing sustainable and efficient workforce policies. This study hopes to build on our previous research that implies recruitment is enhanced when retention is optimal, since AHPs are willing to recommend their workplace.³ Therefore, the factors that influence retention are just as valid and important as the factors that influence recruitment, but many of the existing workforce models have solely focused on recruitment.⁴ Additionally, these models do not adequately address issues regarding rural employment, they are difficult to implement, and costly to sustain.

In order to make policy recommendations on recruitment and retention in Australia, this paper aims to explore the experiences of AHPs who resigned from rural employment

Method

Participants

Exit interviews were conducted with 32 rural Victorian AHPs during 2005-2007 who had resigned from their position within the last three years. The participants were identified from local health service organisations human resources records in the South West, Central West and North East regions of Victoria. These people were then contacted and invited to participate in this study.

Materials

The 32 AHPs participated in a structured telephone interview regarding their experiences of working in a rural area and reasons for leaving. The interview questions explored, participant's intention to stay, reasons for leaving, level of support, career satisfaction, affinity for organisation and community, and ability to recommend workplace (a detailed list of questions is found in the appendix). The interviews were transcribed, with pseudonyms given to each of the participants to mask their identity, and qualitative analysis was conducted to determine the themes from the participants working experiences. The positive and negative aspects of working in rural areas and recommendations to improve recruitment and retention

of AHPs were also examined. Statistical software package SPSS version 14 was used to generate quantitative measurements from the qualitative data. Flinders University granted ethical approval for this project.

Results

Participants in this study were mostly employed in the professions of physiotherapy (25%, n=8), dietetics (15.6%, n=5), speech pathology (15.6%, n=5) and occupational therapy (12.5%, n=4). The majority were employed in the South West region of Victoria (59.4%, n=19) and 34.4% (n=11) identified themselves as being a 'new graduate' (graduated with the last 2 years).

From a thematic analysis of the factors that influence whether allied health professionals decide to stay or leave rural areas, five themes emerged. These themes consisted of managerial, clinical, career, education and training and personal issues. These five themes and corresponding qualitative data were then reorganised under the three domains of organisational issues, professional issues and personal issues.

Participants were asked to provide reasons for commencing their position and reasons for resigning from their position. Responses were categorised into the three domains of organisational issues, professional issues and personal issues (see Table 1).

Table 1 Reasons for commencement of position and reasons for resignation by participants.

	Reasons for commencement of position	n	Reasons for resignation	n
Organisational domain	'to gain experience'	7	'career opportunities elsewhere'	4
			'long hours / lots of travel'	3
			'problems with management'	2
Professional domain	'job was appealing'	10	'couldn't climb career ladder'	3
	'need a job'	6	'no job satisfaction'	2
	'expand career opportunity'	6		
	'variety of patient types'	4		
Personal domain	'want to work in rural area'	7	'lifestyle choice'	6
	'wanting a new location'	7	'family/friends relocation'	4
	'being close to friends and family'	5	'travel / going overseas'	3
	'accompanying partner to new location'	4		

The foremost organisational issue that participants' described was their relationship with management and how this affected their working role. For the most part participants perceived their relationship with management in a positive way, as examples of encouragement in progress towards career goals, support in clinical work, and acknowledgment of work well done, were often provided. However, 40% (n=12) of participants indicated that they felt unsupported by management, and this had a direct influence on their clinical work. Participants' reported an inability to utilise their skills fully and resulting higher case loads were a consequence of 'poor management'. They also described how lack of affinity with the organisation resulted from lack of recognition and appreciation from management.

Clinical issues, education and training issues and career issues were the major components of the professional domain. Clinical support was a key concern of participants as only 53.6% (n=15) felt they

were clinically supported in their working role. Lack of clinical support impacted on resources, supervision and skill development, some of which can be directly linked to lack of management and the nature of the organisation. Conversely, some participants stated that work in a rural area enhanced clinical skills due to the diversity of work and mix of case loads. The second part of the professional domain is career issues. Responses to job satisfaction and fulfilment of career goals were mainly positive, as 86.7% (n=26) of participants affirmed the position fulfilled their expectations and 67.9% (n=19) stated that the organisation assisted in fulfilling their career goals. On the other hand, some participants suggested that there was a lack of clear career path or advancement in rural areas. This is reflected in 57.1% (n=12) of participants revealing they would not take up the position again and 47.6% (n=10) stating that they would not return to the area. The final element of the professional domain is education and training. A high proportion of participants indicated that education and training was available (81.5%, n=22) and this was sufficient to maintain qualifications (76%, n=19). Participants conveyed that the education and training they received improved their skills, enhanced their progression towards their career goals and was supported by management.


Discussion

The results from this study illustrate the complexities involved in recruitment and retention of rural allied health professionals. The assumption is that AHPs are more likely to be attracted to and stay in rural employment if their needs are met, and when they are firmly embedded within the organisation and community. When these needs are not met and affinity is lost, professionals will assess the difference between what they require and what they perceive to receive, and this can ultimately lead to resignation.⁵

These findings are aligned with our previous research, which puts issues of recruitment and retention within 3 domains of organisational, professional and personal.⁶ Although policies need to be directed at all domains, those targeted at the organisational and professional level can be influenced more effectively than others through policy development. Policies directed at this level can filter through to the personal domain. Professionals who; feel supported managerially and clinically, are progressing towards their career goals, and have affinity with the organisation are more inclined to develop a sense of satisfaction and belonging, and hence affinity within the personal and community domain, and ultimately retention. The information provided from this study within the organisational and professional domains, allows the development of evidence-based policy recommendations.

Retention problems can be linked with poor organisational commitment and management.⁷⁻¹⁵ This evidence is aligned with the results of this study as participants did not always have positive experiences with management or the organisation, and described how this influenced their decision to leave. Additionally, the participants in this study indicated both positive and negative experiences within the professional domain. These results also correspond with previous studies that have found that younger AHPs experience stress in the workplace due to excessive workload demands, case-load complexity, covering colleagues on leave, and staff shortages.¹⁶

Current workforce initiatives from the Victorian Department of Human Services to improve recruitment and retention include 'Region of Choice', 'Mentoring', and the 'State-wide Allied Health Workforce Education Program (SAHWEP)'. These workforce development programs offer rural AHPs services such as access to continuing education (CE), mentoring and personal effectiveness training. One such personal effectiveness program implemented in rural Victoria which aimed to improve AHPs leadership, organisational and personal effectiveness has provided positive results.¹⁷ This program utilised training in the areas of negotiation, conflict resolution and time management, which have shown improvement in professionals' ability to cope better within health organisations.¹⁷



All of these programs are designed for people already in the field. One important feature that is overlooked is the preparation for professionals who are intending to work in rural areas. For 'new graduates', this could form part of the training professional education programs or in undergraduate courses. Recent scholarships offered from the Department of Health and Ageing now enable allied health students to undertake clinical placements in rural or remote communities during their degrees.¹⁸ Provision of such training before starting work in a rural location would prepare professionals for some of the organisational, professional and even personal issues that they are likely to confront. It would also alert them to the need for continuing education especially in areas not covered in their initial education such as issues around time management, negotiation and conflict resolution. These training programs designed for AHPs who intend to work in rural areas would at minimum help to overcome the initial 'culture shock' experienced by some professionals.¹⁹ Utilisation of current Rural Health Support, Education & Training (RHSET) program grants²⁰ could assist in delivering evidence-based training modules around preparing AHPs for in rural and remote practice and keeping them there. This is demonstrated through the Services for Australian Rural and Remote Allied Health (SARRAH) RHSET program²¹ and the Occupational Therapy (OT) Australia Queensland RHSET program.²²

Furthermore, there is also a need for better access to CE that is relevant, discipline specific and evidence based, as perceived poor access by AHPs to CE is a barrier to rural employment.²³ Peer coaching could be a logical horizontal extension of the personal effectiveness training that could strengthen and support AHPs in the areas of management, clinical education and expertise, and career pathway development.¹⁷ The extension of this program to other rural centres throughout Australia could assist with retention, as it addresses core issues affecting AHPs within the professional domain. This policy recommendation to extend the program nationally has also been corroborated by SARRAH.²⁴

Whilst these programs work to enhance empowerment of staff from a bottom-up level¹⁷, further policy development is needed to enhance top-down approaches to organisational change. One such recommendation is the development of a rural health workforce framework that is based on creating environments that are conducive to organisational change. Some of these models have been implemented internationally, and have proven to invoke optimal performance, collaboration and enhanced efficiency of professionals.²⁵ Such a framework would allow integration and collaboration of public and private health services, which would offer practitioners flexibility for mixing public and private service. The literature states that private AHPs stay in rural areas longer than those working in the private sector.^{26, 27} Subsequently, this kind of model would increase the critical mass of AHPs in rural areas, embed them within the community, and therefore enhance recruitment and retention of such professionals.

Conclusion

This study provides insight into what attracts professionals to rural employment and what influences their decisions to leave, and assists in creating more efficient and sustainable workforce development policies. What is learnt from these practitioners is that there are significant issues of a personal, organisational and professional nature that make a substantial contribution in their assessment about working in rural areas. While personal issues are not easy to address in the policy domain, organisational and professional issues can be reviewed and adapted for AHPs in rural areas. Central to this approach is the recognition that working in rural areas can be considerably different from working in urban areas, and consequently programs need to be developed that prepare AHPs for the exigencies of the organisational and professional environment in rural areas.

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Appendix—structured interview questions

1. Which town were you employed in?
2. Were you employed as a sole clinician or in a team?
3. What was your reason for taking the position?
4. Did the position / location, fulfil your expectations?
5. How long did you intend to stay when you first went there?
6. How long did you actually stay?
7. Were you offered any incentives to take the position? What were they? (e.g. accommodation, relocation expenses)) Were they adequate?
8. Would you have taken the position without the incentive?
9. Were you supported in your position? (Clinically? Managerially? By whom?)
10. Did the organisation help you fulfil your career goals?
11. Were your skills fully utilized? (management vs. clinical)
12. Were your work contributions appreciated / acknowledged? How?
13. Did you feel an affinity for the organisation and your community? (Identify with, feel you belonged)
14. If yes: what do you think fostered this affinity? If no: why not?
15. Was further Education and training available to you?
16. Was the education available to you of sufficient standard to maintain your qualifications? Improve your skills?
17. What was your primary reason for leaving?
18. Did anything trigger your decision to leave?
19. What was least satisfying about your position?
20. What would you change about your position?

21. With hindsight, was there anything that the organisation could have done to encourage you to stay there?
22. Would you consider going back to the area / position? Under what circumstances?
23. What are your ideas about how to recruit more allied health professionals into the area?

Presenter

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