HRM Policy choices, management practices and health workforce sustainability: Remote Australian perspectives.

Abstract

The challenges for health professionals working in remote regions are diverse, particularly where voluntary turnover is high. This study examined the influence of management practices on workforce sustainability in remote regions of northern Australia using Human Resource Management (HRM) policy choices. In this study, twenty-four semi-structured interviews with HR managers, health professionals and health managers revealed that the impact of HRM policy choices on remote workforce sustainability is significantly influenced by management practices. The emergent themes depict work environments where ineffective management practices for recruitment, remuneration, resourcing and relationships have profound consequences. Despite these contextual challenges, examples emerged where effective management practices created stability and improved retention. Hence, the findings suggest that sustainable remote health workforces are achievable where localised management practices improve equity, where employee-manager relationships are fostered, and where there is equitable access to resources and professional development.

Keywords: HRM, management, turnover, workforce, sustainability.

Keypoints

1. Management practices influence turnover decisions made in remote regions.
2. Management competence and consistent implementation of HRM policies reduces voluntary turnover.
3. The implementation of localised HRM policies in remote regions improves workforce sustainability.

> *[W]e have to treat the same things the same but different things differently and I don't think that we do that very well [...] for us to have a sustainable health workforce across remote Australia, then I think we need to invest a lot more heavily in management and leadership* (M18).

The challenges of working in remote regions are widely recognised and so too are the consequences of poor management practices (Lenthall et al. 2009; Birks et al. 2010). Lenthall et al. (2009) reported four themes from their literature review examining stress and remote nursing: remote context, workload, poor management and violence. Of relevance for the current study, management practices were 'identified as the most significant determinant in leaving' and poor human resource management (HRM) practices and inadequate management systems were linked to burnout and turnover (Lenthall et al. 2009, 210). Poor management practices included poor communication, inadequate preparation of managers, inability to access leave and lack of replacement staff to cover leave (Lenthall et al. 2009, 210). In addition, many of the poor management practices described by Lenthall and colleagues were identified in a literature review by Onnis and Pryce (2016), as well as additional challenges, including unrealistic expectations, non-localised decision-making, and role ambiguity.

In remote regions, poor management must be addressed as managers support workforces already under pressure from the geographical challenges of providing healthcare to vulnerable populations (Lenthall et al. 2011). Service delivery models for remote regions provide flexibility; however, workforce challenges continue with high turnover reported in some regions (Garnett et al. 2009; Hunter et al. 2013). Garnett et al. (2009) reported that for Remote Area Nurses in the Northern Territory, turnover varied from 30-90% over a three year period. Hunter et al. (2013) reported that turnover in one remote health department was on average 10.7% each quarter in 2011 (excluding internal transfers). McGrail and Humphreys (2015) examining GP mobility using the Medicine in Australia: Balancing Employment and Life (MABEL) data from 2008-2012 reported that overall GPs in Australia had a 4.6% mobility rate; however, when examined by remoteness, 13.3% of GPs moved from remote or very remote locations to less remote locations. During the same time period, only 3.4% moved from metropolitan, regional or rural locations to remote locations (McGrail

and Humphreys 2015). High turnover not only requires increased effort in attraction and recruitment to remote regions; it impacts the continuity of patient care. However, there are health services and remote communities that report stability which they attribute to effective and supportive management practices (Hunter et al. 2013; Hegney et al. 2002). Hence, improving management practices to minimise turnover improves remote health workforce sustainability which contributes to improved access to health services.

Humphreys et al. (2006, 33) propose that a sustainable health workforce is a subset of a sustainable health system, reporting that in the remote context 'the concept of sustainability refers to the ability of a health service to provide ongoing access to appropriate quality care in a cost-efficient and health effective manner'. They explain that professional, organisational and social dimensions are influenced by economic drivers and it is their alignment with each other that supports the health system's sustainability (Humphreys et al. 2006). This study used a strategic HRM framework to examine the perspectives offered by managers and health professionals working in remote regions providing complementary empirical evidence. This evidence contributes to Wakerman and Humphreys' (2012) vision for a health system that is sustainable and appropriate to the remote context.

There is a growing body of literature suggesting that effective management practices are influenced by both contextual and situational factors (Bartram 2011). For managers, geographical challenges are compounded by workforce issues, including poor resourcing, workforce shortages and isolation (Lenthall et al. 2009; Onnis and Pryce 2016; Wakerman and Humphreys 2012). Furthermore, reduced access to management education and support limit the opportunities for managers to develop the skills necessary to be effective in remote regions. Likewise, poor management practices are frequently offered as reasons for low retention rates of health professionals (Lenthall et al. 2009; Onnis 2014), with Birks et al. (2010, 28) reporting a need for 'good managers with good management skills'.

There is a dearth of empirical evidence using HRM theories to investigate the challenges and rewards for health professionals working in remote regions so this complementary approach provides empirical evidence where there are gaps in the literature. Furthermore, the existing focus of examining turnover through former employees is complemented by the HRM

approach with its focus on current employees and improved HR outcomes for current workforces through effective management practices and HRM policy implementation.

Remote health workforce

The remote health workforce comprises individuals from varied professions (e.g. nurses, Aboriginal Health Workers, psychologists), who form approximately 2% of the Australian health workforce (Table 1). The remote health workforce is a subset of the entire health workforce and faces the same issues of global workforce shortages with the added challenges of geographical remoteness (WHO 2010). In remote regions, the working relationships between health professionals are reflective of those in cities; however, there are differences shaped by geographical remoteness (Birks et al. 2010). In remote regions, the scope of a professional role is often broader than similar roles in cities (e.g. nurses manage chronic illnesses and respond to emergencies, often out of hours without relief until a doctor can be flown in which may be many hours depending on availability and location) (Hegney et al. 2002; Birks et al. 2010). Furthermore, multi-disciplinary teams often result in non-traditional hierarchies (e.g. cross-disciplinary reporting relationships), inequitable working conditions between professionals (e.g. nurses oncall outside of clinic hours, Industrial Awards) (Birks et al. 2010; Lenthall et al. 2011; Santhanam et al. 2006). Therefore, when considering sustainability, it is essential to recognise that multi-disciplinary teams provide the health workforce required in remote regions in northern Australia, and across remote areas internationally; areas where healthcare is provided by the health professional present, willing and able to assist.

Although the remote workforce may comprise only a small proportion of Australia's health professional workforce (Table 1), they work across a large geographical area, and often work to their full scope of practice and with limited resources (Bent 1999; Hegney et al. 2002). Consequently, managing workforces in remote Australia necessitates management practices compatible with the working conditions, which can include remote-based health services (e.g. primary healthcare centres), Fly-in/Fly-out (FIFO) services, outreach services, Telehealth, emergency services (e.g. Royal Flying Doctor Service (RFDS)) and small remote hospitals. Managers may be located in remote regions where they are professionally and geographically isolated; or they may be managing by distance, at times from regional or metropolitan cities hundreds of kilometres away with limited understanding of the context in which the health

professional is working. Both scenarios require effective management practices so that healthcare remains accessible for remote populations.

Table 1 approximately here

This study used HRM policy choices to examine the influence of management practices on workforce sustainability. The managers and health professionals who participated in this research provided their perspective based on their experiences working in remote Australia.

Methods

This qualitative study used a constructivist methodology to identify the emergent themes. The qualitative data provided a greater depth of understanding on the topic through narrative accounts of working in remote regions which were useful for gaining rich detail about phenomena 'situated and embedded in local contexts' (Johnson and Onwuegbuzie 2004, 20).

The study used a purposive snowballing sampling method to recruit participants who were either: 1) health professionals working in remote regions (HP), 2) managers of health professionals working in remote regions (M), or 3) HR managers (HR) in organisations that employed health professionals working in remote regions of northern Australia. This method captured three perspectives to construct a multi-dimensional picture and ensured that the sample contained participants with longevity (more than five years) working in remote regions. Participants with longevity were chosen as this study was interested in sustainability; therefore, the perspectives of those who have chosen to remain were of particular interest. There were 24 participants; with whom semi-structured interviews ranging from 45-90 minutes were conducted in-person (42%) or via telephone (58%), depending on the participant's location.

Remote northern Australia was defined using the Australian Bureau of Statistics (ABS) categories for 'remoteness' based on 'how far one travels to access goods and services' (ABS 2003, 2). The ABS (2003) categories of *remote* and *very remote* were combined and are jointly referred to as 'remote'. Onnis and Pryce (2016) examined the challenges of working in remote and very remote communities, and found that the challenges were more similar

than they were different; hence, collapsing the categories appeared to be an acceptable approach for this study. Remote northern Australia included the Kimberley, the Northern Territory's Top End, North West Queensland and Far North Queensland.

Implementing established processes for data collection and analysis contributed to the reliability of the qualitative data (Creswell 2009). Interviews were recorded and transcribed to ensure the participant's actual words were analysed improving the accuracy of the data. Participants were offered an opportunity to review the transcript to verify accuracy of the content, often referred to as member-checking (Carlson, 2010). A thematic analysis of the de-identified transcripts was conducted using NVIVO10. The HRM policy choices from the Harvard Analytical Framework for HRM (Beer et al. 1984) provided structure for the first level of analysis. Next, each HRM policy choice category was reviewed and then analysis conducted to identify the HR constructs contained in the data. Then, analysis of the data by HR construct identified the emergent themes. Finally analysis of these emergent themes identified four areas where management practices influence workforce sustainability. Construct validity for the HR constructs was established through the development of a data coding guide (Table 2) which included descriptions for each theme ensuring consistency in coding (Creswell 2009, 228). In addition, transcripts were reviewed for coding consistency by two other researchers.

Table 2 approximately here

The Harvard Analytical Framework for HRM

The Harvard Analytical Framework for HRM which emphasises the 'human' aspects of management, guided data analysis and interpretation (Beer et al. 1984; Safdar 2012). The Harvard Analytical Framework for HRM policy choices are: HR Flow, Reward Systems, Employee Influence and Work Systems (Beer et al. 1984). These HRM policy choices result in desirable HR outcomes for organisations, such as retention and job satisfaction. Therefore, management practices that effectively implement HRM policy choices are desirable for organisations seeking workforce sustainability.

Participants

The 24 interview participants comprised 15 managers and 16 health professionals. Overlap occurred where six participants held management positions with clinical responsibilities and one participant in a clinical role when interviewed, who had, until recently, held a management role in a remote region for more than ten years. Participants worked for government health departments, non-profit organisations, Aboriginal Community Controlled Health Organisations and included: CEOs, nurses, doctors, a dentist, Directors of Nursing (DON), executive directors, general practitioners (GP), HR managers, nurse educators, a nurse manager, social workers, a physiotherapist and a nurse practitioner. Participants were based in cities (8%), regional centres (38%), remote towns (25%) and very remote communities (29%). The higher proportion of nurses (50%) and female participants (75%) is consistent with the demographics of the remote health workforce (HWA 2014). Additional information about the characteristics of the participants is presented in Table 3.

Table 3 approximately here

Findings

The HRM policy choices from the Harvard Analytical Framework for HRM (Beer et al. 1984) guided data analysis providing a framework to explore the emergent themes. Using the constructivist methodology, the HRM policy choices, HR constructs and emergent themes were used to explore the influence of management practices on workforce sustainability. The findings that emerged through data analysis are presented in Table 4 where reading from left to right it can be seen that the HRM policy choices provide the overall structure. Next, are the HR constructs for each HRM policy choice, each containing emergent themes. Finally, in the last column, there are the four key areas where management practices can influence workforce sustainability emerge.

Table 4 approximately here

Management practices and workforce sustainability

The findings indicated that management practices are important for workforce sustainability with all participants describing the influence of management practices on their employment experience. The HR managers described the challenges in attracting and

recruiting managers, e.g. 'I don't think we get too many people with management experience applying for management jobs' (HR10). Another HR Manager highlighted some of the poor management practices that they witnessed, saying:

> *Things go really, really wrong [...] Now, I saw this again and again and I did ask that team leader [...] I said 'what would you do differently next time?' [They said] I'd speak to the referee instead of just emailing them* (HR11).

Health professionals also described experiences which they believed arose from management incompetence, e.g. they 'get promoted to a position incompetent [...] their greatest strength is then their greatest weakness and they fall apart because they can't manage' (HP16). Several managers described the transition from their clinical role to a management role, emphasising difficulties in accessing professional development and the limited professional support available when living and working in remote regions, all of which contributed to their need to learn-on-the-job, e.g. 'I went from finding my way and hoping that I wasn't making too many mistakes, to having a pretty good idea of what I was doing' (M1). These perspectives provide three views of a similar phenomenon. That is, the organisation is recruiting inexperienced managers, the managers know that they are inexperienced and are doing their best to seek professional support which both the HR managers and the managers acknowledge is difficult to do when working in geographically remote regions. Consequently, the manager works the best way they can given the circumstances, which may result in the poor management practices reported by health professionals in remote regions. These poor management practices influence workforce sustainability.

An examination of management practices and their impact on workforce sustainability considers how these practices are experienced by health professionals working in remote regions of northern Australia. The analysis revealed that their experience was influenced by a range of factors. The emergent themes are described by four key areas where management practices influence workforce sustainability: recruitment, remuneration, relationships and resourcing. The evidence suggests that effective management practices will improve workforce sustainability.

Recruitment (HR Flow)

Where *HR flow* describes the processes involved in the movement of employees within or through organisations (Beer et al. 1984); 'recruitment' emerged as an area where management practices influence workforce sustainability. Data analysis identified eight emergent themes all of which described where management practices can influence workforce sustainability. These emergent themes are examined below.

Turnover is high; however, there is some stability

High turnover was a challenge raised by all participants; however, some participants explained that while high turnover was common there are areas of workforce stability. HR Managers highlighted aspects of workforce stability, saying that, 'Some people stay forever and other people go really quickly. So you go quickly or you stay long, there's not much in between' (HR11); and 'Turnover in various parts of the organisation is quite significant but in other parts of the organisation it is not' (HR10). Health professionals also mentioned stability within areas of high turnover, e.g. 'we have twelve nursing positions but only seven of them are filled. So the other five are just rotating nurses that come in and out every, well I just met one at the airport today who is only here for a week' (HP7). This suggests that while turnover is common, stability is possible. Almost one third of the managers described how their management practices had stabilised their workforce, e.g. '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' (M18). In contrast, some described times when their management practices had contributed to increased turnover e.g. 'I wasn't managing him well [...] that's when I lost two good staff' (M8). This suggests that management practices play a key role in improving workforce sustainability.

Job security is influenced by external factors and personal circumstances

As a subset of the global health workforce, the remote health workforce is influenced by the labour market and contemporary employment practices regarding job security. The mobility of health professionals, through increased agency staff and short-term contracts, together with shortened funding cycles for non-profit organisations created further challenges making it difficult for organisations to develop organisational commitment through offering job security. One HR manager explained, 'Every contract we issue says you have a contract until we have funding' (HR2). However, some health professionals were not seeking job security and viewed working in a remote region as an adventure or an opportunity to fast-track their

career. Consequently, they were surprised they were required to renew their contract, saying, 'I thought I couldn't just keep going from fortnight to fortnight' (HP7). Therefore, where job security is not desired, managers will need to seek alternative methods to improve workforce sustainability.

Managers are prematurely promoted

Many participants viewed remote regions as opportunities to gain experience and fast-track their career, e.g. 'I think anyone could land on their feet if they go rural and remote [...] the labour market pool is reduced because nobody wants to go' (HP22). While reduced competition in can advance careers; it can also result in premature promotion. Where health professionals are promoted into management positions before developing or having the capacity to develop the level of competence required; the effectiveness of their management practices are greatly reduced. This results in further unwanted turnover as managers are unable to perform satisfactorily. One HR manager explained, 'one of the most significant things is we promote clinicians as good clinicians into management positions and then we don't support them with any management education' (HR10). When clinicians transition into management roles, it is imperative that they are trained and supported adequately to be confident and competent in effectively managing remote workforces.

Managers are not provided with adequate professional development

Inexperienced managers have limited access to management training and support, e.g. 'We usually recruit inexperienced managers more often than not and try to develop them and we don't do very well in developing them' (HR10). All participants described difficulties accessing professional development, e.g. 'I would have probably spent time going to university and learning a little bit more about management but when you are actually out in the field doing it you don't really have that opportunity' (M12). Furthermore, many explained that the professional development available is usually for clinical skills. A variety of approaches were described, with no consensus on the best approach. Two thirds of the managers reported that they sought their own management development solutions once in a management position e.g. 'I put myself through a short course on management skills 101' (M18). Effective management practices are dependent on competent and confident managers; hence, these findings emphasise the need for professional development for clinicians transitioning into management roles in remote regions.

Recruiting for person-fit improves retention

High turnover created pressure to fill vacancies, e.g. 'you are desperate for staff most of the time and so beggars can't be choosers' (M8). Recruitment processes seek to find the most suitably skilled and experienced applicant; however, in remote regions managers must also consider their capacity to work in remote conditions, e.g. 'the longer you do it the more you can pick somebody who is probably going to have a higher chance of being out there for a while and enjoying it' (M18). Recruitment processes were influenced by effective management practices, particularly in terms of selecting a suitable workforce:

> *[Y]ou look at gender mix, you look at age mix, you look at cultural appropriateness ... my experience is that I think nine out of ten people who recruit into remote don't give any of that any consideration they just employ the person that ticks all the boxes ... I think that's where we let ourselves down* (M18).

The findings suggest that it can be difficult for managers to select suitable applicants, e.g. 'Some people just tend to not recruit well' (M9); and 'you try to explain what it is like living in a remote community' (M17). Person-fit contributes to turnover, e.g. there are 'those who just land and want to get straight back on the plane again' (M18); however, there are 'a substantial amount of the workforce, rural and remote nurses that actually love it and are fully satisfied' (HR6). Therefore, management practices can improve workforce sustainability by attracting health professionals suited to remote regions.

Realistic expectations improve retention

In conjunction with person-fit, all participants suggested that realistic expectations about working in remote regions are important. Managers explained, 'the reality for most people is that it's not a holiday; it's probably the hardest work they have ever done in their lives' (M1). Participants suggested that most people 'research the area before an interview but some do not have a clue' (M5); and 'many arrive in these very remote places with expectations that are not valid really and they wonder what on earth they have struck when they come' (M15). One HR manager explained:

> *I think we have probably been through a phase where we were 'gilding the lily' about what is was like coming up here but I think that we don't do that as much as we used to because we realised that that doesn't help with turnover* (HR10).

Participants suggested that orientation was an important management practice, e.g. ‘they sent me an A4 folder full of information about what to expect in a remote community’ (HP4). Surprisingly, only a few participants discussed recruiting locally emphasising the social and economic benefits associated with employing a local workforce, e.g. ‘I am a big believer in developing the solution locally [...] that includes developing local workforces’ (M3). Hence, management practices can improve retention through local more realistic recruitment processes that focus on the benefits of a workforce that enjoys working in remote regions.

Organisational-identity improves attraction and retention

A few participants reported that the connection between self-identity and an organisation’s reputation improves that organisation’s ability to recruit health professionals, e.g. ‘you cannot underestimate the importance of the brand or the image that they portray’ (M18). Two participants specifically identified RFDS, saying, ‘they don't have any of the recruitment issues because people fall over backwards to work for them’ (M18); and ‘having a sense of self worth, or self-esteem, that I work for RFDS’ (HP16). This suggests that for some organisations workforce sustainability is linked to perceived organisational-identity.

Turnover promotes occupational commitment over organisational commitment

The findings suggested that where there is high turnover health professionals are committed to their profession more than their employer. Participants explained that where there is duplication of services in remote regions, unhappy health professionals often just change employers. That is, they remain working in the same community, with the same clients; they will just be employed by a different organisation demonstrating commitment to their profession, not their employer, e.g. ‘they've now got a new manager ... who is diabolical by all accounts so these people that have worked there for 15-20 years in those communities have now just resigned and they've moved [to a different service provider]’ (M18). This emergent theme suggests that for management practices to effectively influence retention, managers need to consider HRM policy choices that support occupational commitment if they wish to increase retention through organisational commitment.

Remuneration (Reward Systems)

Reward systems describe the extrinsic and intrinsic rewards that employees receive for their work effort (Beer et al. 1984). In this study, three emergent themes capture participants' views about incentives and rewards. While management practices associated with financial remuneration were more commonly linked to retention; intrinsic rewards also influenced retention as described below.

High levels of job satisfaction exist

Many health professionals reported job satisfaction, with one saying, 'you get so much more job satisfaction out of it because you able to work to your full scope' (HP24). They reported satisfaction through intrinsic motivators as well as financial rewards, with one manager saying, 'there is a real sense of engagement and working together for the good of community' (M1). These findings suggest that managers should consider the role of intrinsic rewards, like satisfaction, in workforce sustainability.

Financial incentives improve attraction but not retention

Most participants reported that high remuneration attracts people to remote regions but did not improve retention, providing further support for the previous emergent theme. Some managers felt that financial incentives disadvantage organisations with funding constraints, e.g. 'because we are a non-government organisation we can't subsidise housing and we find that quite an issue if the state department is advertising a similar position' (M5). Managers explained these types of inequities were often a hindrance to workforce sustainability. This study found that few health professionals remained in remote areas purely as a result of financial remuneration, e.g. 'money doesn't motivate people to stay for the long term. Not in my experience and it had certainly never been a driver for me' (M1). Therefore, management practices need to encourage health professionals attracted by financial incentives to remain in remote regions.

Remuneration differences exist between professions

Some had concerns about the inequity of remuneration and reported large differences in remuneration between professions, e.g. 'the woman told me that she was doing the same job as the person beside her and she was getting $30,000 less' (HR2). In contrast, another manager did not find equity problematic, saying 'things were inequitable but I don't think it ever caused real conflict in any of the workplaces that I was in' (M9). While professional

entitlements (e.g. Industrial Awards) influence remuneration, making it unlikely the distribution of resources will be equitable, with multi-disciplinary teams more effective management practices can improve equity, as one HR Manager explained:

> *irrespective of what role you've got, you get the same amount of allowance per week because it's about the cost of living, where we know some of the benchmarks are about your salary package and whether you are a doctor or a nurse [...] But we are saying everybody [...] if they work and reside in community then they are entitled to the same amount of allowance* (HR14).

Relationships **(Employee Influence)**

Employee Influence includes opportunities for participation in decision-making (Beer et al. 1984). These opportunities create relationships inherent in management practices that accelerate feelings of inclusion, social cohesion and organisational commitment. In this study, participants described aspects of working in remote regions associated with the quality of relationships (e.g. collegial) or the lack of meaningful relationships (e.g. lonely). While these seven emergent themes are discussed separately, they all comprise aspects of human interaction that support human connection through relationships. Hence, management practices fostering human relationships influence workforce sustainability.

Personal isolation influences retention

Participants described feelings of personal isolation experienced when working and living in remote regions. A few participants explained that in the absence of their family and friends, colleagues help to reduce the sense of isolation, e.g. 'they're leaving their friends and family behind so we become in one way their extended family' (M5). Other managers explained that in remote regions personal characteristics and talents are used to create supportive work environments, e.g. 'people are coming in and using the commercial kitchen and making food for everybody else' (M15). Management practices recognising the impact of personal isolation will improve workforce sustainability.

Embeddedness influences retention

Similarly, embeddedness can improve workforce sustainability in two ways. Firstly, connections minimise feelings of isolation and secondly, community ties increase the likelihood that health professionals will remain, e.g. 'if I didn't have a partner here now I

would be less likely to stay as long as I have' (HP21). Participants reported that colleagues and community connections provide social support networks, e.g. 'expanding their social world outside of their work world' (M15). Therefore, management practices encouraging community engagement are likely to improve workforce sustainability.

Professional support improves retention

The previous emergent themes described aspects of personal support whereas this emergent theme focused more specifically on professional support at a personal level. The next emergent theme considers perceived support at an organisational level. Professional support was important for all participants, e.g. 'it's the only contact I have with other physios' (HP23); and 'the culture is supportive' (M5). Hence, management practices that shape supportive workplace cultures can influence workforce sustainability.

Perceived Organisational Support (POS) may improve retention

According to participants the level of employer support varies, both within and between organisations. Some health professionals described unsupportive organisations, e.g. 'from their expectations of us they had no idea' (HP4). However, other health professionals described supportive organisations, saying 'when you've got an executive and health service that supports you [...] it makes you want to stay' (HP24). In many remote areas, managers represent the organisation; therefore, management practices influence the level of support health professionals perceive the organisation provides.

Autonomy is both a benefit and a necessity

Generally, autonomy was seen as both a benefit and a consequence of geographical remoteness, e.g. 'autonomous practice which is what you need to be able to do when you are in a remote area' (M3); and 'purely because of the ability to be more autonomous' (HP24). Therefore, management practices associated with the emergent themes described earlier such as person-fit, realistic expectations, and isolation, may be more effective if they also consider individuals preferences for working autonomously particularly where working conditions necessitate autonomy (e.g. single nurse posts).

Situational factors influence Leader Member Exchange

Leader Member Exchange (LMX) describes the quality of the employee-manager

relationship, and contributes to effective communication and shared understanding of the challenges of working in remote areas. Health professionals described the benefit of LMX, particularly where managers understand the remote context:

> *it just helps to have someone who knows where the communities are, what the troubles are, travelling between, how people get there, roads cut off , things like that. Someone that understands the little things that make you day a lot harder* (HP19).

LMX relationships influences organisational commitment

When participants were asked to describe how they thought their manager would describe working in remote regions, differences in employee-manager relationships emerged. Some described managers who lacked understanding of remote work environments resulting in unsupportive relationships:

> *your unit cost to deliver one half hour session of service is like six times what is costs a service provider in a metropolitan area. I just thought, oh my god, she's got no idea. It is the cost of remote service delivery that is so high, we have to get somebody out to the area, we have to pay for their accommodation* (M5).

Others described managers that were effective in remote regions highlighting the significance of the employee-manager relationship, e.g. 'the respect that I had for that leadership and the nurturing and support that I got' (M8). It appears that management practices reinforcing shared understanding of remote working conditions are significant for workforce sustainability.

Resourcing **(Work Systems)**

Work systems describe the way work is conducted and contribute to perceptions of management control and organisational culture (Beer et al. 1984). This study found that management practices are variable within work systems and create dissatisfaction and perceived injustices, the six emergent themes are discussed below.

Work conditions provide further challenges for managers

Aspects of poor resourcing described by participants included outdated equipment and excessive work hours; however, the most frequently discussed concern was accommodation.

Most participants described accommodation as being expensive, poor quality, inequitably distributed and often did not meet expectations. In contrast, other participants had satisfactory accommodation, which was free or subsidised by their employer, e.g. 'the quality of the [nursing] accommodation was so poor [...] one room flats, like bedsits out the back, in the compound of the clinic' (HP4); and 'we've got a great house [...] three bedroom, air con in every bedroom, we've got a water view [...] accommodation was not an issue' (HP7) (doctor). In addition, participants discussed safety concerns, particularly fatigue associated with excessive oncall work at night, workplace bullying, violence and burnout. These are discussed later when considering wellbeing; however, this emergent theme highlighted the influence of management practices on safe work conditions:

> *they employed three new nurses all N3, now they need a lot of supervision, can't do any on-call [...the] nurses who can do on-call, so they are pretty much on-call all the time and they're knackered and then they get snappy because they are sleep deprived and then they leave. Then you get a whole new batch in* (HP7).

Several participants discussed the cyclical nature of resource challenges, evident in the above scenario, that is, poor management practices due to workforce shortages and turnover, create further workforce shortages and turnover.

Attention to individual wellbeing influences sustainability

Health professionals working in remote regions need regular time away from their remote workplace. Some participants reported that there was insufficient leave whereas for others it was plentiful but difficult to access, as one manager explained, 'Having access to leave and being able to use it are two completely different things' (M1). In fact, safety was a concern for all participants, particularly fatigue, workplace bullying and violence, e.g. 'a lot of nurses become very stoic and put up with it. If someone violent and aggressive turns up and you're the only nurse at the primary healthcare centre at night what do you do? Call the police. Well if there's police there, other than that you've got to deal with it' (M8). This manager emphasised that for remote nurses available resources, in this case the police, may not be available; hence, effective management practices must include the localisation of policies to provide safe working conditions for health professionals working in remote regions without the resources taken for granted in cities.

Management and clinical responsibilities conflict

Managers with clinical responsibilities must manage competing responsibilities. It was widely acknowledged that clinician-managers must prioritise clinical responsibilities above management responsibilities influencing their capacity to be an effective manager, e.g. 'clinicians being managers as well it is difficult [...] their patients and their clinical workload is the priority. The administrative stuff can wait' (M9). Both managers and health professionals suggested that clinician-managers have difficulty switching between their clinical and management role, view the management role as less important than their clinical role or view the management role as an extension of their clinical role. In contrast, one manager proclaimed, 'you can get just as much pleasure, and job satisfaction through doing a good job in management as you can as a clinician'(M18)'. Therefore, it is essential that managers fully embrace the management role if they are to manage effectively.

Mix of labour influences organisational commitment

Participants explained how a mix of labour sources and employment modes (e.g. short-term contracts, agency, FIFO) shape reliable and consistent service provision e.g. 'everyone is poaching everyone else to get the staff' (M8). Participants described how the mix of labour impacts organisational commitment, e.g. 'people don't take ownership if they are not part of the unit' (HP22); and:

> *In nursing the great stopgap measure is agency. So you've got this workforce who, I won't say are mercenary, but they are always there to tap into [...] [T]he most important backbone to sustainability is that workforce that either has grown up or is rural and remote in their heart, it's in their DNA and they stay [...]You can use supplementary agency staff to top up the boots on the ground and you can recruit in 12-18 months [contract staff] knowing that they are going to come. [It is] those mainstayers that you've got to look after* (M8).

Policies should be localised

Most participants accepted remoteness as part of the context, saying 'remote is remote you can't change the geography' (HP4); yet, they described frustration with work systems and management practices emphasising that in remote regions policies need to suit the work environment, e.g. 'sometimes people grab policy from the city and put it straight into the rural context and that doesn't apply' (M22). While this emerged as a theme in its own right, the localisation of policy is a thread that goes through all four management practice areas.

More specifically, localised recruitment policies can respond to lower demands for job security, create realistic job previews, provide flexibility to accommodate person-fit and occupational commitment, and improve access to professional development, including management development for newly promoted remote-based managers. In terms of remuneration and resourcing, localised policies can minimise perceived inequity in remuneration, resource allocation and working conditions, including access to leave and the provision of safe workplaces. Finally, through the development, implementation and review of localised policies, managers strengthen relationships and form an appreciation of the challenges of working in remote regions. Management practices that strive to localise policies without compromising the integrity of health services are better positioned to create sustainable workforces.

Implications and conclusions

The emergent themes depict contextually challenging work environments where ineffective management practices for recruitment, remuneration, resourcing and relationships have profound consequences. Despite contextual challenges, some examples emerged of how effective management practices created workforce stability through localised implementation of HRM policies. The findings suggest a setting where managers incognisant of the value of localised implementation of HRM policies has resulted in workforce instability. While previous studies have described how organisations can improve retention (e.g. financial incentives), this study contributes to the literature proposing that the implementation of localised HRM policies will improve workforce sustainability. This study's contribution is the use of the remote context to show that it is the effective implementation of localised HRM policies by managers that improves remote health workforce sustainability.

The influence of management practices on recruitment outcomes is two-fold. It is crucial that competent managers are recruited and that these competent managers recruit suitable health professionals for remote health services. The findings from this study support the proposal that in a hierarchy, people rise to their level of incompetence (Taylor et al. 2010). This phenomenon, called the 'Peter Principle', explains why people are promoted for being good at their job, to positions where they are unable to perform satisfactorily (Fairburn and Malcomson 2001), often arising from differences in the competencies required to undertake

management roles and those required for clinical roles. This study found that remote-based managers have reduced access to management development programs, particularly when they transition into management roles in remote regions (Hegney et al. 2002). Therefore, effort is required to access management training, requiring clinician-managers to recognise the need for management training. For remote-based managers, management responsibilities often extend beyond the workplace. These broader management responsibilities, together with geographic isolation means that the implications of poor management practices take longer to be noticed, often with greater repercussions once identified.

Management practices influence remuneration and the equitable distribution of resources. There was a widely held view in this study, that financial rewards improve attraction but not retention which is consistent with Wright and Kehoe's (2008, 15) proposal that job satisfaction only influences retention when 'pay is at a level that would require employees to take a pay cut if they left'. This study proposes that for remote health professionals, retention is contingent on both intrinsic and extrinsic rewards. Therefore, only offering financial incentives does not mean employees will feel valued and reciprocate with commitment behaviours (Ko and Hur 2014). Instead, managers could focus on improving employment relationships and ensuring that rewards are aligned with individual employee motivations (Ko and Hur 2014). Regardless of whether they consider themselves clinicians with management responsibilities, or managers with clinical responsibilities, the management philosophy that accentuates entrepreneurial practices is at odds with the values of health professionals in the caring profession (Bolton 2003). Nowhere is this more evident than in remote health services where health professionals, 'live and work in conditions few would tolerate because of a deep need to provide care for their patients' (Garnett et al. 2008, 67).

Effective management practices foster healthy working relationships which were considered an essential aspect of workforce sustainability. Social Exchange Theory (SET) explains the employment relationship using perceived organisational support (POS) to describe the relationship between the employee and the organisation, and leader-member exchange (LMX) to describe the quality of the relationship between the employee and their manager (Ko and Hur 2014; Xerri 2013). SET has relevance to this study. Health professionals working and living in remote regions often feel professionally isolated; hence, a supportive employee-manager relationship becomes vital for workforce sustainability, especially for

those geographically separated from their regular support networks (Buykx et al. 2010). Moreover, SET proposes that employees who perceive that the organisation treats them well, reciprocate by working to benefit the organisation. Consequently, employees who consider their employer supportive are more likely to reciprocate which often, as this study found, translates into improved retention (Xerri 2013).

In remote regions, localised management practices are critical. Robertson (2014, 78) commenting on the lack of specific management training for her role as Station Manager in Antarctica said, 'I thought that surely such a harsh and uncompromising environment would create unique management scenarios that aren't found in the average workplace'. The findings from this study, support Robertson's (2014, 78) conclusion about managing in a remote and isolated location, 'Towards the end of my time in Antarctica I would reflect on the leadership and management challenges and agree. They are no different in principle, but they are vastly different in application!'; thus, emphasising the significance of implementation.

In this study, managers and health professionals working in remote northern Australia described employment experiences that emerged from ineffective management practices when implementing HRM policy choices. These ineffective management practices included inconsistent implementation and failure to localise policies to the remote context. The findings from this study suggest that a sustainable remote health workforce is achievable where localised management practices improve equity, where employee-manager relationships are fostered, where there is perceived organisational support, adequate and equitable access to resources, and access to professional development. Hence, management practices that effectively translate HRM policy choices into desirable HR outcomes are vital for improving remote workforce sustainability.

References

Bartram T (2011) Employee management systems and organizational contexts: a population ecology approach. Management Research Review 34(6), 663-677.

Beer M, B Spector, PR Lawrence, DQ Mills and R Walton (1984), Managing Human Assets. The Free Press, New York.

Bent A (1999) Allied health in Central Australia: challenges and rewards in remote area practice. Australian Journal of Physiotherapy 45(3), 203-212.

Birks M, J Mills, K Francis, M Coyle, J Davis and J Jones (2010) Models of health service delivery in remote or isolated areas of Queensland: a multiple case study. Australian Journal of Advanced Nursing 28(1), 25-34.

Bolton S (2003) Multiple roles? Nurses as managers in the NHS. The International Journal of Public Sector Management 16(2), 122-130.

Buykx P, J Humphreys, J Wakerman and D Pashen. (2010) Systematic review of effective retention incentives for health workers in rural and remote areas: towards evidence-based policy. Australian Journal of Rural Health 18, 102-109.

Campbell N, L McAllister and D Eley (2012) The influence of motivation in recruitment and retention of rural and remote allied health professionals: a literature review. Rural and Remote Health 12, 1900.

Carlson J (2010) Avoiding Traps in Member Checking. The Qualitative Report 15(5),1102-1113.

Creswell, JW (2009) Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 3rd Edition. Los Angeles: Sage Publications, Inc.

Fairburn JA and JM Malcomson (2001) Performance, Promotion, and the Peter Principle. The Review of Economic Studies 68(1), 45-66.

Garnett S, K Coe, K Golebiowska, H Walsh, K Zander, S Guthridge, S Li and R Malyon (2008) Attracting and Keeping Nursing Professionals in an Environment of Chronic Labour Shortage: A Study of Mobility among Nurses and Midwives in the Northern Territory of Australia, Charles Darwin University Press, Darwin. http://digitallibrary.health.nt.gov.au/dspace/bitstream/10137/228/1/nurse_report.pdf (accessed 28/10/2015).

Health Workforce Australia (HWA) (2014) Health Workforce by Numbers - Issue 3. http://iaha.com.au/hwa-releases-second-edition-of-health-workforce-by-numbers/ (accessed 19/04/2016).

Hegney D, A McCarthy, C Rogers-Clark and D Gorman (2002) Why nurses are Resigning from rural and remote Queensland health facilities. Collegian 9(2), 33-39.

Humphreys JS, J Wakerman and R Wells (2006) What do we mean by sustainable rural health services? Implications for rural health research. Australian Journal of Rural Health 14(1), 33-35.

Hunter E, L Onnis, R Santhanam-Martin, J Skalicky, B Gynther and G Dyer (2013) Beasts of burden or organised cooperation: the story of a mental health team in remote, Indigenous Australia. Australasian Psychiatry 21(6), 572-577.

Kabene SM, C Orchard, J Howard, M Soriano and R Leduc (2006). The importance of human resources management in health care: a global context. Human Resources for Health 4(1).

Ko J and S Hur (2014) The Impacts of Employee Benefits, Procedural Justice, and Managerial Trustworthiness on Work Attitudes: Integrated Understanding Based on Social Exchange Theory. Public Administration Review 74(2) 176-187.

Lenthall S, J Wakerman, T Opie, S Dunn, M MacLeod, M Dollard, G Rickard and S Knight (2011) Nursing workforce in very remote Australia, characteristics and key issues. Australian Journal of Rural Health 19(1), 32-37.

McGrail MR and JS Humphreys (2015) Geographical mobility of general practitioners in rural Australia. The Medical Journal of Australia 203(2), 92-6.

Onnis L (2014) Managers are the key to workforce stability: an HRM approach towards improving retention of health professionals in remote northern Australia. Conference Proceedings, 28th ANZAM Conference, 3-5 December, UTS Sydney. ISBN:978-0-9875968.

Onnis L and J Pryce (2016) Health professionals working in remote Australia: a review of the literature. Asia Pacific Journal of Human Resources 54: 32-56. doi:10.1111/1744-7941.12067

Robertson R (2014) Leading on the Edge, John Wiley and Sons, Australia.

Safdar R (2012) Relative and Cross-National Human Resources Management Research: Development of a Hypothetical Model. Global Journal of Management and Business Research 12(2) 7-19.

Santhanam R, E Hunter, Y Wilkinson, H Whiteford and A McEwan (2006) Care, Community, Capacity: Rethinking Mental Health Services in Remote Indigenous Settings. Australian Journal of Primary Health 12(2), 51-56.

Taylor R, B Blake and F Claudio (2010) An analysis of the opinions and experiences of Australians involved in health aspects of disaster response overseas to enhance effectiveness of humanitarian assistance. School of Population Health: University of Queensland.

Wakerman J and J Humphreys (2012) Sustainable workforce and sustainable health systems for rural and remote Australia. MJA Open (Supplement 3), 14-17.

World Health Organisation (WHO) (2010) Increasing access to health workers in remote and rural areas through improved retention. France: WHO Press.

Wright PM and RR Kehoe (2008) Human resource practices and organizational commitment: A deeper examination. Asia Pacific Journal of Human Resources 46(1), 6-20.

Xerri M (2013) Workplace relationships and the innovative behaviour of nursing employees: a social exchange perspective. Asia Pacific Journal of Human Resources 51(1), 103-123.

Table 1: Proportion of health workforce working in remote Australia in 2012

Health Profession	**Remote** (number employed)	**Australia** (number employed)	**Proportion of workforce in remote regions**
Medical	1435	97,345	1.47%
Nursing	6172	239,758	2.57%
Allied Health	945	92,121	1.03%
Aboriginal & Torres Strait Islander Health Worker	144	348	41.38%
Aboriginal & Torres Strait Islander Health Practitioner	142	233	60.94%
TOTAL	8,838	429,805	2.06%

(Source: HWA 2014)

Table 2: HR Construct definitions to guide data analysis

HR Constructs	Examples of coding
Autonomy	Freedom from external control; independence, autonomous practice, sole practitioner.
Embeddedness	Connections to place, organisation or community.
LMX	The relationship between the employee and their manager, discusses issues with manager.
Equity	Includes distributive and procedural justice, fairness.
Incentives	Monetary and non-monetary rewards used to motivate individuals.
Job Satisfaction	Employee is satisfied with aspects of the job.
Job Security	Employment feels secure, ongoing/continuity of employment.
Occupational commitment	Professional loyalty, commitment to profession
Organisational commitment	Loyalty, commitment to the employer, organisational-ties.
Organisational-identity	Individuals feel attached to aspects of the organisation that reflect positively on themselves.
Person- Fit	The closeness of the person's characteristics to those required.
Relatedness	Isolation/connection with others - colleagues, family and friends.
Professional Development	Professional skill development, skills, conferences, mentoring.
POS	Support perceived at an organisational level
Realistic Expectations	How close the preconceived expectations about the job and/or location are to their experience.
Role Conflict	Role contains conflicting responsibilities.
Turnover	Leaving remote workplace prematurely.
Wellbeing	The physical and emotional health of individuals.
Work Conditions	Resources, infrastructure, safety, 'the politics' and work systems.

Table 3: Characteristics of participants

HP/M/HR (Interview Method)*	Position	Discipline	Gender	Location	State
M1(T)	Health Service Manager	Nursing	Male	Town	NT
HR2(T)	HR Manager	HRM	Female	Regional	QLD
M3(IP)	Executive Director	Nursing	Male	Regional	QLD
HP4(T)	General Practitioner	Medicine	Female	Remote	NT
M5(T)	CEO	Nursing	Female	Town	WA
HR6(IP)	HR - Recruitment	HRM	Female	Regional	AUST
HP7(T)	General Practitioner	Medicine	Female	Remote	NT
HP8(IP)	Nurse Educator	Nursing	Male	Regional	QLD
M9(IP)	Executive Director	Nursing	Female	Regional	QLD
HR10(T)	HR Manager	HRM	Male	Town	WA
HR11(IP)	HR Manager	HRM	Female	Regional	QLD
M12(T)	Director of Nursing	Nursing	Female	Town	WA
M13(IP)	Doctor/Governance	Medicine	Male	Regional	AUST
HR14(IP)	HR Director	HRM	Female	Regional	QLD
M15(T)	Director of Nursing	Nursing	Female	Remote	QLD
HP16(IP)	Clinician	Allied Health	Female	Remote	QLD
M17(T)	Director of Nursing	Nursing	Female	Town	NT
M18(IP)	CEO	Nursing	Male	Regional	QLD
HP19(IP)	Social Worker	Allied Health	Female	Remote	QLD
HP20(T)	Nurse	Nursing	Female	Remote	QLD
HP21(T)	Dentist	Allied Health	Female	Remote	QLD
M22(T)	Nurse Manager	Nursing	Female	City	QLD
HP23(T)	Physiotherapist	Allied Health	Female	Town	QLD
HP24(T)	Nurse Practitioner	Nursing	Female	City	QLD

*IP=In-person, T=Telephone

Table 4: Identifying Emergent themes and management practices

HRM Policy Choices	HR Construct	Emergent Theme	Management practice areas
HR Flow	Turnover	Turnover is high; however, there is some stability	Recruitment
	Realistic expectations	Realistic expectations improve retention	
	Person-fit	Recruiting for person-fit improves retention	
	Job security	Job security is influenced by external factors and personal circumstances	
	Professional Development	Managers are prematurely promoted	
	Occupational commitment	Turnover promotes occupational commitment over organisational commitment	
	Organisational-identity	Organisational-identity improves attraction and retention	
	Professional Development	Managers are not provided with adequate professional development	
Reward Systems	Incentives	Financial incentives improve attraction but not retention	Remuneration
	Job satisfaction	High levels of job satisfaction exist	
	Equity	Remuneration differences exist between disciplines	
Employee Influence	Relatedness	Personal isolation influences retention	Relationships
	Embeddedness	Embeddedness influences retention	
	POS	Professional support improves retention. Perceived	
	POS	POS may improve retention.	
	Autonomy	Autonomy is both a benefit and a necessity	
	LMX	The LMX relationship influences organisational commitment	
	LMX	Situational factors influence LMX	
Work systems	Work conditions	Work conditions provide further challenges for managers	Resourcing
	Wellbeing	Attention to individual wellbeing influences sustainability	
	Role Conflict	Balancing management and clinical responsibilities	
	Organisational commitment	Mix of labour influences organisational commitment	
	Work conditions	Policies should be localised	