6. Human Resource Management

Competitive Session

Managers are the key to workforce stability: an HRM approach towards improving retention of health professionals in remote northern Australia

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Managers are the key to workforce stability: an HRM approach towards improving retention of health professionals in remote northern Australia

Sound management practices, including effective employee-manager relationships, influence turnover and retention. Accordingly, in Australia's remote regions, where high turnover of health professionals is reported, the impact may be even more significant. This paper presents the findings from a study in tropical northern Australia that explored how a Human Resource Management (HRM) approach contributes to the stability of remote health workforces by examining the impact of the relationship between employees and their managers on retention. The study found that a supportive work environment and positive employee-manager relationships can improve workforce retention, so that those living in Australia's remote regions can experience better health outcomes through improved access to stable and consistent health services.

Key words: HRM theory, recruitment, turnover, retention, employee engagement.

> *[P]eople leave managers, not companies. So much money has been thrown at the challenge of keeping good people – in the form of better pay, better perks, and better training – when in the end, turnover is mostly a manager issue. If you have a turnover problem, look first to your managers.* (Buckingham & Coffman, 1999, p.27)

Managers are critical to the success of an organisation; they have a large influence over the financial and human resources. If employees make decisions to remain with their employer based on their experience in the current practice setting it follows that the most influential person in that setting, their manager, may have a substantial impact on turnover (Cutchin, 1997; Fisher & Fraser, 2010). This study considers the impact of the relationship between managers and health professionals working in remote regions of northern Australia and how this may impact on retention in an area where voluntary turnover is predominantly high (Garnett et al. 2008; Hunter et al. 2013).

In particular, this study focuses on three regions of tropical northern Australia – Kimberley (WA); Top End (NT); and North Queensland. Sub-populations living in these regions have a high burden of chronic disease and access to healthcare is imperative (Australian Institute of Health & Welfare (AIHW), 2012). In fact, the further people live away from major cities, the less healthy they are likely to be (AIHW 2012). Accessing health services is a key component to improving health outcomes for the remote population and access depends on a consistent and competent health workforce (Fisher & Fraser, 2010; Humphreys et al., 2008).

Socioeconomic differences, health inequalities, poor resourcing and extreme climates make remote regions unattractive to many health professionals (Campbell, McAllister, & Eley, 2012;

Margolis, 2012). Turnover in remote regions of Australia is high and costly (Chisholm, Russell, & Humphreys, 2011; Garnett et al., 2008; McKenzie, 2011); however much of the focus has been on clinical aspects of these roles and how to attract professionals with the necessary clinical skills to work in these challenging roles. (Humphreys et al., 2008; McKenzie, 2011). While management scholars have examined the impact of managers on employee engagement, satisfaction and turnover intention few have studied the benefits that improved management support could have on turnover intentions for health professionals working in remote regions specifically (Chalofsky, 2010; Rosete, 2006).

This study used a Human Resource Management (HRM) approach to examine the impact that managers have on turnover and retention. This complements the health sector approach which focuses on reducing turnover and improving service delivery through improved clinical proficiency (Allan & Ball, 2008). HRM is about 'the policies, practices and systems that influence employees' behaviour, attitudes and performance' (De Cieri et al., 2004, p.596) providing sound evidence from which to examine workforce challenges, such as the retention of remote health professionals and access to appropriate healthcare (Allan & Ball, 2008; Kabene, Orchard, Howard, Soriano, & Leduc, 2006).

Working in remote Australia is challenging (Bent, 1999; Greenwood & Cheers, 2002); however, for managers there are additional challenges. Managers experience an additional burden undertaking the duties of planning, supporting and motivating others in a complex environment often with limited management experience (Hasselhorn, Heijden, & Dam, 2009; Lenthall et al., 2009) or support (Greenwood & Cheers, 2002). In isolated areas where health professionals live and work in close proximity, the impact of effective management practice may be considerable. An HRM approach is beneficial in these circumstances where work and home life overlap and where social networks are essential in minimising turnover (Birks et al., 2010; Iverson, 1999). Supportive, appropriate management practice encourages competent health professionals to remain, thus stabilising health services and positively impacting the health of remote populations (Hunter et al., 2013).

Social exchange theory provides a foundation to explore the complexity of the employee-manager relationship and affords a mechanism for understanding how these relationships influence the

stability of health services in remote regions. In this study, social exchange theory provides the theoretical framework for interpreting the findings. Social exchange theory suggests that the quality of the employee-manager relationship impacts on several employee outcomes including job satisfaction, commitment and turnover (Xerri, 2013). Social exchange theory therefore provides a sound theoretical perspective to consider the challenges of managing health professionals in remote regions.

In northern Australia many health professionals live and work in remote communities or small towns where work and social relationships can be complicated by the interrelatedness of roles and responsibilities. For example, the patient may also be the mayor, the nurse may also be on the council, or the family friend becomes the terminal patient. The complexity of these roles exposes the difficulties health professionals in remote regions experience as their personal and professional roles intersect (Birks et al., 2010; Greenwood & Cheers, 2002). Remote-based workforces are often supported through workforce models such as fly-in/fly-out (FIFO), drive-in/drive-out (DIDO) and outreach services. These models add another dynamic to the work environment and can mediate tensions within the remote workplace by providing clinical services where personal relationships create conflict for the remote-based workforce (Birks et al., 2010). Psychological contracts, organisational commitment and social identity (Gould-Williams & Davies, 2005) may be complicated by these integrated working environments and may further impact workplace relationships.

The manager is an agent of the organisation and has their own exchange relationship with their employees thus influencing the relationship the employee has with the organisation. Managers are therefore considered to be the 'pillar that supports the social exchange framework' (Xerri, 2013, p.106). Examining the employee-manager relationship for remote health professionals is a sensible next step in understanding turnover in remote regions.

METHODS

A mixed methods research design was used for this study which brings together the findings from three data sources to examine the challenges for managers and the impact of employee-manager relationships on turnover and retention. Interviews and online questionnaires were used to ascertain

the perspective of the manager and health professionals and a review of advertisements during the study period provided a labour market perspective for the study.

Interviews

Purposive research methods were used to recruit participants. Semi-structured interviews (n=19) of approximately one hour with health professionals (HP), human resources professionals (HR) and managers (M) were conducted and the transcripts analysed using NVIVO 10. This paper focuses on the following three areas of interview data: 1) the transition from clinician to manager; 2) the challenges of managing in remote regions; and 3) how they described remote staff appointments in terms of turnover and retention. The Harvard Analytical Framework for HRM (Beer, Spector, Lawrence, Mills, & Walton, 1984) was used to guide the categories for NVIVO 10. This framework provided an overview of the determinants and consequences of HRM policies and was particularly relevant to this study as it guided analyses about HRM policy choices (work systems, human resource flow, employee influence, and reward systems) and HR Outcomes (commitment, competence, congruence and cost-effectiveness) when considering long term consequences, situational factors and stakeholders (Beer et al., 1984). A thematic analysis of the coded data identified emergent themes.

Questionnaire

An online questionnaire distributed to health professionals working in the study region provided further data. Of the 424 health professionals invited to participate, 111 responded (26% response rate). Incomplete questionnaires were removed leaving 85 questionnaires for analysis. Participants were asked the extent to which they agreed or disagreed with each of the following statements: *I am provided with sufficient opportunities for training and development*; *I have a close relationship with my supervisor/manager*; *I have great respect for my supervisor/manage*; and *My supervisor/manager understands what I do in my job*; as well as a text question *What are the greatest challenges of working in a remote region?* Quantitative data were analysed using SPSS and qualitative data using NVIVO 10.

Labour Market – Vacancies / Advertisements

An ongoing review of the labour market provided the third data source. This was achieved by analysing role descriptions for management positions advertised on government websites or seek.com (August 2013 - May 2014) to identify the type of qualification and experience required for the role.

Ethics

This study has approval from the James Cook University Human Research Ethics Committee (HREC) (JCU HREC - H5227), the Townsville Hospital & Health Service HREC (HREC113/QTHS /225) and the WA Country Health Service HREC (HREC 2013:31).

Participants

The study included participants from a range of occupations and locations (Table 1). Most of the questionnaire participants lived in a regional centre (57%) and one quarter (26%) lived in a very remote community, confirming the presence of remote-based and FIFO/DIDO workforce models. One quarter (27%) had worked in a remote region for less than one year and more than half (52%) had been with their current employer for less than two years. This is consistent with other studies reporting high numbers of remote health professionals with less than two years tenure (Battye & McTaggart, 2003). Managers were well represented in the interview data (79%) and questionnaire data (42%).

Table 1 approximately here

RESULTS AND DISCUSSION

The emergent themes from the interviews were: transition to management; rewards and incentives; employee-manager relationship; remote context; role clarity; and recruitment, turnover and retention. These themes shape the structure of the results and discussion section.

Transition to management

'We promote clinicians as good clinicians into management positions and then we don't support them with any management education' (HR-10). The progression from clinician to manager is significant and was described by managers as being pivotal in their career. Now established managers in their respective areas, they all remembered their first management position with the majority recalling an absence of support. One exception was a manager who had progressed through the government health department ranks from a registered nurse to management in the

1990s and recalled support within succession planning policy that existed at that time. Others did not receive this level of support with one saying, 'as soon as you put on a managers hat there is an expectation that you just get on with it' (M-18) and another frustrated by the lack of support saying 'they knew me as a clinician, they all knew my background' (M-9).

Organisational support according to both managers and HR professionals was often lacking. HR professionals explained that they thought that there were professional supports and development opportunities through their clinical disciplines, e.g. 'I naïvely thought that the managerial leadership aspects of their role were part of the supervision conversation' (HR-11). Several explained that seeking organisational support was their greatest challenge when transitioning to management, 'how do you know what you need because you don't know, what you don't know' (M-18).

Most of these managers transitioned from clinicians in remote areas and suggested that the geographic barriers, both physical and financial, contributed to the diminished level of professional development and support. Several undertook management training, including post graduate qualifications to consolidate their skills after some time in the management role. Most thought that if they had been in a metropolitan area during the transition that they would have had increased access to professional development and support mechanisms that would have improved their capacity to manage more effectively. When asked the question *I am provided with sufficient opportunities for training and development*, almost one third (31%) of questionnaire participants disagreed. When stratified by management status, a higher proportion of managers (35 %) than health professionals not in management roles (18%) disagreed with the statement. Difficulties accessing professional development are common for remote health professionals (Bent, 1999; Birks et al., 2010) and this contributes to reduced management capabilities and competence, as one HR professional explained:

> *How they got to be there was not necessarily because of their managerial and leadership skills. They got to be there because they were very good at their technical skills ... and usually what happens is the wrong people go in to the manager's job ... so we don't choose the right people very well; and the next thing is so we don't groom the next lot of people well. So we are not training the next generation of potential managers* (HR-11).

Lenthall et al (2009, p. 210) note that '[i]nadequate preparation of operational managers' and 'inadequate recognition of health services management as a health discipline' impedes retention. Hence, these findings suggest that organisations need to prepare the employees they are promoting and proactively identify, train and support potential managers (Taylor, Blake, & Claudio, 2010).

Rewards and Incentives

When asked about turnover and retention, managers emphasised that intrinsic motivation is important to retaining staff, e.g. 'money and conditions is what will attract people, retention is around the work environment' (M-9). The managers interviewed explained that the motivation to work in remote areas could arise from an intrinsic altruistic drive or a more extrinsic financial stimulus. This supports the findings of other studies where extrinsic rewards were beneficial in attracting health professionals to remote areas; however, they had minimal impact on long term retention (Campbell et al., 2012). Managers accepted the importance of those motivated by financial gains because they are the short-term (e.g. three months) workers that remote areas depend on. They complete the contract, collect the bonus and leave. Then the next one arrives and the pattern repeats. By comparison, they suggested that intrinsically motivated employees are more likely to stay longer. However, they fall into two categories: those that come to save the world and burn out quickly; and, those who find their place in the community and stay for a long time. While the latter is preferred, for a manager, a health professional with these attributes still needs to be effectively managed, as one manager explained:

> *There are always people who are going to be wanting to go out there and work in this really amazing complex unique environment, that's not the challenge. The recruitment isn't the challenge it's the retention and the retention is about management* (M-18).

Managing the latter of these groups is crucial to the stability of a remote health workforce; however, organisational policy often constrained managers' ability to do this effectively. One manager described a situation where policy to exit a poor-performer took so long they lost two good health professionals, 'so I just thought I need to find a better way to recruit people so that we don't lose good staff' (M-9). There was a strong sense that some of the policy that is developed in the city can be too restrictive in remote areas and necessitates localised decision-making for implementation.

Employee-manager relationship

Overall, questionnaire participants responded positively to the statements about management (Table 2). However, more than 20% disagreed with the statement '*I have a close relationship with my supervisor/manager'*. These findings are important as the employee-manager relationship underpins the extent to which high commitment HRM practices are implemented in the workplace (Gould-Williams, 2004). Employment relationships form where managers and employees are joined together by mutual dependence (Bartram, 2011). In addition, social exchange theory proposes that high commitment HRM practices shape employee behaviours and attitudes developing psychological links between employees and the organisation (Gould-Williams & Davies, 2005). It is these links that consolidate the employee-manager relationship. In turn, these positive feelings toward their manager often influence turnover intention (Maertz, Boyar, & Pearson, 2012).

Insert Table 2 approximately here

Furthermore, one third of questionnaire participants (36%) disagreed with the statement '*I trust management to look after my best interests'* (Table 2). Trust is considered a critical factor in social exchanges and facilitates the development of social exchange relationships (Gould-Williams & Davies, 2005). '[S]tudies on employee satisfaction, engagement, commitment, and loyalty identify trust in immediate supervisors and senior management as a crucial element of the organization's culture.' (Chalofsky, 2010, p.137). Other studies also showed that employees 'were more satisfied and committed to the organisation when their values were congruent with that of their supervisors'(Rosete, 2006, p.8) and that the quality of the employee-manager relationship impacts employee outcomes including job satisfaction, commitment and turnover intention (Xerri, 2013). Hence, it is reasonable to suggest that a trusting, supportive employee-manager relationship is essential for improving retention.

Remote context

The HR professionals interviewed understood the challenges for managers, e.g. 'every day they work in such hard conditions so it's a challenge to get people who care about compliance and best practice in business to go and work in these roles' (HR-2). An emergent theme was that unless a manager has lived and worked in a remote region, they do not understand what it is like, implying that

without this understanding they cannot effectively manage remote workers. This theme elicited the most emotion in the interviews with health professionals working in remote regions and was also evident in responses to the questionnaire where participants were asked about challenges of working in a remote region. Almost 10% of questionnaire respondents mentioned this discord with one participant say that 'the city based staff have no understanding of conditions, resources and remote areas' (Q-1).

Overall, the responses to the statement '*My manager understands what I do in my job'* were positive (Table 2). However, when stratified by length of time working in a remote region, the longer participants had worked in a remote region the less likely they were to agree with the statement, for example, only 15% of those who had worked in a remote region for less than one year disagreed with the statement. This proportion increased for those that had worked in remote areas for 5-9 years (25%) and 10-20 years (40%). When stratified by management status some managers (14%) and one quarter (25%) of the non-management health professionals disagreed with the statement. It is quite likely that this impacts performance against outcomes and promotes 'the disconnect' between management and remote practice (Cramer, 2006). The participants highlighted frustrations with unrealistic expectations that extended from a lack of awareness about the work environment.

One health professional's frustration was evident when asked for five words that their manager would use to describe working in a remote region, 'I just have to say they did not know, from their expectations of us they had no idea. That's four words; make it capitals THEY HAD NO IDEA! and the exclamation can be the fifth one' (HP-4). Others said 'is there a word that captures the feeling that my team leader does not understand my work?' (HR-2) and 'it was good to have someone who actually knew what it was like to work in a remote community' (HP-19). Several suggested training in distance management, 'just because they are able to manage a team face to face doesn't mean they have any capability of managing a team from a distance. My experience being out bush was that you only ever heard from a manager when they wanted to yell at you' (M-1). These comments reinforce the importance of the employee-manager relationship and evidence the factors which impact on turnover. Another factor identified in this study was 'role clarity'.

Role clarity

Clinical duties were identified as part of the management role in almost one third (32 %) of the management role descriptions reviewed. So it was common for managers to have both clinical and management responsibilities. Several managers discussed their desire to maintain their clinical skills while in a management position. One senior manager said that they thought that it was 'their point of difference as a manager' (M-18) going on to say:

> *Otherwise why wouldn't you just put generic managers in these roles that actually have formal management qualifications? There would have to be a point of difference otherwise we're not the smartest workforce solution in regards to management'* (M-18).

Occupational commitment, particularly identification as a clinician first and manager second may exacerbate the challenges. As clinicians, managers focused on client needs and this focus may, at times, influence their decision-making capabilities as managers.

Drawing on the vacancy data, role descriptions were available for 57 of the 72 management roles advertised during the study period. These role descriptions were reviewed to determine the qualifications and experience required to undertake the role. Management qualifications were required for very few positions (0.5%) and demonstrated management experience was required or well-regarded for one quarter (28%) of the positions (Table 3). Clinical qualifications were not only more highly regarded, the absence of management qualifications (or experience) corroborates the interview data. These findings identified significant deficiencies in the quality of applications and competency of new managers highlighting the importance of 'recruitment'.

Table 3 approximately here

Recruitment, turnover and retention

Recruitment was an emergent theme for reducing turnover and stabilising the remote workforce and this includes the recruitment and retention of competent, experienced managers that are suited to working in remote regions. One HR professional explained 'that managers were key; they were the critical thing and they were the deal breakers' (HR-11). The number of experienced managers who apply for management positions in remote areas is low according to one HR Manager who said 'I don't think we get too many people with management experience applying for management jobs ...We

usually recruit inexperienced managers more often than not and try to develop them and we don't do very well in developing them' (HR-10). Accessing professional development and support in remote areas is difficult so this is not ideal for an inexperienced manager.

Participants discussed the personal characteristics that they brought to the role of manager, be it their previous management skills and experience, e.g. 'an ability to keep centred in amongst the chaos' (M-16), remote experience or personal resilience, e.g. 'I grew up in the country' (M-1). These characteristics were the foundation on which they built their management career. Turnover is high in remote areas; however, stability exists, e.g. 'turnover in various parts of the organisation is quite significant but in other parts of the organisation it is not' (HR-10). Some managers gave examples about how they turned things around, e.g. 'we had 51 vacancies across remote and then we got down to having a waitlist, so there was one time when we had every position filled with a permanent appointment and then we had a few people on the waitlist' (M-18). Another said 'I took the turnover rate from 200% a year to basically we had one staff leave in the four and a half years that I was there' (M-1). The findings indicated that managing in a manner that is congruent with the values and philosophy of the community, the organisation, and the local health team was crucial in stabilising the workforce, e.g. 'It was nice to be able to say I don't have any vacancies at the moment ... We'd turned it around we'd become a unified team, we had respect' (M-9).

In summary, many studies report on the impact of poor management; however, few focus on the how increased management support could improve retention and reduce turnover. Being a manager is often viewed as a career progression within a specific field and subsequently clinicians occupy manager roles without the necessary skills and support needed to succeed in the complexity of the remote setting. In fact, only one acknowledged the rewards of management irrespective of clinical practice saying: 'I realised that you can get just as much pleasure, and job satisfaction through doing a good job in management as you can as a clinician' (M-18). Overall, these three data sources provided findings that supported the central argument of this paper; that through an effective employee-manager relationship, managers are the key to reducing turnover in remote regions.

CONCLUSION

Managers need access to support that complements their current skills so that they can manage a diverse, professional health workforce in remote regions. The HRM approach used for this study uncovered themes that were conducive to examination using social exchange theory. These themes: transition to management; rewards and incentives; employee-manager relationship; remote context; role clarity; and recruitment, turnover and retention, reinforced the notion that the employee-manager relationship is critical in remote regions and social exchange theory helps us to understand how they impact turnover. The managers in this study provided evidence that it is possible for managers to transform health facilities with high turnover into health facilities with a stable workforce through management practices such as localised policy implementation supporting health professionals and organisations. Consideration of prior management experience and qualifications; improving support and access to professional development; and building positive employee-manager relationships can reduce turnover. These improvements are imperative if managers are to be competent in managing the diverse range of challenges encountered in remote regions.

Managers are the key to workforce stability, as such, they need support in improving their ability to manage health professionals; however, this needs to extend beyond the current management workforce. Attention should also be focused on supporting health professionals in remote regions with the potential to be the next managers. These health professionals understand the remote context; they are making decisions from within the work environment, so retention through ongoing professional support is vital for organisations facing workforce shortages through high turnover. Buckingham and Coffman (1999) proclaimed that turnover is a management issue, thus managers are the key to maintaining workforce stability.

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Table 1: Demographics for Interview and Questionnaire participants

Interviews (n=19)		
Gender	Male	26%
	Female	74%
Region	Queensland	58%
	Western Australia	16%
	Northern Territory	26%
Occupation	Allied Health	11%
	Doctor	21%
	Nurse	42%
	HR	26%
Management Status	Manager	79%
	Non-Manager	21%
Online Questionnaire (n=85)		
Gender	Male	16%
	Female	84%
Region	Queensland	29%
	Western Australia	71%
Age	20-29	11%
	30-39	29%
	40-49	20%
	50-59	31%
	60+	9%
Location	Very Remote	26%
	Remote small town	17%
	Remote Regional Centre	57%
Mode of service delivery	Live in remote area	38%
	FIFO/DIDO (regional centre)	33%
	FIFO/DIDO (city)	10%
	Other	19%
Occupation	Allied Health	26%
	Doctor	8%
	IHW	4%
	Nurse	55%
	Other	7%
Management Status	Manager	42%
	Non-Manager	58%
Length of time with current employer	< 1 year	24%
	1-2 years	28.5%
	3-4 years	23%
	5-9 years	21.5%
	10 + years	3%
Length of time working in a remote region	< 1 year	27%
	1-2 years	16%
	3-4 years	26%
	5-9 years	21%
	10-20 years	7%
	20 + years	3%

Table 2: Response to questionnaire statements about their relationship with their manager (n=85)

	Strongly Agree (%)	**Agree (%)**	**Somewhat Agree (%)**	**Somewhat Disagree (%)**	**Disagree (%)**	**Strongly Disagree (%)**
I have a close relationship with my supervisor / manager	25.9	37.6	14.1	10.6	5.9	5.9
I trust management to look after my best interests	8.4	25.3	30.1	7.2	19.3	9.6
My supervisor/manager understands what I do in my job	23.5	40	15.3	10.6	8.2	2.4

Table 3: Qualification requirements for health service managements positions advertised for remote northern Australia (August 2013 – May 2014). (n=57)

	Mandatory	Desirable
Clinical Qualification	50 (88%)	3 (0.5%)
Management Qualification	3[a] (0.5%)	12 (21%)

[a] Two positions required both mandatory clinical and management qualifications.