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'It's All Part of the Package' in Rural Allied Health Work: A Pilot Study of Rewards and Barriers in Rural Pharmacy and Social Work

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Abstract

Objective: The objective of this pilot study was to identify personal and professional factors that influence health workers' commitment to remaining in rural and remote areas with the aim of identifying research directions for a larger study and informing workforce recruitment and retention strategies. **Design:** Accidental sampling then qualitative interviews with pharmacists and social workers. **Setting:** Six rural communities with populations less than 5,000 in New South Wales, Australia. **Methodology:** Deductive and inductive analysis of data. **Results:** Common rewards included the value attached to pharmacists' and social workers' contributions to rural communities, ability to assist people to solve problems, and accessibility. Common barriers included lack of peer support, inability to attend professional development, and inadequate social and cultural facilities. The key factor mediating personal and professional experiences was a perception of community connectedness. Personal and professional issues are interrelated. Social workers in the public health system are more likely to change jobs than community pharmacists. **Conclusion:** Social workers and pharmacists appear to experience similar rewards and barriers in their professional and personal lives when compared to other rural health workers, including general practitioners, all of which are mediated by the degree to which they are connected to their community. Rewards and barriers in personal and professional life exist on an interrelated continuum that has to be balanced to manage a high degree of visibility experienced by health workers in small rural communities. **Implications:** The need for a systematic evaluation of workforce retention strategies is highlighted. New practitioners require skills in managing the connections between personal and professional life rather than viewing them as separate. Further work is required into the implications of life stage on decisions about work location.

Introduction

Primary health care is a frontline strategy for improving the health of Australia's population. It flows from and is consistent with the World Health Organisation's holistic view of health as incorporating social, physical, and mental well-being – a goal for the world's citizens.¹ Primary health care is the model that Australia's publicly funded health services aim to deliver.

Primary health care is intended to be accessible, affordable, and effective for all Australians, yet has failed to improve rural/remote populations' health status. Rural/remote dwellers have higher morbidity and mortality rates than urban dwellers and restricted access to health services.^{2,3} Workforce shortages are a key factor restricting delivery of rural/remote primary health care.^{4,5} Recruitment and retention of health workers is as much a problem for

communities and funding bodies in Australia as it is internationally.

Health outcomes are the result of inputs from a range of health workers. However, most research on the rural health workforce and health status has focused only on general medical practitioners (GPs) and nurses. Pharmacists and social workers are among key allied health workers in rural and remote areas providing assessment, treatment, and referral services for physical and mental health problems. Both professions have important roles in a multidisciplinary approach to health care working in a network of health professionals (including GPs and nurses).

In Australia, rural and remote areas comprise a substantial part of the total land mass. In New South Wales (NSW), where this study was conducted, eighty percent of the state is considered rural or remote. This area has only five percent (306, 831) of the state's population who are entitled to health care services that are equitable to those delivered to urban citizens.⁶

This paper reports the findings of a qualitative study investigating the personal and professional experiences of social workers in primary health care centres and community pharmacists living and working in rural New South Wales. The study identifies rewards and barriers experienced by rural allied health workers. Implications for workforce retention and further research are discussed.

Social workers

The Australian Association of Social Workers (AASW) is social work's national professional body responsible for developing and maintaining the profession's code of ethics, educational standards, and accreditation system. According to the AASW, social workers aim to promote social justice and human rights and empower individuals and communities to overcome disadvantage by equitable access to social, political, and economic resources.⁷ Social workers practice counseling, group work, and community work in government, non-government, and private practice settings. In 2004, 42% of social workers were employed in the health system.⁸

Pharmacists

Pharmacists are authorised to dispense medicines and provide medical advice by state based pharmacy registration boards. The Pharmacy Guild of Australia is the principal body representing pharmacy interests to government, although their membership is pharmacy owners, who comprise only about 33% of the pharmaceutical register. The International Pharmaceutical Federation (FIP) developed good practice guidelines in 1993 that were endorsed by the World Health Organisation in 1997.⁹ The guidelines have four main elements:

- The promotion of health and avoidance of ill-health, and achievement of health objectives;
- Supply and use of medicines, medication delivery devices and related items;
- Provision of advice and/or supply of medicines for self care of symptoms or ailments; and
- Activities that influence the quality of prescribing or use of medicines.

Pharmacists practice in two main settings – around 80% in shops in local communities, approximately 10% in hospitals, and the remainder in a wide range of industrial and academic roles.¹⁰

Despite the pivotal role pharmacists and social workers can play in the health outcomes of rural populations, Australian health workforce research over the last decade has focused around medical practitioners, particularly GPs. GP shortages have affected the delivery of health care to rural and remote communities, whose health status has been clearly shown to be significantly lower than urban communities.¹¹⁻¹⁷

The findings of research into rural GPs have repeatedly confirmed that those working in rural and remote areas can experience professional and personal isolation, heavy workloads, and extreme stress, and that they are concerned about the opportunities their family members may miss out on, particularly in education and employment opportunities. Research findings have also indicated that GPs rely on other health professionals to provide them with professional support. For example, counselling or speech pathology services may be required for their patients alongside diagnosis and treatment of medical conditions (e.g. rehabilitation after stroke).

GP research has suggested that students from rural areas are more likely to return to rural areas and that students who have a rural placement during their training are more likely to accept a rural position when qualified.^{12,16} This has resulted in rural recruitment campaigns and the establishment of university departments of rural health to work towards increasing the number of graduates prepared to undertake rural work in the future. While these results provide insight into the rewards and barriers of rural GPs, little is known about the lasting effects or the extent to which these can be extrapolated to other health professions.

However, one response to providing rural health education was the formation in 1997 of the pharmacy school at Charles Sturt University in Wagga Wagga. Early evidence suggests that around 70% of the graduates do commence their career in rural or remote areas.¹⁸ However, without an understanding of the drivers and motivators affecting this

group, it cannot be guaranteed that these graduates will stay in the country long-term.

Methodology

This project received approval from the Charles Sturt University Human Ethics Committee (approval number 2006/123).

An accidental sampling method was used to identify participants.¹⁹ Participants had to be working in a town with a population of less than 5,000. Australian towns of less than 5,000 residents generally have one pharmacy and these are listed in the business section of the local phone directory. Potential social work participants were identified from a list supplied by the area health service social work advisor. Potential pharmacist participants in the towns with social workers were identified from the telephone directory.

Initial contact was made by telephone; the project was explained and information and consent forms were faxed or emailed to those willing to be interviewed. In July and August 2006, eleven in-depth semi-structured interviews with five social workers and six pharmacists located in rural NSW were recorded and transcribed. During the interviews, participants were asked to discuss their perception of rewards and barriers currently experienced in their professional, personal, and social lives, the networks they used to deliver services, the way these needed to change to meet their community's future needs, and what plans they had for the future.

The interview schedule contained three dimensions of rewards and barriers; personal, professional, and social. Professional rewards and barriers were those which participants perceived as arising from their employment, including their professional role, duties, and also the workplace. Personal rewards or barriers included any aspects of an individual's personal life -- intimate relationships, family, health, and hobbies for example. Social rewards and barriers were conceptualised as those relating to recreation activities, friends, and community involvement.

The grounded theory approach consists of "simultaneous cycles of data collection and analysis with each informing and focusing the other throughout the research process."²⁰

A small sample size is usual as an in-depth analysis locates subjective and collective experience in larger structures.²⁰ In this case, the larger structure is health care in rural and remote areas. The planned sample size was 20 as a pilot project to inform the development of larger projects. However the pilot sample was considered saturated after 11 interviews as no new data were emerging.²¹ In the process, several new research directions were identified.

Data analysis

Deductive analysis was used to determine if the issues facing pharmacists and social workers were the same as those reported by medical practitioners. This analysis was shaped by the GP literature which had influenced the development of the interview schedule (appendix A). An inductive analysis was also employed to develop the conceptual framework emerging from the data reduction process consistent with a grounded theory approach.^{19,21}

The data analysis considered the fact that all of the participating social workers worked for the area health service and all the pharmacists in the community. Other rural practice contexts, such as pharmacists employed in hospitals, may support different work experiences.

A workshop was held at a national allied health conference, and it was this that allowed the researchers to conclude further data collection within this pilot project was not needed.²² Thirty allied health workers, educators, and policy makers participated in the workshop focus groups answering the same questions as the interview participants. The workshop findings are reported at <http://www.ruralhealth.org.au/conferences/sarah2006/docs/program/workshop4.pdf>.²³

Findings

Participant demographics

All the participants were women. One male pharmacist agreed to be interviewed but was unavailable during the interview period. His female business partner participated instead. All participants worked and lived in central west and northwest NSW, rural areas with several large regional centres surrounded by small towns and villages. The map below shows Area Health Services in New South Wales. Participants were drawn from the Greater Western Area.

Figure 2. NSW Area Health Services - state and metropolitan maps²⁴



Rural origin and rural work experience are key issues identified in the GP literature positively affecting an individual's willingness to work in rural areas. Participants were asked where they attended school and university. During this discussion they were asked if they considered themselves a city person or a country person.

TABLE 1
Location of education

Topic	6 Pharmacists	5 Social Workers
City or country (self defined)	3 city people (1 from O/S) 3 country people	2 city people (1 O/S) 3 country people
High School	Rural school 2 City boarding school 1 City school 3	Rural school 2 City boarding school 1 City school 2
University	City university 5 Rural university 1	City university 4 Rural university 1

It was found that participants who lived as children and went to school in the city identified as city people and similarly those who were brought up in the country identified as country people. For example:

I'm a city person through and through
(pharmacist)

A country person, born and bred, definitely
(Social Worker)

While most of the participants went to university in the city, the country people described this as a temporary situation that they had to endure. For example:

I couldn't wait to finish, to get out (Social Worker)

Those participants from the city recalled some reluctance and trepidation at moving to a rural location. For example:

I never liked going out into the country except to come home again. I said I'd never marry a

country person and I did and I knew he'd drag me out here (pharmacist).

The town was a very small country town and coming from the city I had no idea. The house had a vacant block on each side of it. It seemed so strange, so isolated (social worker).

Regardless of the initial experience, most participants expressed a continuing commitment to living and working in a rural area. The exceptions were young women who both viewed their jobs as a good opportunity currently but

not necessarily for the long term although for them, a change of job did not necessarily mean moving to an urban area:

This is my first time in charge and it's good. We intend to stay for three years and then see what happens. Both our families are in Western Australia so we might go back (pharmacist).

Participants were asked how long they had worked in rural areas and how long they had been in their current position.

TABLE 2: Length of time in rural work and in current position

	Pharmacists		Social workers	
Length of time in a.) rural work	a.) 15 months a.) 9 years a.) 18 years	b.) 3 months b.) 7 years b.) 11 years	a.) 3 years a.) 5 years a.) 15 years	b.) 8 months b.) 18 months b.) 3 years
b.) current position	a.) 18 months a.) 3 years a.) 25 years	b.) 18 months b.) 3 years b.) 14 years	a.) 15 years a.) 25 years	b.) 8 years b.) 1 year

In this sample social workers changed jobs more frequently than pharmacists. Social work participants described both personal and professional reasons for this:

My husband was in a job that meant he was moved every three years.

Most of the pharmacists in this sample had spent substantial periods of time in their current location and all had worked in rural areas previously.

Rewards of rural health work

Pharmacists frequently expressed the important role they played in being a frontline health worker accessible to the community. All the pharmacists described their work role as providing advice, support and referral about physical and psychological health problems to anybody who requested it. For example:

Anyone can walk in here. We are the only health workers where you don't need to make an appointment.

Social workers described similar experiences of personal and professional rewards. Generally, social workers believed they played an important role in supporting rural populations in identifying their problems and finding ways to address them. Social workers described the job of a social worker in the health system (all were in Community Health) as counseling individuals and families in relation to issues including domestic violence, sexual assault, marital

and parent-child relationships, depression, drug use, and advocacy issues such as problems with schools or courts. Participants also described community education activities that promoted health messages.

Rewards specifically identified by social workers

Rewarding aspects of social work included seeing a wide age range of clients about diverse issues, being in charge of their own case loads and work schedules, being able to develop specialty skills according to their own interests, and working in multi-disciplinary teams where they could learn about other approaches and get advice and support. All of the social workers expressed a strong commitment to working in rural areas, had good personal and professional support networks, and believed their families benefited from a rural lifestyle.

Rewards specially identified by pharmacists

Pharmacists were clear about their professional role and its benefits to the community. In addition, participants stated that they are financially well rewarded as sole pharmacists in small towns and this enabled them to support their families. This was a significant part of personal rewards.

It's a good business, very rewarding financially.

It's a great business. My husband's a farmer and while he's had plenty of hay this year in spite of the drought we don't have to worry about next year.

Community connectedness

The key factor affecting a rewarding rural work experience for both pharmacists and social workers is a sense of belonging or connectedness to the community. This is derived in two ways. The first is a family or historical connection to the place that results in physical, emotional, and social support. The second is a commitment to rural life that eschews an urban landscape and its perceived problems. This commitment is typified by statements such as "I couldn't wait to get out [of the city]" and "I wouldn't live anywhere else [but a rural area]". Frequently, these two perspectives were expressed by participants simultaneously and often arose when participants were talking about whether they were city or country people. It wasn't necessary to be born and raised in a rural setting for participants to feel they belonged to one. For example:

I was dragged kicking and screaming from Melbourne out here. I thought when I retired we'd go but now the thought of going... where would we go? I love it here, all our friends are here. (pharmacist)

Those participants who had historical connections to the area they worked in were more likely to talk about a sense of belonging in that they mentioned family members, celebrations, and so on that gave a pervasive sense of ease and comfort in the location and described others experiences as likely to be problematic. For example,

My mother grew up in the area and while that's a complete coincidence, I do have aunts and uncles and cousins around the place, so it was very easy; it was an easy move from that perspective (pharmacist).

However, nine of the eleven participants were living and working in towns they moved to from elsewhere. Two had moved directly from a large city to a small rural town.

Those who didn't have easy connections to the area described a commitment to finding a way to fit in a place they were not familiar with. The pharmacists tended to find this easier than the social workers because of their visible and prominent role. For example:

We joke about it in the shop but you're the pharmacist. That's what you are wherever you go. That's really rewarding in the sense that you're part of the community and making a real contribution. (Pharmacist)

Community connectedness increased rewards of rural work for both professions. For example:

It sounds odd, but it's good to see people through their disease or illness, to know them over time and know their families (Pharmacist).

I know who can help, what the networks are, I can link people up with support and rely on those networks for my clients and myself (social worker).

Barriers of rural health work

Differences between urban and rural work

Both social workers and pharmacists tended to believe that there would be fewer professional barriers in urban work. For example, that collegiate support for themselves and services for clients would be more available, and they would be attending regular updates to maintain their professional registration.

You can't choose, you can't say, I don't do that I'll refer you to someone else because there isn't anyone else – you're it (Social Worker).

However, most participants expressed a view that they were not missing out on personal rewards. For example:

Do you think that people are going to the theatre and the restaurants all the time? I don't think so they're going home like the rest of us (Pharmacist).

There's only so many 'lattes' you can drink (Social Worker).

The exception to this was a young woman who had only been in her position in a small rural town for three months. She said:

We have to drive 50ks to go to the movies, 120ks to a decent shopping centre, I suppose you can get used to it.

Barriers identified by pharmacists

The most significant barriers expressed only by pharmacists were also related to their professional role and its relationship to their personal responsibilities. In NSW, a registered pharmacist has to be present all the time the pharmacy premises are open. If the pharmacist has to leave the shop, even to go to the toilet or for a cup of coffee, the pharmacy must close. This requirement means that locums are needed regularly. Participants had several ways of managing this: Regular locums, business partners, or pharmacist employees were used. However they had experienced problems and were expecting more in the future. For example:

My daughter was sick and taken to hospital. The shop was shut for two days. There was nothing I could do, and I wouldn't hesitate to do the same again, but it's a constant concern.

Responsibilities of being a sole pharmacist also meant that access to training was more difficult. For example:

I believe they have regular night lectures at Sydney Uni but that's just completely impossible to attend. There's stuff on the web, but I like the stimulation and learning from being with others in the same business.

Barriers identified by social workers

Overall, social workers described experiencing more professional barriers than pharmacists. The barriers were not different to those described by pharmacists. However, the language they used to describe experiences conveyed the impression that the barriers they faced were more difficult to overcome. Frequently the social workers' professional barriers had personal implications because they worked alone and because stress related to the seriousness of their client's issues had a significant impact on them. For example:

It's emotionally draining work, very hard some days. Hard to have anything left for anyone else.

NSW Community Health Centres employ multidisciplinary teams in a primary health care approach. Team members ideally include speech pathologists, podiatrists, community nurses, and social workers among others. Social workers described feeling professionally isolated as a problem that the multidisciplinary team could not address:

When I need to talk to someone about a particularly trying day, they don't always realise that the situation might have been life or death for that client. We deal with very vulnerable people.

Other examples were given of difficulties encountered in the work setting. For example:

They're waiting to see if I'm going to last the distance. It's like, "Oh yeah how long are you staying?" A real negativity is around the whole place.

Accessing training was described as a significant professional and personal barrier for social work participants. Travel time and cost of travel had to be incorporated into personal schedules as well as professional ones. For example:

I was approved to do the course, to take the time off work but I had to pay for half of it myself, cover the accommodation in Sydney, and leave my mum with the kids for a week. It was just too much.

Social workers did not experience financial rewards as pharmacists did. For example:

I don't think we get paid very well relative to the stress of the job.

Regardless of these perceived barriers, all social work participants were intending to continue living and working in rural areas.

It is rewarding overall, it's just overwhelming sometimes. You don't know what's going to come up next, but I, we, won't go east of the divide.

Other people in the city might say what's [town] got to offer me? It's not just the job, it's not just changing jobs; you've got to want the place, the country. I want to say how great that can be.

Impact of community connectedness on perceived barriers
Community connectedness decreased the perception of barriers professionally and personally. Privacy is a significant issue for rural health workers who may feel that they never get away from their role in health care. However for those participants who felt they belonged to the community, this was an issue they had learned to deal with. For example:

Privacy can be a problem when ... you're out at a barbeque and your new client is handing round the drinks helped by her violent husband – that can be tough but when you have friends and some way of talking about this stuff, supervision, it's okay it's just part of the package (Social worker).

I moved out of town. We got a few acres 10Ks out and I'm out of town and out of work. I've got friends and family, lots of things to do, it's great (pharmacist).

Discussions about privacy and confidentiality revealed the intensely personal nature of issues that health care workers deal with. Depression, domestic violence, and head lice carry an unavoidable social stigma regardless of efforts to bring them out in the open. While the need for openness and acknowledgement can be justified as a factor in accessing or receiving treatment, health workers

themselves can experience just as much reluctance to divulge personal details as anyone else. For example:

I go to the doctor myself out of town. I'm not going down to the doctor, the two male doctors in town for a pap smear. I talk to them on the phone, you know, every day, and I trust, I trust both the doctors but that sort of stuff. I'll stick to my girl doctor in [nearby town]. (Pharmacist)

Conclusions, Discussion and implications

Social workers and pharmacists appear to experience similar rewards and barriers in their professional and personal lives compared to other rural health workers. Many of the rewards and barriers are similar to those GPs experience, although similarly, the barriers were less of a problem for those who felt strong ties to the community and expressed a commitment to rural life. There is a clear perception that work is easier in urban areas. It seems that challenging cases are referred to others, consulted about with colleagues, and managed and resolved more effectively in urban areas. Rural health workers maintain the urban-rural dichotomy by perceiving their work experiences as fundamentally different to those in urban locations.

Rewards and barriers of rural work are usually portrayed as an "either/or dualism," but they clearly exist on a continuum. For example, a rewarding aspect of rural work, such as knowing a lot of people well, can also be experienced as a barrier through a lack of privacy or anonymity. Similarly personal and professional dimensions of rural life have the same quality; having an important role as a health worker in a small community can result in work demands impinging on personal time. All of these experiences are mediated by the degree of community connectedness an individual perceives themselves to have. The mediating effect of community connectedness strengthens rewarding experiences and weakens barriers.

Questions about the personal dimension including personal relationships, health, and well-being were responded to in a similar way to questions about the social dimension such as activities and social relationships. Participants did not appear to view the dimensions as being separate. This was confirmed in the conference focus groups when participants were asked to respond to the two categories separately and found that they couldn't separate them, collapsing both categories into personal rewards and barriers.²³ The importance of community connectedness was also highlighted during this process most often expressed as "*being [or not being] a local.*"

Privacy legislation and ethical guidelines about confidentiality establish practice strategies for setting professional boundaries and separating professional and

personal life. Participants revealed this as an artificial and impractical separation. Privacy has limited meaning when you are always visible, as many famous figures attest. The professional / personal dualism may also be artificial in urban contexts. However, it is likely to take substantial practice experience in small towns to understand the implications of being "always the pharmacist" or having to "get out of town" to get "out of work." If health workers do not have, or cannot develop, community connections, there is more likelihood of people becoming personally isolated through their efforts to maintain their professional role.

Pharmacists have a clearly defined role that they are confident about undertaking. While some participants noted the way past job experiences in hospitals, for example, helped them in their current role, they were comfortable within the health care system and with their daily duties. In contrast, Social workers perceive less success in their interventions and describe professional and personal barriers in relation to this. It may be the health setting that influences this perception, as social workers do not assess or treat people in the way most other allied health workers do. It is also notable that social workers, regardless of their experience, say they are "dumped with all these really difficult cases" and also with the expectation that they will not stay in their job.

Having a family and diverse work experience already may affect an individual's commitment to rural work/life and increase the likelihood of remaining in an area even if not in a particular job. All participants except one had families and most had extensive work experience in several jobs and locations. It seems likely that experiencing professional and personal rewards in rural health work comes from a combination of confidence and experience in the professional role and having a commitment to a rural location that assists in developing community connectedness if it doesn't already exist. Further research investigating the way life stages influence decision-making in relation to work could usefully inform recruitment and retention strategies for rural and remote areas.

Implications for workforce planning

A number of workforce retention strategies such as financial incentives including higher pay, travel and training allowances, mentoring, and community and work orientation plans (that include an employee's family members) have been suggested in the literature and in health worker reviews.²³ Some of these are being implemented in various locations across Australia.²⁵ However, a comprehensive and systematic evaluation process does not appear to be developed alongside these initiatives. Most of the participants in this study, particularly the social workers, had changed jobs and moved location at least once, some several times. Reasons given included family responsibilities, spouse's work, and new work

opportunities. Recording and reporting health employee exit interviews would provide valuable information establishing reasons for turnover.

An issue affecting health workers' experience is their own health needs. It is likely to be difficult for those in the health system to ask for personal treatment or support from those who they work with regularly. It is likely that mental health needs such as workplace stress, relationship breakdown, and the like might be addressed by relocating rather than seeking support locally. The focus of investigation into rural health status and workforce development minimises the way that rural health workers are also community members needing their own health care, housing, social networks, and activities in the same way as any other person.

The requirement in NSW (where this study was conducted) that a pharmacist always be in attendance whenever pharmacy premises are open places severe limitations on the services that can be provided from a single-pharmacist establishment. The precise requirements vary between the states and territories, but this personal supervision aspect severely limits the opportunities for development of services such as home medication reviews, clinical services to public hospitals, and wider involvement in multidisciplinary approaches to chronic disease management and illness prevention. Research in Australia

and internationally shows that the participation of pharmacists in these roles can be cost effective through providing improved outcomes and reduction in hospitalisations. Using this approach to increase the number of pharmacies supporting more than one pharmacist, which would alleviate a number of the other barriers discussed. For others, technologies such as remote video supervision could be explored.

Further research is required to investigate the way life stages affect health workers' decisions about work location. It is also important to target remote locations to identify issues that may compound or exacerbate any barriers experienced in rural work or offer particular rewards.

Limitations

The limitation of the study is that participants were not from remote areas. Most had access to a large regional centre within 150kms. Some participants who had worked in remote NSW discussed problems of isolation and stressful workloads that they did not currently experience. It is not clear from participant narratives in this project the way the barriers are related to the remote location, their skill and experience at the time, or their personal circumstances. While it is likely to be a combination of all three, further research investigating these issues is required.

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Appendix A

Rewards and barriers of rural health work: Pharmacy and social work

Interview schedule

Read information sheet and sign consent form

Preferred name and confidentiality discussed

Demographic information – Education history - age, background prior to uni (school locations etc.), length of time since quals gained, place quals gained, prep during uni course for rural work?

Describe current job – title, tasks, how long been doing it

Describe previous jobs – rural/remote? note similarities – differences,

How did participant come to live/ work in this area?

Where does participant live? Local or elsewhere. Discuss positives/ negatives of this and why.

What **rewards** does the job have in this setting?

- Consider *professional* (what's good about the job?)
- *Personal* (what personal relationships, health, well-being are promoted in this setting?)
- and *social* aspects (what relationships, activities are enjoyed or important to this location?)

What **barriers** does the job present in this setting?

- *Professional* – limitations, demands, missed opportunities etc
- *Personal*
- *Social*

What **changes** could be made to recruit/retain others to similar or supporting jobs?

What **networks** exist or are used by you to deliver health services?

What **service delivery changes** are needed to meet the needs of the local community?

Where do you hope to live and work **in 5 years time**? If changing location – why?