DOI: 10.33470/2379-9536.1373

EDITORIAL Volume 8 Issue 2

Allyship for the Rural Health Care Workforce

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ABSTRACT

The COVID-19 pandemic revealed a lot about the impressive, fragile, and overtaxed American health care system. Our support systems, both institutional and human, were stressed. Building our network through various methods can help to strengthen our support system while dismantling the structural inequities that negatively impact our workforce and patient care. Seeking allies in medicine has become an integral component of building one's network. Becoming an ally for isolated, under-resourced, or underrepresented communities in medicine has become an important way to help promote structural change at the institutional level.

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KEYWORDS

Allyship, rural, network, health care

INTRODUCTION

The COVID-19 pandemic gave the public a front-row seat to the inequities and structural racism of the American health care system, the impact of the disappearance of our safety-net hospitals, and the great need to invest in our public health infrastructure. The pandemic shined a light on barriers to resources and support that underserved populations face. Becoming an ally for isolated, under-resourced, or underrepresented communities in medicine emerged as an important way to help promote structural change at the institutional level.

WHAT IS ALLYSHIP, AND WHO IS AN ALLY?

The Coin Model defines allyship as seeking "justice for all by addressing the systems of inequality that harm everyone."[2] Allyship is also defined as a "supportive association with another group, specifically members of marginalized or mistreated groups to which one does not belong."[3,4]

Allies try to drive systemic improvements to workplace policies, practices, and culture and work to fight discrimination.[5] They affirm belonging and dismantle structural inequity. Allies listen, amplify, advocate, and collaborate to fight injustice. Allyship aims to change individual behavior and institutional structures that contribute to disparities: "social structures play out through institutions like science, health care, and education, which are therefore key sites for practicing critical allyship. Practicing critical allyship encourages individuals to transform their own institutions."[1]

Health care practitioners are ideally suited to be allies, as they already fight for the health of their patients.[6] This allyship muscle flexed on behalf of the ill and dying is the same muscle that can support marginalized colleagues and communities.

While the concept of allyship in medicine has often been associated with underrepresented and LGBTQIA+ communities, it can also be a source of support for underfunded, under-resourced communities and for workforces that are isolated or marginalized for a variety of reasons, including demographics.[6,3]

CHALLENGES

Rural areas face numerous challenges, including a smaller health care workforce and a confusing health insurance system that impacts rural consumers more than urban consumers; rural communities have been found to have lower health insurance literacy levels than urban populations.[7] However, challenges to rural areas are not monolithic; rural areas in different parts of the country face challenges uniquely associated with their area.

Only 1% of American ICU beds are located in rural regions, a problem exacerbated by the COVID-19 pandemic. Rural areas have fewer physicians, nurse practitioners, physician assistants, and mental health care providers than metropolitan areas.[8] For example, the disparities in the Appalachian region are striking: per 100,000 residents, there are 12% fewer providers than in the country overall, 35% fewer mental health providers, 28% fewer specialty physicians, and 26% fewer dentists.[9] This creates a strain on the health care workforce, possibly leading to burnout, attrition, and other adverse outcomes.

Rural residents struggle to access providers because locations are too far away or difficult to reach.[9] Although the rural health system model of relying on outpatient care was upended by the pandemic and required a pivot to telemedicine,[1] a lower percentage of households in rural regions have computer devices and internet subscriptions versus metro areas.[9] The lack of internet and broadband access in some rural communities creates barriers to accessing health care and insurance information.[7]

Obesity and its linkage to chronic illness is another challenge for the rural community. In a study that examined physical activity in rural Appalachia, the presence of a health condition was cited as a frequent barrier leading to low levels of physical activity.[10] An unhealthy population creates more stressors on an already thinly-stretched health care system.

WHAT ALLIES CAN DO

While rural and urban differences are often profound, there are some universal problems, including access to health care, transportation, and education.[8] While solutions to rural and urban health care problems may differ, support that offers a different perspective may create novel opportunities for change. Seeking allyship with those outside the rural environment can create an opportunity for shared approaches to problems and offer new insights into tackling issues, relieving a sense of isolation, and providing support when seeking to dismantle structural inequities.

Urban health care workers and institutions with more resources and financial and political power can provide allyship for their rural peers by promoting equitable distribution of hospital resources and lobbying for government-supported loan forgiveness or repayment programs. Rural hospitals would then attract more workers and more diverse workers. This would support policies that ensure that equitable dollars of federal funding are allocated to rural communities and push for expanded broadband access for rural Americans. Additionally, medical and allied professional schools can add more to the rural health curriculum and provide clinical opportunities to encourage providers to go into the rural workforce. On an individual level, urban health care providers can share networks with their rural peers and support their scholarship and career trajectory through invitations to submit to journals, present Grand Rounds, join committees, and speak at conferences.

Rural areas that are predominantly non-white have additional challenges that can be helped by allyship; this can be an important tool to support rural health care workers who are underrepresented in medicine. There is a tendency for white men to confer promotability to other white men.[11] Allyship for those in majority non-white rural areas can break this pattern. By becoming "amplifier" allies and sponsoring those underrepresented in medicine, white men can break the "similarity-attraction paradigm," where people gravitate to those who resemble themselves.

Many white employees have never spoken out against racial discrimination at work. Only ten percent of Black women and 19 percent of Latinas say most of their strongest allies are white, compared to 45 percent of white women. Black employees who speak out may find themselves

penalized.[12] White allies can speak out in support of diversity, equity, and inclusion while facing less severe backlash.

By supporting the rural health care workforce, we are promoting better health for all Americans. There has never been a more important time to support our health care workforce, whom the pandemic has battered. Now is a critical time to change our structures and embrace a culture of allyship within our practices, institutions, and across healthcare as we continue to try to make health care equitable and excellent for everyone.

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