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Research Article

The Community, the Workplace, and Public Health Measures: A Qualitative Study of Factors that Impacted the Wellbeing of Rural Health Service Staff in Victoria, Australia, during the COVID-19 Pandemic

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Increasing evidence of the effects of the COVID-19 pandemic on healthcare workers' mental health and wellbeing has prompted concerns about the longer-term impacts on healthcare delivery and health workforce sustainability. For rural health services and communities, the pandemic has compounded existing challenges including workforce shortages, potentially leading to further health inequalities. This qualitative interview study aimed to explore factors within and external to the health service environment that influenced health service staff mental health and wellbeing in rural and regional Victoria, Australia, during the first two years of the COVID-19 pandemic (2020-2021). Participants were recruited from nine publicly funded rural and regional health services. Semistructured interviews were conducted via videoconference, audio-recorded, and transcribed. Data were analysed using a five-stage framework approach. Eighteen health service staff from four rural areas participated in the study. A range of factors that were perceived by participants to influence their wellbeing were identified. These were coded to four main themes: (1) rural community relations, (2) the nature of the health workplace, (3) self-care and supportive networks, and (4) public health measures and the unpredictable nature of the pandemic. Factors coded to these themes were described as both positive and negative influences on health staff mental health and wellbeing. Optimising the mental health and wellbeing of rural health staff is imperative to the sustainability of this workforce during and beyond the COVID-19 pandemic. Rural health services must consider the community and health service (meso-level), individual (microlevel), and broader pandemic context (macrolevel) when developing and implementing strategies to promote staff wellbeing. Strategies must encompass the development of senior leadership capabilities, mechanisms to support effective leadership, and optimal communication processes within health services. Given the potential for community support to positively influence rural health staff wellbeing, community engagement should be a feature of health service wellbeing strategies.

1. Introduction

Increasing evidence of the deleterious effects of the COVID-19 pandemic on healthcare workers' mental health and wellbeing has prompted concern among health policymakers, health services, and communities, about the longer-term impacts on healthcare delivery and health workforce retention [1–4]. The COVID-19 pandemic has compounded existing health workforce recruitment and retention challenges for rural communities and health services [5, 6] and potentially exacerbated rural health inequities [7]. Mental health outcomes, including suicide rates, are poorer in rural Australia [8]. Unprecedented demand on health systems was recognised during the early stages of the pandemic [9]; however, there was little acknowledgement of the potential for comparatively higher pressure on rural and regional health services, and the associated impact on the wellbeing of their health staff [7].

Healthcare in Australia is provided via a mix of publicly funded and private health services, delivered across a range of settings including large acute hospital, subacute facilities, and in the community [10]. Primary care is predominantly funded by the federal government while hospitals are jointly funded by the federal government and state/territory governments [11, 12]. Some seven million people, representing one-quarter of Australia's population, live in nonmetropolitan areas [13]. Health services are central to the sustainability of rural communities and are often among the largest employers in these areas [14], yet rural Australia has experienced significant health workforce shortages that predate the COVID-19 pandemic [5]. Early in the pandemic, Australia experienced relative protection from COVID-19 through instituting strict international border closures [15]; however, case numbers eventually increased, and during the period of data collection, the state of Victoria experienced a wave of daily COVID-19 cases higher than any point to date [16]. Furthermore, during the first two years of the pandemic (2020-2021), the number of COVID-19 cases per capita was higher in Victoria than in any other Australian state or territory [17]. The Victorian state government implemented a suite of public health measures designed to reduce the spread of COVID-19, including the most extensive and protracted lockdowns in Australia, a "ring of steel" which restricted travel between metropolitan and rural Victoria, the widespread use of masks in the community, and in the latter stages of the pandemic, vaccine mandates [18–24]. The spread of COVID-19 continued and, at times, escalated rapidly, causing significant and enduring demand for health services resulting in rapid and substantial changes to the delivery of care [25–27]. At the time of interview data collection in August–December 2021, Melbourne, the capital city of the state of Victoria, had spent more time under COVID-19 lockdown than any other city in the world [28] and underwent a 79-day lockdown from August–October 2021 [29].

The growing body of literature on healthcare workers' experiences of working during COVID-19 and the impact on their mental health provide critical evidence to inform strategies for promoting the wellbeing and stability of the health workforce [30–33]. To date, research on the experiences of rural clinical and nonclinical health staff during COVID-19 globally is sparse. In Australia, rural health research is underfunded relative to metropolitan research [34]. This has contributed to a lack of research into rural health service staff wellbeing which predates the COVID-19 pandemic.

This study aimed to explore factors both within and external to the health service environment that influenced the mental health and wellbeing of clinical and nonclinical staff at health services (health staff hereafter) in rural and regional Victorian communities during the first two years of the COVID-19 pandemic. For the purposes of this study, wellbeing is defined as an individual's state of emotional, psychological, physical, financial, and spiritual health [35].

2. Methods

2.1. Study Design. This qualitative study is underpinned by social constructionism, which recognises that knowledge is generated through social interaction and that there are multiple versions or interpretations of reality [36].

2.2. Study Setting, Participant Sampling, and Recruitment. As part of the larger CReW study (COVID-19 and Rural and Regional Health Staff Wellbeing) multiphase study investigating the impact of the COVID-19 pandemic on the wellbeing of staff in rural and regional health services (see Figure 1), participants were recruited from seven publicly funded Victorian rural and regional health services (rural health services hereafter) that service communities in modified monash model (MMM) categories 1–6 (MMM category 1 is a metropolitan area and MMM category 7 is a very remote community) [37]. Participating health service characteristics are presented in Table 1. Full-time, part-time, casual, and regular contractor staff working in community and hospital-based settings at participating health services was eligible to participate in the staff survey phase of the study. Students and volunteers at participating health services were not eligible to participate, as the study focus was on the wellbeing impacts of paid employment at health services during the COVID-19 pandemic. Working understanding of written and spoken English was required. Participants of an earlier phase of the study were invited to express their interest in an interview by providing their contact details at the end of a survey [38]. Members of the research team reviewed participant expressions of interest, and a purposive sampling approach was used to ensure representation across health workforce roles and different geographic areas. Of the 61 survey participants who expressed interest in an interview, 21 were sent an email with an invitation to participate and participant information and consent form.

2.3. Data Collection. Semistructured interviews exploring participants' perceptions of the factors that influenced their health and wellbeing during the COVID-19 pandemic were undertaken between August and December 2021. Four
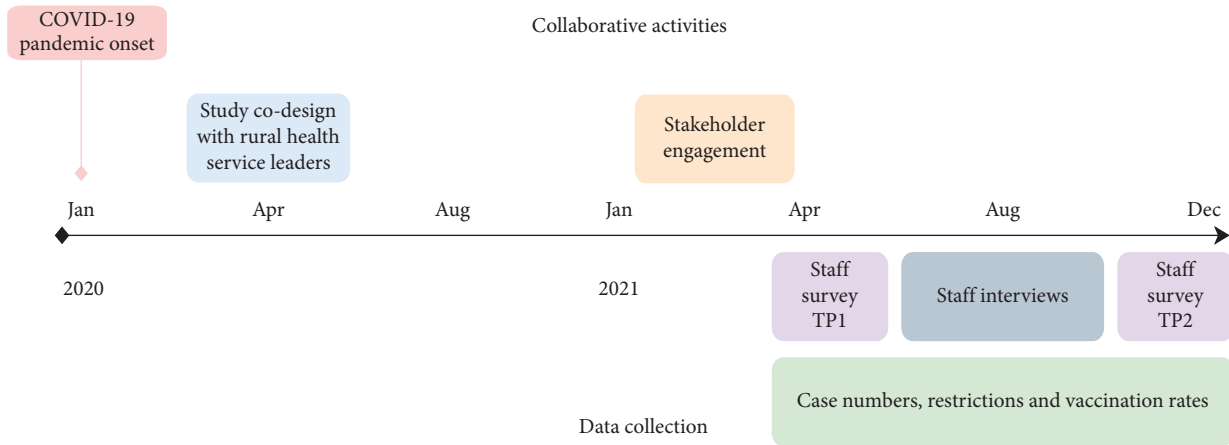
FIGURE 1: Overview of study development and research methods of the *CReW* study. NB data collection for the current article is represented by the blue "|staff interviews" box. TP1 = time point 1 and TP2 = time point 2.

TABLE 1: Participating health service characteristics.

Degree of remoteness as per modified monash model (2019)	Staff number
1[†]	7,100
1[¶]	160
2	4,300
3	930
4	772
4	549
4	518
4	517
4	515

[†]Main tertiary hospital located in regional city classified as MMM category 1; however, the health service also operates community health centres in MMM categories 2–5. [¶]Head office located in metropolitan capital city of Victoria; however, majority of staff are located in stations situated across rural Victoria. Organisation services entire state (MMM category 1–MMM category 6; please note: there are no MMM category 7 regions in Victoria) however has a particular focus on rural communities.

researchers with no direct collegial relationship with participants conducted the interviews using an interview guide flexibly to ensure key topics were discussed and explored with each participant as appropriate (see Supplementary file 1). Demographic data were collected at the conclusion of the interview. Interviews were conducted via videoconference (Zoom) and were recorded and transcribed. Interviews were conducted until the research team was satisfied that sufficient information power had been achieved [39].

2.4. Data Analysis. Data were analysed using a team-based five-stage framework approach [40]. Six researchers familiarised themselves with the data and conducted cursory analysis of ten interview transcripts (A1, 2, 4, 5, and last author). Two researchers developed the initial coding framework (A1 and A2). One author (A1) used the framework to code all interview transcripts via NVivo12 (QSR International; https://www.qsrinternational.com/).

Three researchers analysed the coded data to identify patterns in the data (A1, A2, and last author), and results were mapped and interpreted in the context of existing literature in collaboration with the wider research team.

2.5. Reflexivity. All interviewers completed a reflexivity exercise prior to the interviews [41]. The exercise highlighted varying levels of qualitative research experience, health workforce and mental health research experience, different theoretical perspectives, and experiences of the COVID-19 pandemic. These diverse experiences facilitated a balanced approach to data collection and analysis phases and enhanced the quality and rigour of the study. Two interviewers were female, two were male, and they represented allied health, mental health, and medical professions. All researchers were based in rural areas.

2.6. Ethics Approval. Ethics approval was received from St. Vincent's Hospital Melbourne Human Research Ethics Committee (project local reference number LRR 313/20). Site governance was sought from each partnering health service.

3. Results

Eighteen health staff from four regional areas participated in an interview, lasting between 28 and 65 minutes (mean 48 minutes). Participants represented a mix of clinicians, health service managers, administrative staff, support staff, and program officers (see Table 2 for a summary of participant demographic characteristics).

A range of factors that were perceived by participants to influence their wellbeing were identified. These factors were coded to four main themes: (1) rural community relations, (2) the nature of the health workplace, (3) self-care and supportive networks, and (4) public health measures and the unpredictable pandemic. These themes are described as follows and are depicted visually in Figure 2.

TABLE 2: Participant demographic characteristics ($N = 18$).

Characteristics	n (%)
Employment status	
Full time	7 (38.9)
Part time	10 (55.6)
Casual	1 (5.6)
Tenure with health service (years)	
<5	5 (27.8)
5 −< 10	6 (33.3)
10 −< 15	1 (5.6)
15 −< 20	1 (5.6)
≥20	5 (27.8)
Role (greatest time fraction if >1 role)	
Clinical	8 (44.4)
Health service manager	3 (16.7)
Program officer (nonclinical)	3 (16.7)
Administration (nonclient facing)	2 (11.1)
Support staff (e.g., food services, biomedical engineering)	2 (11.1)
Victorian region of employment	
South west (including Geelong, Colac, Warrnambool)	10 (55.6)
Central/grampians (including Ballarat, Ararat, Willaura)	5 (27.8)
North west (including Mildura, Robinvale)	2 (11.1)
South east (including Leongatha, Korumburra, Warragul)	1 (5.6)

3.1. *Theme 1: Rural Community Relations.* Participants described community related factors that influenced their wellbeing, including the strength of the relationship between the health service and the community it served:

> People [in the community] are fantastic and they'll say things like, "we've been waiting for your call" and "do I need to go and get a COVID swab?"… I think the general public, are pretty on board… and we do have to question people a lot when we're booking them in for surgery now, "have you been to an exposure site? Have you had your vaccination? One or two?"… I'd say 99% of people are so on board with what's going on and what we need to do. Participant 7, Administration worker

The relationship between health services and community was attributed by some, to leadership:

> there's definitely the connection that <Health Service> has with the community I think has made a difference… Our CEO was just in a meeting the other day with [company] to see if they can start production again. Participant 15, Clinician

The participant above went on to describe:

> collaboration with the Shire too. I think that helps. Everyone's kind of coming together for the good of the community (Participant 15, Clinician).

Perceived adherence to public health measures by their community during the pandemic seemed to influence health staff wellbeing. Conversely, observed nonadherence by community members to public health measures appeared to contribute negatively to health staff wellbeing:

> The frustration is that you can see people walking around the supermarket that, they've got a mask on, but they've got it here [under the nose]. If you're not covering your nose, you may as well not have it on. Participant 8, Support staff

Participants described the wellbeing benefits of recognition from the community:

> I remember early, it's funny that early on… the community was dropping off all sorts of care packages. They don't do it anymore, they're all tired too. Those things were kind of nice, just that people were thinking about you, but again it wasn't the organisation that was doing that, that was others, outside of the place. Participant 13, Clinician

Once again, when recognition and respect were not evident at the community level, this appeared to influence health staff wellbeing:

> [The Community] had respect for us as health professionals, early on, where is it now? Gone. It's expected that you keep going. Participant 14, Clinician

Rural communities were perceived to influence the wellbeing of health staff through their relationships with, recognition of, and support for their local health services.

3.2. *Theme 2: Nature of the Health Workplace.* Several factors within the health service environment reportedly influenced participants' wellbeing. Participants frequently described the positive impacts of a rural team environment within which they felt supported:

> Working in [Rural Victoria] we work with a very small group of people, we all provide support to each other. If anybody's on a "downer" or you note something's different we have an in-house support system between us. That ensures people are okay, because we're all in the industry of caring for people. Participant 16, Clinician

Conversely, for some, there was a perceived lack of support from within the immediate team, negatively influencing their wellbeing:

> [At work] I was just more heightened, reactionary, overworked. Working overtime was just not sustainable… I verbalised where I was coming from… but I think they weren't ready for my forthrightness at how bad it is. I thought "okay, everyone's response to this is going to be very

Nature of the health workplace

Team support +-

Leadership +-

Healthcare environment and workload -

Communication within health service +-

Recognition of workers +-

MACRO LEVEL

MESO LEVEL

MICRO LEVEL

Self-care and supportive networks

Self-care +-

Friends & family +-

Personal qualities & experience +

Socio-Political Context

Lockdown (s) –

Personal protective equipment –

Pandemic uncertainty –

Communications technology & virtual care +-

Rural communities

Relationship with health service +

Adherence to public health measures +-
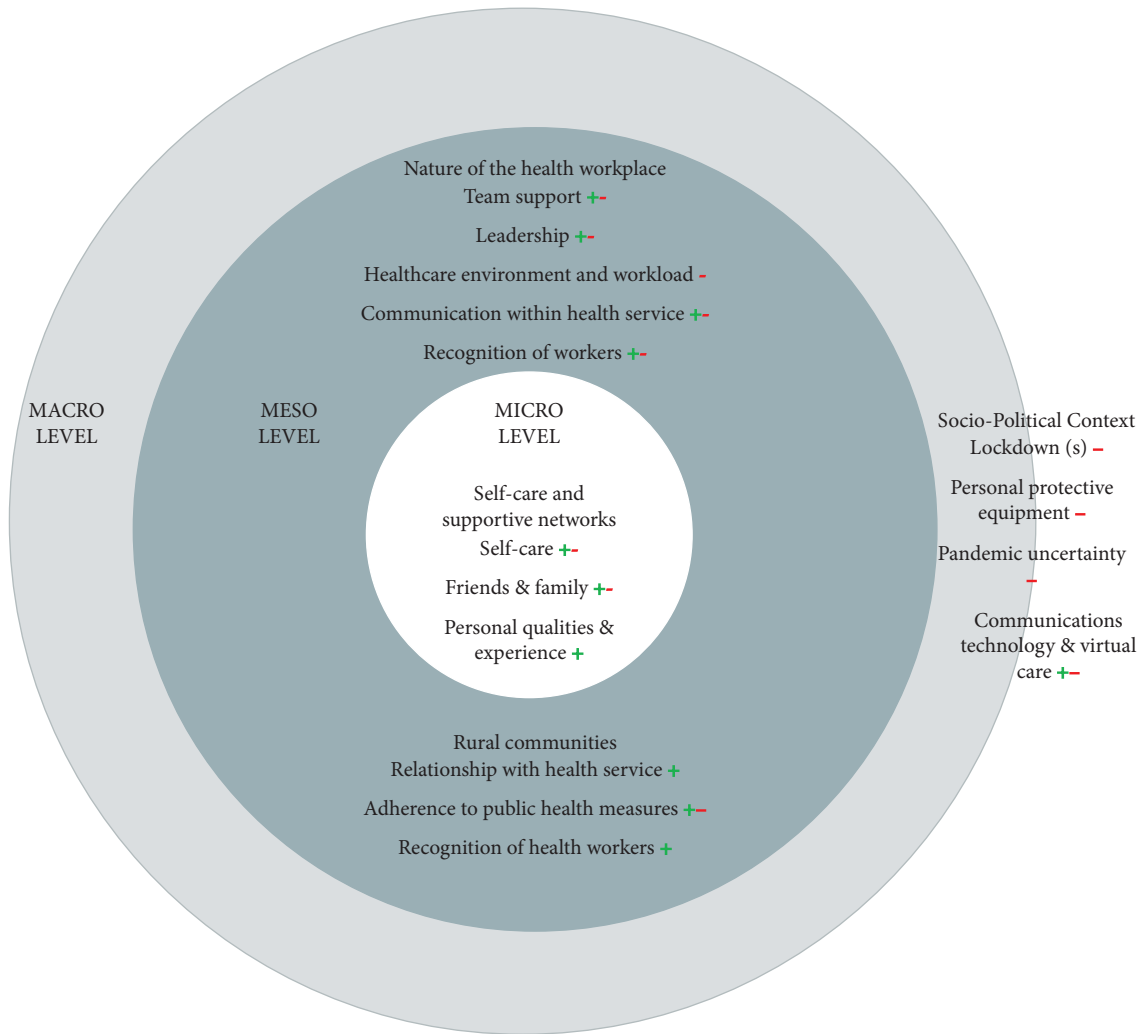
Recognition of health workers +

FIGURE 2: Visual depiction of themes. (−) factor was described as having a predominantly negative impact on wellbeing. (+) factor was described as having a predominantly positive impact on wellbeing. (+−) factor was described as having a positive and negative impact on wellbeing.

different"... I had to back up and say "okay, I can't even call on my team to support me I have to just be responsible for my own well-being". That's really hard. When we're a health professional sector and we're not even caring for each other or don't have the capacity to care for each other while we're dealing with this horror show. Participant 14, Clinician.

The participant above highlights a paradox that as healthcare professionals, they lacked the capacity to care for one another at the height of the pandemic. Other factors within the team were also described as influencing wellbeing, including support from their team leader:

Our team leader-she's really great, runs a very democratic team-said "look, how do people feel, we've been doing this for this number of weeks, do you feel as though you need to go [to home visits] in doubles or are you happy to go alone?"... if someone does not feel that comfortable going

alone, they have the option of requesting that they go accompanied. Participant 10, Clinician

The perceived quality of leadership at the health service executive level was also described as a factor that both positively and negatively influenced health staff wellbeing:

[CEO's] leadership from the top has been incredible... That open communication being there from the very top. Participant 9, Health service manager. this is a by-product of working in a rural regional setting... resources are already limited, it amplifies the gap. I was looking for leadership or some direction, about clinical guidelines on how to take PPE off. What are the specific items that we need to worry about cleaning? We didn't get the support or leadership because they were undermanned already... At that time of heightened anxiety, you're really looking

for clinical pathways, slash leadership, and if you're not getting it... I'm finding that a bitter pill to deal with. Participant 14, Clinician

Related to leadership was the clarity and consistency of communication within the health service, which was also frequently referred to as a factor contributing participants' wellbeing. There were examples of positive communication between senior management and health staff:

From the [Health Service] point of view the communication has been very regular, very consistent and very clear. Participant 3, Administration worker

Some participants, however, described their perceptions of poor leadership visibility within the health service setting, and inadequate communication:

... the way [Health Service] handled some of the requirements and restrictions... they didn't sort of come down and talk to people about them. Participant 13, Clinician

Alongside, general communication in the health service setting was the overt recognition of the work and commitment of health staff. When recognition was apparent, this was described as having a positive impact on wellbeing:

The thing that upper management can do best is to keep open communication, and to continue to acknowledge the good stuff, the sacrifices and the work that people have done right across the organisation. Participant 9, Health service manager

On the contrary, a lack of observable recognition of health staff within or by the health service was described as a factor that negatively influenced wellbeing:

Sometimes people at the end of the chain don't get appreciated. I don't think people are necessarily aware of the little worker bee stuff that goes on at the end of the chain. I sometimes feel like the admin area, it's just expected to work with minimal "thank yous"... I think the little tiny admin bits and pieces that we do to contribute to a day go a little bit unnoticed. Participant 7, Administration worker

Mechanisms of expressing thanks and recognising health staff appear to be a challenge for health services to get right. Indeed, some participants described a feeling of inequity and discontent when some staff were recognised and they were not:

It's interesting, the choices that were made both in our organisation who sent support to a lot of the workers in the form of free coffees or fruit baskets or whatever. Where we were situated, we didn't get a lot of that so it kind of actually bred... that inequity, a feeling of

discontent rather than the content that it was supposed to be bringing. Participant 4, Health service manager

The very nature of healthcare work, the healthcare environment, and abnormally heavy workloads exacerbating existing workforce pressures were described as impacting participants' wellbeing. Some participants raised concerns about burnout:

... we worked understaffed for 12 months, with high referrals, high complexity, less staff. My team were really burning out, and then I had to send a couple of them into the monitoring and tracing space as well. It left the rest of the team really thin, and all of their mental health suffered. Participant 9, Health service manager

Health workplaces and multiple factors therein including team support, communication, recognition of effort, and workload were perceived to influence health staff wellbeing both positively and negatively.

3.3. Theme 3: Self-Care and Supportive Networks. Participants described a range of personal factors and strategies both within and beyond the healthcare workplace to support their wellbeing. Many described using self-care strategies such as practicing gratitude and maintaining healthy lifestyle behaviours (e.g., exercise, gardening, limiting alcohol intake, healthy eating) to promote their wellbeing:

I've reduced drinking... I made a drunken phone call early on in the pandemic and just thought, "woah, we're going to stop this". I have not regularly taken up drinking again yet. Participant 1, Administration worker

Some participants, however, reported that they were unable to maintain positive lifestyle behaviours throughout the pandemic due to strict public health measures, which had a negative influence on wellbeing:

I've stopped exercising as much as I did beforehand. To get on the bike and ride, I used to ride to work, where now I get on the bike and I go, "where am I gonna ride to? And when I get there, what am I going to do?" Participant 8, Support staff

Family support was a key factor for many participants to promote self-care, healthy lifestyle behaviours, and wellbeing:

I couldn't have done it without my family feeding me and packing my lunch so I could eat at work. I think those factors external to work kept me upright. Participant 4, Health Service Manager

For others, concerns they held for the mental health of, and general impacts on their family members negatively impacted their wellbeing. This was the case for the following

participant living in a rural area, geographically distanced from their family during the protracted lockdowns:

It's been very difficult because our son's in [metropolitan area] and had significant mental health issues with other things going on in his life. We've actually only seen him twice this year... that's been difficult because we know he's really struggling. Participant 10, Clinician

Personal qualities, such as resilience, pragmatism, an optimistic outlook, and professional and personal life experience, were described frequently as positive influences on participants' wellbeing:

going through COVID you have your highs and your lows... with lots of reflection-and being on farm-you're subject to seasonal fluctuations that are totally out of your control. If it's a drought, you're under financial pressure. And I never forget those times. Participant 14, Clinician

3.4. Theme 4: Public Health Measures and the Unpredictable Nature of the Pandemic. There were factors beyond the health service, individual, and community levels that were described as having an impact on health staff wellbeing. Public health measures, including lockdowns, social distancing requirements, hospital, and residential aged care visitor restrictions, were frequently described as negatively impacting wellbeing. At times, public health measures were considered illogical and impacted health staff workloads:

We got hairdressers back into the system before we got podiatrists... The no-visitors rule affected everybody, not just the [aged care] residents. [The visitors] take a little pressure off staff members. So that affected staff, just put extra work on everybody. Participant 18, Clinician

The rapid rise of virtual care prompted reluctant health staff to engage with communication technology, which appeared to influence health staff wellbeing:

In a lot of ways, it's been really beneficial because people have had to move into the video conferencing space, which we had all dabbled in previously, but we really hadn't really connected with it... COVID has really just brought that on in leaps and bounds, the whole teleconferencing and videoconferencing with clients has evolved very quickly... in that respect it's been a really positive thing. Participant 9, Health service manager

Technology and virtual care were also described as problematic for some health staff, for example, by those working with older people who felt they were unable to provide optimal services:

We're talking about health and provision of services, these are personal interactions that are so vital... Particularly older people, they don't hear so well... they're looking for facial expression, they're looking for the whole assessment... how much we take in with people in their face and their character, through looking at them, and the genuine smile or the fake smile or nuance of expression, that's lost. Participant 5, Program officer

In the earlier stages of the pandemic, the general shortage of personal protective equipment (PPE) was described as a cause for concern:

We were asked to stand at the front and take temperatures. I did a couple of shifts doing that, but we were not actually in PPE, "cause there was a, a shortage of PPE. You did feel quite vulnerable standing out there not wearing anything, we're sticking a thermometer within the 1.5 distance, I'm really putting myself on the line here and feeling vulnerable. Participant 1, Administration worker

With time, PPE became more widely available and mandated in all health settings. Paradoxically, PPE requirements were also described as negatively impacting health staff wellbeing:

Working in PPE for long periods of time you get incredibly dehydrated, because you can't drink, you can have breaks and they allow the breaks, but you're out there and you've got the mask, the shield, the gown, the gloves... Participant 12, Administration worker

Other public health measures, such as the eventual availability of COVID-19 vaccines, were frequently described as promoting participants' wellbeing:

The day I had my first [COVID-19 vaccine] dose, our manager was there at same time. And there was a real feeling of excitement. People were really getting a buzz out of that first dose. I almost felt like I was going to cry. Participant 10, Clinician

For rural and regional health staff, the relaxing of pandemic restrictions was met with concern about the associated workload, particularly when the "ring of steel" was removed:

We don't know what tomorrow will bring. The politicians are having that huge effect on us too... all your friends are jumping up and down, because regionally we're open, but I'm like, "oh my God that means case numbers are probably going to go through the roof," and we've got huge workloads already. Participant 4, Health service manager

As both members of the community and rural health staff, participants were also impacted by the general uncertainty about the pandemic, its nature, course, and duration:

> it's the... the bigger picture... it's the pressure. It's almost oppressive because you think, "oh, when will this be over?"... There could come a time when people think "is it going to get over?" Participant 5, Program officer

Given the direct and enduring effect on their workload, and the exacerbation of pre-existing workforce pressures, this unpredictability appeared to compound the perceived negative impact on rural health staff wellbeing.

4. Discussion

This study sought to explore rurally based clinical and nonclinical health staff perspectives of the factors that influenced their wellbeing during the first two years of the COVID-19 pandemic. To our knowledge, this is the first qualitative study of this scope to be undertaken in a rural Australian setting, where existing workforce shortages and pressures were compounded by factors related to the pandemic. The findings demonstrate that there were factors within and beyond rural health services that promoted and adversely affected health staff wellbeing. Factors described as influencing health staff wellbeing were coded to four key themes: rural communities; the nature of the health workplace; socio-political context; and self-care and supportive networks. It was apparent that these microlevel (individual or personal), meso-level (community and health service), and macrolevel (broader public health) factors and themes were interdependent. This study focused predominantly on meso-level factors.

The strength of the relationship between rural communities and their health service facilitated health staff wellbeing. The "ties" with the community enabled effective approaches to managing COVID-19 outbreaks, efficient vaccination, and adherence to public health measures. These connections, sometimes initiated or fostered by senior health service leaders, ameliorated the burden on the health services and in turn, benefited health staff wellbeing. Indeed, visible effective health service leadership engendered trust and reassurance in their rural communities; the sense of collaboration within rural communities in turn had positive impacts on staff wellbeing. Working *with and for* the community promoted a sense of shared purpose and wellbeing for staff. Reflected in our data is the recognition that rural health services are key to the social fabric in rural communities and foster connections that can facilitate health, which has been previously recognised in the literature [14]. Quilliam et al. [42] also emphasise that the role relationships between rural health staff and community members play in promoting a sense of belonging for health staff and enhanced rural health consumer access to services. This current study highlighted the sense of pride health service staff experience when working for their community, which reflects the findings of Ohta et al. [43]. This reinforces

the need to nurture strong and positive relationships between health services and their communities, for the wellbeing of both health staff and health service users. The current study has also highlighted staff wellbeing-related risks the COVID-19 pandemic has presented regarding these important health staff, community, and workplace relationships. The potential for exacerbation of health workforce shortages and rural health staff fatigue due to COVID-19 may threaten meaningful community engagement and undermine relationships between health services and the communities they serve [7]. Globally, the pandemic has resulted in decreased confidence in healthcare systems' ability to manage major health crises [44], and rural health service leaders must lead in ways that actively increase community trust in order to promote both relationships between health services and their communities and staff wellbeing [45].

Within the rural health service context, the perceived quality, strength, and visibility of health service leadership during the initial phases of the pandemic were a key factor that influenced health staff wellbeing, with examples of both positive and negative experiences of leadership described. Willis et al. [46] noted the critical role that clear and united leadership plays in supporting the preparedness and engagement of health staff, enabling them to work as safely as possible through the pandemic. Consistent and open communication between the various levels of management was also identified as a key contributor to health staff wellbeing. In contrast, health staff who did not receive consistent communication from senior managers and executives reported experiencing a poorer sense of wellbeing. These findings concur with that of Chemali and colleagues [31], who, through their scoping review of healthcare workers' experiences and support needs during the COVID-19 pandemic, identified the lack of consistent and coordinated communication as problematic. The development of senior leadership capabilities, mechanisms to support effective leadership, and optimal communication strategies within health services are clearly important points of focus for supporting and protecting health staff wellbeing.

Further at the meso-level, health service teams characterised as supportive and caring promoted individual team members' wellbeing. This reflects Lewis et al.'s [32] findings that the collegial environment engendered a sense of belonging for frontline healthcare workers. In the current study, a lack of support within local teams was identified as a factor that inhibited wellbeing, which suggests initiatives targeted at the team level may be an effective approach to promote health staff wellbeing.

It is not surprising that the very nature of the health workplace with large and complex workloads that have been exacerbated by the pandemic, negatively influenced health staff wellbeing. Although this experience is not unique to rural health staff [46, 47], enduring increased workloads in a previously stretched and chronically under-resourced health workforce will likely impact medium and longer-term health staff retention [48] and threaten the sustainability of rural health workforces. This reinforces the need for holistic solutions and coordinated strategies to promote

health staff wellbeing and, in turn, rural workforce attraction and retention [48].

Senior health service managers' overt recognition by publicly thanking staff and departments or providing free coffees and meals demonstrated an appreciation for their work under significant and enduring demand. When there were perceived inequities in the recognition of staff in different roles or settings, this undermined attempts to foster a sense of appreciation of health staff. This highlights the importance of considered approaches to the recognition and rewarding of health staff across the diverse settings and types of roles within which they work. These findings echo Holroyd et al. [49] who described the sense of injustice experienced by community-based healthcare workers when they observed other health professionals being recognised for their work when they were not.

Macrolevel factors, such as lockdowns, difficulties accessing or using PPE, and the need to rapidly adapt care delivery and use technology, all contributed to increased workload and personal stress for health service staff. Public health measures heavily impacted staff wellbeing and the ability of individuals to enact fundamental aspects of self-care. Day-to-day self-care (e.g., exercise, healthy eating) and social supports were recognised as vital to health staff wellbeing. This emphasises the interdependence of various levels of influence on health staff wellbeing and highlights the challenges for health staff engaging in individual-level self-care strategies within a meso- and macrolevel environment characterised by prolonged stress [50]. Although self-care strategies are important for protecting health staff wellbeing, they must be reinforced or complemented by organisational strategies and interventions to enable effective engagement by health staff [51, 52]. Given rural communities experience higher rates of preventable chronic disease relative to metropolitan areas [8, 53], it is essential that health services support their staff to engage in self-care and healthier lifestyle behaviours. This is critical in both the current pandemic and future health crises to minimise further impacts on mental health and physical wellbeing in this population [14, 53].

Social and family support was pivotal to maintaining health staff wellbeing, and yet, concerns for the mental and physical health of friends and family, particularly those living geographically distant, contributed negatively to their own wellbeing. This illustrates the complex personal and social circumstances experienced by rural health staff and that initiatives to promote optimal wellbeing for health staff must consider influences both within and beyond the health workplace [32].

4.1. Strengths and Limitations. This study involved a highly informed sample from rural health services from across the state of Victoria, Australia. A further strength is that our recruitment strategy led to an even mix of participants across a range of clinical and nonclinical areas, from seven different rural Victorian health services. One potential limitation could be that investigating any differences between the perspectives of clinical and nonclinical staff was not explored as this was beyond the scope of this study; however, future research may wish to explore this area given the potential for further role-specific nuances in the impact of COVID-19 on the wellbeing of rural health staff. The study was conducted in Victoria, Australia, where the health system and government responses to the pandemic differ from that of other Australian states and countries, meaning that these experiences of the pandemic may not completely reflect those in other rural areas or metropolitan areas; however, given the depth of analysis and the four major themes that emerged, some of the key learnings may be valuable to other contexts. Finally, the sample comprised only one casual health staff member and no contractors. The experiences and perspectives of this component of the health workforce, which has increased in size since the pandemic began, are not well represented.

4.2. Recommendations. Given the role that community support for, and relations with, health services play in promoting rural health staff wellbeing, and community engagement should be a feature of rural health service staff wellbeing strategies. For example, health services could invite community members to show their support and appreciation for health staff by sharing messages of gratitude (e.g., short videos or posts on social media), and local businesses could be approached to sponsor or otherwise support health staff wellbeing initiatives (e.g., by providing vouchers for wellbeing-related services). Strategies must also consider health service factors including strong and visible leadership, opportunities to foster team-level wellbeing, consistent communication processes to keep staff abreast of developments, and equitable approaches to acknowledging the efforts of staff across settings and role types. Senior leadership and communication are critical areas for support and optimisation. Finally, self-care strategies are critical to health staff wellbeing and should be supported by health services to ensure health staff have opportunities to engage in these during and outside of work hours.

5. Conclusion

Health staff working in rural settings described a range of factors that influenced their wellbeing during the first two years of the COVID-19 pandemic. The strength of the relationship between health services and the communities they serve mostly positively influenced health staff wellbeing. Health workplace factors were related to the strength, quality, and visibility of leadership, the dynamics of the teams within which health staff worked, the clarity and consistency of communication within health services, and recognition of the health staff's contribution. Initiatives to promote rural health staff wellbeing can leverage existing ties between health services and communities and must account for the range of interdependent factors within and beyond the health service setting that influence wellbeing.

Data Availability

Due to the nature of the research and the participant privacy considerations, supporting data are not available.

Additional Points

What is Known about this Topic. (i) The health outcomes of people living in rural communities are poorer than those in metropolitan areas. (ii) The COVID-19 pandemic has exacerbated pressures on rural health services and staff. (iii) The experiences of Australian rural health staff during the first two years of the COVID-19 pandemic have not been explored qualitatively. *What this Paper Adds.* (iv) Rural health staff identified factors that influenced their health and wellbeing at the macro, meso, and microlevels. (v) Mesolevel factors influencing health staff wellbeing include community support and relations, and health service processes. (vi) Community engagement should be a feature of rural health service staff wellbeing strategies.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Acknowledgments

Supplementary Materials

Supplementary file 1: Interview guide including participant demographic questions. (*Supplementary Materials*)

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