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# LITERATURE REVIEW ABORIGINAL HEALTH WORKER PROFESSION REVIEW

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NORTHERN TERRITORY DEPARTMENT  
OF  
HEALTH & FAMILIES

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## Background

The Department of Health and Families (DH&F) has engaged the services of Human Capital Alliance (HCA) to undertake an important review of the Aboriginal Health Worker profession. The Department of Health and Families and the Liquor, Hospitality and Miscellaneous Union agreed to a review of the Aboriginal Health Worker profession focusing on career structure, workforce size, participation and progression. This Review came out of discussions associated with the Enterprise Bargaining Agreement that covers Aboriginal Health Workers (AHWs).

The specific purpose of the Review is to provide accurate information about the current AHW profession and advice on strengthening its size and capability, as well as career development for AHWs. The Review's scope includes both the government and Aboriginal community controlled sectors. This Review's terms of reference includes but is not limited to:

- Providing recommendations to strengthen and grow the AHW profession in the Northern Territory (including identification of specific support and career structures for AHWs employed by the Department of Health and Community Service);
- Reviewing the current AHW workforce size, structure, nature, and strengths, weaknesses, opportunities and threats;
- Identifying the key factors and service models that enhance AHW employment and retention in a range of different service settings;
- Determine the number of qualified AHWs who are not currently working in the profession and the reason for this;
- Providing advice about incentives and initiatives that would encourage AHWs currently not working in the profession to rejoin the AHW workforce;
- Identifying the barriers to AHW education and training, recruitment, retention and career progression;
- Investigate AHW education and explore options for the future.

This literature review forms a part of the Review process and focuses on articles or reports that explore the factors influencing recruitment and retention of AHWs — that is the number of people entering the profession and the number that are kept. There are many other human resource management issues that could have been explored, chief amongst these being issues of performance. Clearly there is little value in a focus on retention if the performance of the retained is poor. This and other such issues will be explored in subsequent Review reports (in any case there is considerable overlap in the factors that influence performance and those that influence retention); for this report the literature is almost exclusively explored to understand recruitment and retention and what motivates or influences the behaviour of workers in general, and Aboriginal health workers in particular.

This report is broken up into three main sections. The first part examines more broadly the factors that influence worker behaviour in any workforce, first by looking at the workforce in general, then by focusing on health care professionals, and then by studying the motivations and behaviour of health professionals working in rural and remote areas. We hope to establish a general list of influencing factors, the assumption being that some if not many will also apply to AHWs. To the extent that this assumption holds, 'solutions' can then be sought from the broader human resource management paradigm.

The second part will identify factors that influence AHW behaviour to enter or leave the workforce. This section will attempt to differentiate factors that are common with the rest of the workforce, and those that are peculiar to AHW circumstances. Unique solutions might need to be created for factors that influence only AHWs.

Finally, a range of interventions to improve recruitment and retention outcomes for AHWs is discussed. These interventions are only those that could be gleaned from the literature — clearly other interventions might be proposed and indeed will be in future Review reports.

## Methodology

The literature review commenced with a robust and comprehensive literature search. First, an effort was made to collect and collate any existing documentation already gathered by DH&F or the consultant. This was supplemented by an extensive search of the web and relevant abstract databases. The databases that were interrogated were:

- a. Cochrane, Medline, Cinahl, Embase, Healthstar, PubMed electronic databases.
- b. Internet search engines (Google Scholar, Scirus).
- c. Internet sites of other State Governments in Australia
- d. Department of Health & Ageing website (including OATSIH)
- e. Citation checking.

Set out in the table below is the search criteria for the literature review.

<b>Search terms</b>		
<b>Workforce</b>	<b>Human resource issues</b>	<b>Service settings</b>
Aboriginal health worker	Work organisation	Remote community
Indigenous health worker	Employment conditions	Clinical settings
Remote area health professional	Remuneration	Acute care
	Career development / progress	Urban settings

	Professional development	
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The review of the literature attempted to differentiate between two different types of literature as follows:

- 1) studies attempting to report on the evidence of the effectiveness of different recruitment / retention approaches. These articles were drawn into a separate part of the literature review that reflects research studies of reasonable scientific method.
- 2) articles or reports that discuss and explore the drivers and barriers to recruitment and retention of Aboriginal Health Workers (in various settings). These articles enhanced the understanding of current and past practices, implications for managers and workers and included viewpoints of specialists in the field (eg editorials and commentaries) and reports on surveys of opinion.

Together, these approaches enabled the development of a thorough review of the literature so that thoughts on the way forward are “evidence-based” as much as possible and take into account implementation issues of different approaches.

## **Factors that influence recruitment and retention decisions**

This first part of the literature review identifies factors influencing recruitment and retention decisions of workers across the broader labour market, then those factors more specific to the health workforce, and then factors that influence behaviour of health worker choosing work in rural and remote areas. The aim of this component was to establish recruitment and retention factors that might be common to all workforces including the AHW workforce.

### **All workers**

In the dynamic context of the labour market, recruitment and retention actions / decisions are being made continuously by actors on both the demand and supply sides of the market. They are the natural mechanisms by which the market operates.

For instance, a survey of Australian employees across eight industry groups (Day 2005) identified ten main factors influencing recruitment and retention decisions. As shown in Table 1 below, the most important factor influencing workers’ decisions to both take (or seek) a job and to stay in that job is whether the work is rewarding or not.

**Table 1: Factors influencing decision making on recruitment and retention (ranked in order of importance where 1 = highest importance)**

Factors	Importance of influence on decision to join		Importance of influence on decision to stay	
	Rank	%	Rank	%
Rewarding work	1	80%	1	88%
Level of pay/benefits	2	79%	3	82%
Career prospects	3	74%	5	78%
Good super benefits	4	67%	8	70%
Company culture	5	64%	6	72%
Training and development	6	61%	7	71%
Relationship with manager	7	58%	3	82%
Flexible work arrangements	8	58%	9	65%
Relationship with colleagues	9	54%	2	83%
Other financial benefits	10	44%	10	38%

According to the same survey results the influence of these factors remains remarkably stable across the different industry categories. Table 2 summarises the level of influence of factors on attracting a worker to a job and Table 3 summarises the influence on decisions to stay in a job.

**Table 2: Most popular “attractors” for employees in various industries (ranked in order of importance where 1 = highest importance)**

Factors	Business Services	Education	Finance	Government	Information Technology	Chemical/Coal/Mining	Construction/Engineering	Manufacturing
Rewarding work	2	1	1	2	2	1	2	1
Level of pay/benefits	1	2	1	1	3	1	1	2
Career prospects	2	4	3	2	1	3	4	3
Good super benefits	5	4	4	7	4	3	4	4
Company culture	7	8	5	7	5	5	4	4
Training and development	4	2	6	9	6	6	9	8
Relationship with manager	8	7	8	5	7	8	3	4
Flexible work arrangements	5	8	7	2	8	6	7	9
Relationship with colleagues	10	4	9	5	8	9	7	7
Other financial benefits	8	10	9	10	10	10	10	10

What limited differences between industries that were identified existed in respect to factors influencing retention decisions (see table 3).

**Table 3: Most popular “retainers” for employees in various industries (ranked in order of importance where 1 = highest importance)**

Factors	Business Services	Education	Finance	Government	Information Technology	Chemical / Coal/Mining	Construction/ Engineering	Manufacturing
Rewarding work	2	2	2	2	1	1	1	1
Level of pay/benefits	2	4	5	5	2	2	1	2
Career prospects	2	8	4	5	2	7	4	5
Good super benefits	7	6	9	1	7	3	8	7
Company culture	6	6	7	5	6	5	6	7
Training and development	7	4	6	9	7	8	8	6
Relationship with manager	2	2	1	5	2	3	3	4
Flexible work arrangements	9	9	8	2	9	9	7	9
Relationship with colleagues	1	1	2	2	2	5	4	3
Other financial benefits	10	10	10	10	10	10	10	10

Despite the apparent linear influence of the above factors, a major study of turnover in New Zealand (all workforces) found that the reasons for job change are complex and multidimensional; rarely could one factor alone explain the decision to stay or go (Boxall, Macky & Rasmussen 2003). Notwithstanding this finding, Boxall et al. (2003) found very similar results to Day (2005) at least in respect to turnover. They found the five main reasons persons who had recently left their job offered for their decision were:

- For more interesting work elsewhere (67%);
- For better training opportunities (54%);
- Because management didn’t recognise employee merit (51%);
- To obtain better balance between the demands of work and life outside work (51%);
- For a change of career (47%).

Those that stayed offered different reasons for their decision except in respect to one major factor. The top five reasons again were:

- Happy with co-workers (94%);
- Interesting work (90%);
- Good relationship with supervisor (90%);
- Good job security (87%);
- Personal reasons, eg like living in the area (78%).

Again similar to Day (2005), Boxall et al (2003) found little differences in response across the industries. However, they did find that age was an important characteristic; younger workers and non unionised workers were more likely to have changed employment in the recent past. Boxall et al. (2003: 209) concluded:

*"... younger people's career choices are more provisional; they experiment more with career choices and types of employer... the study identifies the under 30's as the workers most likely to use labour mobility to gain better pay and better access to good training opportunities.... The young, as ever, fancy their chances."*

The findings of Boxall et al. (2003) on age effects are supported by a growing body of literature into intergenerational differences in workforce behaviour (e.g. Hill 2002, McKenna 2003). In particular the basic approach to workforce participation is thought to vary importantly between the 'Baby Boomer', 'Generation X' and 'Generation Y' generations (Schoo, Stagnitti, Mercer and Dunbar, 2005). Their findings in respect to intergenerational differences in approach to recruitment and retention are outlined in Appendix A).

## Health workers

Do these factors which seem to most influence recruitment and retention decisions of the broader workforce also influence decision making by health professionals? Benchmarking data from nurses at a number of public and private hospitals (surveying almost 17,000 nurses) provided by Parle (2003, a) suggests health professions (at least nurses, who make up a significant proportion of the health professional workforce) do behave in a very similar way to other forms of labour. For instance, when asked to identify the reasons why they would consider staying in their organisation, the top reasons given by nurses and the percentage of nurses who gave each reason were:

- The people I work with (51%)
- Convenient (close to home) (28%)
- Enjoy the work (25%)
- Hours and shifts (18%)
- Current position/type of work (16%)
- Money (13%)
- Education and experience (12%)

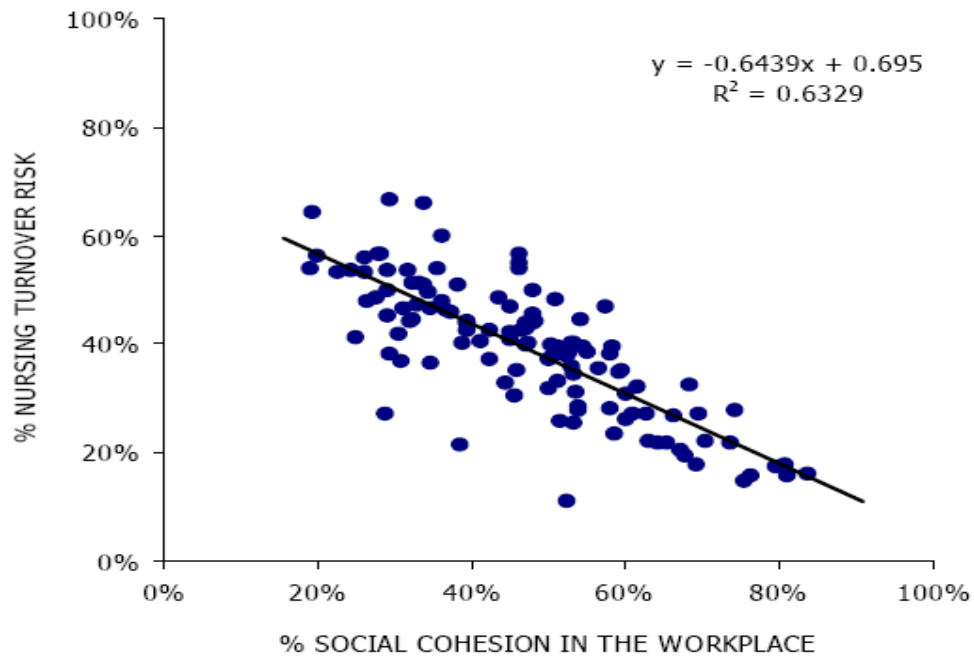
These reasons, and their rank order, are similar to those identified by Day (2005) and Boxall et al (2003).

Another Best Practice Australia study (Parle 2003, b) reinforces the primary place of work colleague relationships in retention decision making. They looked at the relationship between 'social cohesion' and intention to leave employment. They define "Social Cohesion in the Workplace" as:

*"The extent to which employees feel a sense of belonging to a friendly, cohesive community – versus – the extent to which they feel alienated from their work colleagues."*

The chart below looks at the benchmarking partners in their Benchmarking Study and compares each organisation's rating for Social Cohesion in the Workplace with its Nursing Turnover Risk (defined as the percentage of nurses who often think of leaving the organisation). A strong inverse relationship was found between social cohesion and turnover risk, with the relationship able to explain over 60% of turnover risk variation.

**Figure 1 Nursing Turnover Risk vs. Social cohesion in the workplace**



In the same benchmarking study (Parle 2003, b) nurses cited the following reasons for being initially attracted to work in their organisation:

- Location (31%)
- The type of position/role, presumably the job satisfaction (22%)
- Development and experience (15%)
- Reputation (10%)
- Money (7%)
- Flexible work arrangements / Hours (7%)

Apart from 'location' (which is also important for retention), the factors influencing recruitment decisions of nurses are similar in nature and order to the rest of the workforce. One could hypothesise in respect to 'location' that this is a peculiar option for health workers, nurses in particular, in so far as there are only a few other occupations (e.g. teachers) where a potentially acceptable place

of work is highly probable to be geographically close. So, they have the option to choose to work close to home, or to choose their home location and then be confident an employment opportunity will be nearby. As we shall see below, location of work is a particularly important driver of AHW decision making in regard to choice of employer.

Saggers and Tilley (2004) identified five primary factors associated with recruitment and retention for three categories of therapist labour as follows:

- Career structure;
- Workload;
- Quality of management and management structures;
- Rural versus metropolitan location; and
- Professional development opportunities.

Saggers and Tilley (2004) identified management issues as critical to worker decisions. At the heart of the management concern was the need to value and support therapists in their role and their work; such valuing could “melt away” a number of the otherwise important factors such as salary, excessive workloads and even career advancement (at least in the short term).

## Rural & remote employment

Most of the literature on recruitment and retention of health workers does not cover broader labour market issues but rather focuses on those employers or employment contexts where recruitment and retention is ‘difficult’. A primary area of concern is employment opportunities in rural and remote locations; an issue especially pertinent to the employment of most AHWs.

A typical example of this type of literature is that from Belcher, Kealey, Jones & Humphreys (2005) who studied the decision making of allied health professionals who had been recruited into rural positions. In the two following tables, the top 10 reasons they identified for choosing to go to rural employment and stay in rural employment respectively are listed.

**Table 4: Recruitment factors: Top 10 factors influencing recruitment decision making of rural health workers**

<b>Factors influencing recruitment decision</b>	<b>% of sample mentioning factor</b>
1. Lifestyle choice	57.8
2. Career opportunities	37.1
3. Current or past rural person	34.4
4. Good for the family	29.5
5. Spouse/partner issues	20.8
6. Positive attributes of rural practice	20.0
7. Satisfaction with rural practice	15.2
8. Rural community attributes	13.4
9. Good working conditions	10.3
10. Not urban	9.5

'Lifestyle choice' essentially equates with location; that is choosing a place to live (in this case a rural community). It was noted earlier that health workers generally placed 'location' as their number one consideration in recruitment decision making. For some health workers a rural or remote location is their preferred choice.

**Table 5: Retention factors: Top 10 factors influencing rural health workers decision to stay in rural employment**

Factors influencing decision to stay	% of sample mentioning factor
1. Rural practice attributes	45.7
2. Professional satisfaction	36.1
3. Work environment	20.3
4. Good working conditions	19.0
5. Career opportunities	8.5
6. Professional support and supervision	6.7
7. Lifestyle and family	6.0
8. Organisational issues	3.5
9. Financial return	2.1
10. Clients	1.7

The factors identified by Belcher et al. (2005) as influential on decision making are consistent with findings from similar studies (e.g. Central Hume Primary Care Partnership, 2005) but appear quite different to those found by Day (2005) and Boxall et al. (2003) from broader workforce surveys. This appears to be further confirmed in the factors that act as triggers to a decision by allied health professionals to leave rural employment.

**Table 6: Top triggers influencing the decision by rural health workers to leave**

Factors influencing decision to leave	% of sample mentioning factor
1. Family issues	22.1
2. Health and well being	21.8
3. Career advancement	16.6
4. Job opportunities	12.9
5. Spouse/partner issues	12.2
6. Lifestyle	11.2
7. Professional satisfaction	7.5
8. Lack of support and supervision	7.0
9. Personal working conditions	6.3

Interestingly, the Belcher et al. (2005) results show that:

- 'personal' factors are the strongest influences in the decision to be *recruited* to a rural location (four of top five factors);
- 'professional / occupational' factors dominate the decision making about *staying* in rural practice (five out of top five); and
- mixed 'personal' and 'professional' factors are most influential on the decision to *leave* (three and two respectively out of the top five factors).

Thus the findings on worker decision making regarding rural and remote location employment is not too consistent with the broader workforce, including health workforce, results. That is, workers primarily stay in their jobs because they enjoy the work, their colleagues and the work environment. Equally, they tend to leave their jobs because of a mixture of professional (e.g. better career prospects) and personal (e.g. family / life – family balance) reasons.

The main difference between the results of Belcher et al. (and the many similar studies) and the broader workforce studies lies in the factors associated with recruitment. The difference can probably best be explained by the focus on recruitment to unattractive employment opportunities (in this case rural locations). It would appear that successful recruitment to such positions relies more on 'personal' factors to influence the decision making (e.g. lifestyle choice, rural background), or personal career circumstances (e.g. actual job availability, chance to fast track career in a less competitive environment).

## **Summary of factors influencing worker decisions that impact on recruitment and retention**

The general labour market literature explored above has developed an understanding of the key factors influencing worker decision making; to join, stay with, or leave an employer. People in the Australian workforce seek a particular job / employer (recruitment) and leave a particular job / employer (retention) for remarkably consistent reasons across gender, age group (a little different) and industry sectors. Ridoutt & Wong (2005) suggest the following factors are the most important in influencing decisions of most workers:

### Recruitment

- Personal factors, particularly associated with choice of place to live;
- Job satisfaction / interesting and challenging work;
- Career prospects, especially the potential to 'fast track' progression;
- Income earning capacity, including salary, benefits, security;
- Balance between work / life (style) / family.

### Retention

- Relationship with work colleagues;
- Job satisfaction / interesting and challenging work;
- Personal factors, particularly associated with choice of place to live;
- Work environment, including a supportive culture;
- Balance between work / life (style) / family.

In a subsequent study building on the above factors (Ridoutt & Santos, 2006) a description of an attractive workplace (to go to work and stay for a significant period of time) was built that largely satisfied the above worker needs.

# Indigenous worker experiences – especially AHWs

If we accept that the above factors are important influences on most workers in Australia, what factors are important to Indigenous workers?

Tiplady and Barclay (2007) in a study of Indigenous workers in the mining industry found that many of the factors impacting on the wider workforce act in common to influence Indigenous worker decision making. These include concerns about skills development, costs associated with getting to the workplace, career progress / development and working hours especially some flexibility. They identified though that Indigenous employees working in the mining industry (possibly a broader workforce context) face considerable additional challenges viz.:

- balancing work with family commitments<sup>1</sup>;
- making the transition to a new organisational and cultural environment. Hierarchical management practices conflict with Indigenous workers' expectations of working in an equal team environment;
- accepting some management directives and communications, which, partly the result of Western organisation hierarchical supervision practice and partly the result of a harsh male-dominated workplace environment, are deemed rude and culturally inappropriate.

Available research suggests that Indigenous workers in the mining industry often have difficulties in adjusting to corporate employment structures and the industry's strong focus on 'industrial discipline', and often encounter real or perceived racist attitudes from management and supervisors (Tiplady & Barclay 2007).

In the following sections some of the factors that influence AHW recruitment and retention behaviour are discussed.

## AHW recruitment

Personal factors including the choice of place to live play a major role in the recruitment of AHWs. Tregenza and Abbott (1995) report that AHWs are:

*"... motivated by a desire to care for members of their family and the community and to improve the general health status and quality of life in their community" (p15).*

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<sup>1</sup> This too is a common factor with other parts of the broader workforce, however Tiplady and Barclay argue this factor is significantly more challenging for Indigenous workers.

Other authors reviewed similarly described a great desire from AHWs to assist their communities in the treatment and management of chronic illness and to prevent ill health increasing in their community. From a recruitment perspective this creates a somewhat unique or at least unusual influencing factor for AHWs; a requirement to be employed not just close to where they work, but in the very same community.

This has generally been perceived as a positive influencing factor but has raised some interesting consequential issues around the recruitment / selection process itself. Successful recruitment of AHWs, who will subsequently work in the community, has been seen as dependent on elders within the community being intimately involved in the selection process — they are most likely to select one of their community members who has the appropriate respect and community authority to become an AHW (Bartlett, Duncan, Alexander & Hardwick, 1997). Accordingly, Tregenza and Abbott (1995) recommend that existing Health Workers in communities be actively involved in the recruitment and selection of all new AHW staff in consultation with the community in order for them to select the most appropriate person to be trained. Bartlett et al., (1997) proposed that in communities where there was no AHW there needed to be a community process to identify appropriate community members to be medicine kit holders or AHWs. They allowed that an AHW Association might also play a role in this selection.

Tregenza and Abbott (1995) identify that complex issues arise when AHWs are recruited by non-Aboriginal health workers or others from outside the community in which they will be working. Non-Aboriginal health workers may select or recruit an AHW based on literacy levels rather than cultural or community acceptability and in any case place that AHW into a different community to that in which they have cultural and family affinity. Problems can then arise with cultural behaviours (such as conflicting skin affiliations) which can reduce access to health services for some community members.

Recruiting from within the community is not without problems, most of which are related to the processes of training. Because of the 'on-the-job' nature of training for AHWs, training is more integrally linked to recruitment outcomes than for most health workers where there is a clearer demarcation between training / education (usually at an education institute) and subsequent recruitment into the health workforce.

Abbott and Fry (1998) provide a history of AHW education and training and note that prior to 1990 AHWs were trained on the job as trainees in their community. They were trained in basic health literacy and numeracy, basic clinical competencies and their training was flexible to allow for cultural events and individuals to learn at their own pace. After 1990, AHW training was separated from service provision and tied to a curriculum based course at the Batchelor Institute of Indigenous Training & Education. They argue that this process has not been successful for the majority of AHWs as:

- current training arrangements require AHWs to leave their communities for extended periods to receive their formal training qualifications. This creates problems since the very reason they seek employment in their

community, to fulfil their family and community commitments, now comes into conflict with the requirement to be out of town for training;

- community selection processes place less emphasis on literacy skills, and for those with poorer skills, problems arise within a classroom environment and a course that demands comparatively high literacy and numeracy skills. Low literacy health worker recruits do not want to leave their communities to sit in a classroom separated from learning skills on the job<sup>2</sup> and they experience embarrassment and confusion in classrooms with lecturers 'talking at them';
- most prospective AHWs are unable to live on Abstudy; and
- there is only poor support for learning 'on-the-job' in their community clinic.

All these factors contribute to increased rate of failure in AHW training. Abbott and Fry (1998) recommended that AHW training should be undertaken as a traineeship engaging people selected by the community. The training should be to appropriate competencies supported by a regional structure representing the interests of all parties.

Similarly, Tregenza and Abbott (1995) identify that AHWs have difficulty in relating classroom training to real life situations. They (AHW students) don't view literacy as importantly as non-Aboriginal staff to complete particular duties of an AHW. Tregenza and Abbott criticised the education program run by Batchelor Institute as they believe it was not applicable to Aboriginal people whose first language is not English and that its numeracy and literacy requirements are prohibitive to many potential AHWs<sup>3</sup>.

Tregenza and Abbott (1995) also inform that AHW education has not been culturally appropriate for men and thus dominated by women and that health clinics can be viewed by Aboriginal people as women's and children's areas. They recommend that:

*"... male Health Workers must be seen to be Health Workers for men and must have a clearly defined role which has high male status within the community. Male Health Workers should be then able to bring health care to their half of the community and fulfil all the roles of a primary health care practitioner in the men's world" (p 64).*

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<sup>2</sup> Literacy skills are a factor with regard to recruitment for indigenous workers more generally. Tiplady & Barclay (2007) found that human resource practices make it hard for Indigenous people to enter the workforce as they don't always have the literacy skills to read job advertisements and prepare job applications. They proposed that new recruitment strategies needed to be developed with an emphasis on face to face meetings.

<sup>3</sup> In the intervening years since Tregenza and Abbott formulated their views the requirements for the AHW training have further increased with the introduction of a National training Package for AHW and the requirements of the AHW registration authority to complete Certificate IV level training to qualify for registration.

Another concern with AHW training identified by Morgan, Slade & Morgan (1997) is that western medical oriented AHW training does not address Aboriginal philosophies of holistic health and healing. The training needs to acknowledge and include an understanding of “*kinship, ritual and spiritual relationships and responsibilities, [which] are inseparable from each other and nature*”. This is in conflict with western medicine which separates the patient from the disease, which creates problems when communicating treatment plans to Indigenous patients who need contextual based information within a social dynamic. AHWs have a pivotal role in the communication of treatment plans between non Indigenous medical staff and Aboriginal patients and this is an area in which training has in the past been considered lacking (see also Rose & Pulver, 2004).

## Issues related to AHW retention

### Cultural difficulties

Howard (2007, p 5-6) argues the difference in cultural values of Aboriginal and communities Western organisations are significant and require AHWs to work through and negotiate these differences. He notes the fundamental characteristics of the western organisation culture are:

- hierarchical ways of organisation;
- direct communication styles typical in line ‘management’;
- focus on individual roles; and
- professional practices that focus on ‘individual’ responsibility.

This contrasts markedly with the general characteristics of the collective / interdependent Aboriginal focus where:

- the quality of the relationship between practitioner and client is a key determinant of health outcomes;
- there is intense shame felt by Aboriginal Health Workers when they are individually criticised in a public way; and
- there are difficulties in coping with the disconnection from family that can be associated with participation in training or meetings.

Howard (2007) states these differing cultural perspectives highlight one of the major difficulties of the AHW role and a significant source of occupational stress. This is illustrated when community pressure is applied on AHWs to negotiate between the two cultures and to ‘speak up’ and advocate on behalf of their community to the health service. However, when issues are not resolved in the way in which the community expects, the AHW is held responsible (Mitchell and Hussey, 2006). On the other side, the health service or clinic expects AHWs to be able to negotiate between the two cultures but don’t perceive them as doing their job when desired outcomes (for instance when patients do not comply with treatment plans) can’t be achieved. The community and health service pressure to perform this negotiating role and the lack of understanding from both sources when a desired outcome is not achieved can affect AHWs negatively and adds to the stress of the role.

Williams and Thorpe (2003) discuss the concept of 'emotional labour' as a level of emotional involvement in working with Aboriginal patients. AHWs by necessity utilise and control their emotions when dealing with patients in the community in which they belong. The emotional involvement of dealing with patients that are related or personally known to an AHW can lead to emotional exhaustion and burnout. Williams and Thorpe (2003, p 51) also discuss the concept of 'obligatory community labour' which includes a 'sense of duty' when dealing with an Aboriginal patient for AHWs. This sense of responsibility includes cultural expectations, family and kinship obligations in conjunction with work responsibilities which contribute to the stress and burnout of practising AHWs.

In a separate article, Williams (2003) attributes the high level of burnout of AHWs to the emotional intensity of their job as cultural brokers as they are subject to:

1. a lack of boundaries that AHWs have in the workplace;
2. verbal abuse; and
3. everyday social racism.

Community controlled health services are seen by Tregenza and Abbott (1995) to be more accommodating when personal issues impact on an AHW's ability to attend and perform at work. They report that Aboriginal management is more aware of cultural responsibilities and an individual AHW's family responsibilities and personal health and can better manage to accommodate these issues affecting AHW employment.

### **Career pathways**

Another retention issue for AHWs identified in the literature, and one that is potentially common within the broader workforce, is the lack of career progression opportunities through health services. Clearly if the desire of both employer and employee is for AHWs to largely complete their work life in a single community health service, there are serious potential boundaries on career opportunities. Nevertheless, and even within the confines of a small service context, some authors argue progression of AHWs could have been greater (Tregenza & Abbott, 1995). Hecker (1997) identified three factors preventing AHWs from taking on a greater role within the health service as:

1. Standard of training they receive – trainers are busy training new staff rather than maintaining current levels of training across all AHWs in an area<sup>4</sup>;
2. Low literacy and numeracy levels – desires to improve literacy and numeracy levels to increase expressed confidence; and
3. Lack of participation in decision making in the health service.

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<sup>4</sup> This issue was attempted to be addressed many years ago with the construction of professional development support structures at least for DH&F AHW staff. An internal unit was established in the Top End and the service was sub-contracted to CAHDS in Central Australia. The outcomes of these initiatives are commented upon in a separate report.

Similarly, Abbott and Fry (1998) report that AHWs who want higher qualifications are restricted by not having achieved reputable base qualifications in the first place which limits their future training options and therefore to specialise in their AHW practice<sup>5</sup>. This stops not just career progression within the AHW area but also limits capacity to develop a career path in health services.

Of course the obvious pathway for AHWs, especially those who want to remain in their community, would be to aspire to a management role. Wakerman, Matthews, Hill & Gibson (2000) report on barriers to the recruitment, retention and professional development of Aboriginal and Torres Strait Islander Health into management roles. The recruitment barriers include a lack of training and skills development to develop a pool of potentially qualified managers, western cultural bias in recruitment practices, lack of confidence of individual AHWs, negative perception of an established management role and communities perceiving government management jobs negatively. The retention barriers include (amongst many others) difficulties in balancing accountabilities as an Aboriginal person and manager, widespread institutionalised racism and discrimination, lack of mentoring or support networks once in the role and being sidelined from decision making at higher levels.

### **Relationships with work colleagues / lack of definition of role of AHW**

One of the major retention issues for all workers identified earlier in this paper was the relationship with work colleagues. Most workers want to enjoy the professional and social relationship with their colleagues. For many AHWs various literature sources suggest (eg Tregenza and Abbott, 1995; Jackson, Brady & Stein, 1999) workplace relationships are far from satisfactory and relationships between AHWs and nurses within the clinical setting especially difficult. Tregenza and Abbott (1995) comment that in working with AHWs, nurses can be either incredibly supportive or 'bullies' and the resulting relationships are essential to workplace satisfaction. Parle (2003 b) indicates that work colleague relationships and social cohesion is a most important factor for nurses as well in wanting to stay in a job.

The lack of a universally agreed definition of the role of AHWs is thought by Jackson et al (1999) to have led to problems with nurses misunderstanding the role and functions of AHWs. At times too the role of the nurse in a remote setting can be widely misunderstood. Accordingly, differences in perceptions of the two roles have increased the level of tension in some nurse and AHW relationships. Given the context where nurses have higher qualifications, receive higher pay, better accommodation, access to transport and other benefits; this has created differences in the power and status of nurses vis a vis AHWs. Conflict between the two therefore is likely to generate worse outcomes for AHWs; for example Tregenza & Abbott (1995) report that negative relationships between nurses and AHWs often result in under-utilisation of AHW skills, leaching the role of interest and challenge. In an earlier section of this paper the importance of work being interesting, challenging and rewarding for the individual was emphasised.

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<sup>5</sup> The more recently introduced Certificate IV in Aboriginal Health Work may address some of these problems.

Tregenza and Abbott (1995) also believe that an AHW's role is unclear and the status of AHWs is deteriorating due to frustration, confusion and stress created by this lack of an agreed definition in the role. They comment that many of the positive images created by public rhetoric and theory do not exist in reality. One of the recommendations in their report was to formally recognise and include in the AHW job descriptions the role of AHWs, especially to acknowledge functions in:

*"... traditional health, environmental health, community care, administration, management and control, and policy development and program planning" (p vi).*

When considering the roles of the health team, Tregenza and Abbott (1995) advise that AHWs believe that they are members of the health team in conjunction with nursing and medical staff. In reality, in most health services the doctor or nurse is usually the team leader within the clinic as they perceive themselves to be ultimately responsible for the delivery of health care. AHWs on the other hand view the health team as consisting of equals where each member brings his/her own skills and knowledge to the group. Within this context, AHWs should be the team leaders and direct the health team within their own community as they are responsible to their community for health outcomes.

The National Rural Health Alliance (2004) notes the high turnover of non Indigenous health service staff as a factor influencing relationships. Nursing and medical staff are changed regularly resulting in a lack of consistency of staff and a reduced ability for good working relationships being developed between AHWs and other health staff. This is confirmed by Tregenza and Abbott (1995) who have identified that due to the high turnover of nurses and doctors the AHW remains the constant staff member within a health service. They believe that this creates a need for more AHWs to be present (especially male) in the health service structure.

Tregenza and Abbott (1995) note that AHWs often acknowledge nurses for their superior knowledge of western medicine but a reciprocal recognition of AHWs for their advice on traditional and cultural matters is not regularly provided. Josif and Franks (1994) indeed propose that this lack of mutual recognition is at *"the heart of the issue of why Aboriginal Health Workers do not stay, [that is] a **lack of equivalent status to outsiders**"*. They believe that:

*"The issues of adequate training, honest exchange of ideas, the duties of health workers, the hours worked, or who runs the clinic are secondary to the issue of equivalent status. New styles of training can be implemented, but until the issue of equivalence is addressed, no real changes to the present situation can happen." (Part A, p5)*

They offer the observation that within an Aboriginal community all people who have different roles are granted equivalent status within their same generational status. Within health services, AHWs do not perceive an equivalence of status with visiting non-Aboriginal health professionals whether doctors or nurses. This creates difficulties for AHWs who wish to work in a health team with equivalent

status whilst acknowledging the values of an outsider in performing health tasks without the same cultural impediments.

## Summary of factors influencing AHW decisions that impact on recruitment and retention

It was an important aim through this literature review to not focus on what is unique about the decision making of AHWs and in so doing lose sight of more obvious areas of concern potentially more open to being addressed through standard human resource management interventions. In the table below key factors that influence the general worker's decision making in regards to recruitment and retention outcomes are compared to factors that most seem to influence Aboriginal Health Workers.

**Table 7: Comparison of AHW workforce with the broader workforce on factors influencing recruitment & retention decision making**

Factors influencing	General workforce	AHW workforce
<b>(1) Recruitment</b>		
Personal factors, particularly associated with choice of place to live;	X	X Very important
Job satisfaction / interesting and challenging work;	X	X
Career prospects, especially the potential to 'fast track' progression;	X	
Income earning capacity, including salary, benefits, security;	X	
Balance between work / life (style) / family.	X	X
Vision to provide value to the community		X
Capacity to complete the training requirements		X
<b>(2) Retention</b>		
Relationship with work colleagues;	X	X
Job satisfaction / interesting and challenging work;	X	X
Personal factors, particularly associated with choice of place to live;		X
(Safe) work environment, including a supportive culture;	X	X
Career prospects, including the potential to continue evolving in the same workplace;		X
Balance between work / life (style) / family.	X	X

Table 7 indicates that there is much common ground between AHWs and workers in general in what influences recruitment behaviour and decisions to stay with an employer. Just like other workers, AHWs want interesting and

challenging work roles, they want to balance their work and family commitments, they want good relations with their fellow workers and they want to come to work each day and feel safe and supported. Similar to other parts of the workforce, in particular other health workers, but perhaps at a higher order of importance, working near their family and community is a strong influence on decision making about where to work. AHWs differ most from the rest of the workforce in their lower mobility (more difficult for them to change jobs or job location), higher exposure to occupational stress, and the altruism with which they at least initially approach their work.

The National Rural Health Alliance (2004) summarised the range of factors influencing AHWs' recruitment and retention outcomes as a set of four disincentives to stay in the AHW role as follows:

- economic – lack of access to housing
- professional – lack of career pathways
- educational – training and education issues
- family/social cultural – stress from managing work with community/family expectations / dealing with Humbug.

## Discussion — Solutions to AHW recruitment and retention

### Single issue solutions

The literature proposes a number of potential solutions to problems associated with the recruitment and retention of AHWs. They all fall though into four basic themes which are somewhat interlinked:

- improving the **status** of AHWs vis a vis other health workers;
- enhancing the **education and training** of AHWs to improve their chances of progressing within and beyond the AHW classification;
- defining better the **role** of AHWs; and
- improving basic **human resource management practice**.

With regards to increasing the status of the AHW role within health services, Jackson et al (1999) believe that AHWs receiving equal pay rates and accommodation benefits as nurses would create equality between the roles therefore reducing workplace conflict and the dissatisfaction of AHWs with their conditions. Abbott et al (2008) also believe that AHWs need acknowledgement as an essential component of the health service. Lowell et al (2004) similarly muse that in order to improve communication between patients and health workers there is an argument first to be made for the importance of the role of AHWs in health services. Howard (2007) proposes organisational strategies to be inclusive of AHW perspectives by establishing systems to ensure that they have

an understanding of issues to be discussed and their views are expressed at management meetings.

With regards to education and training factors, Rose & Pulver (2004) would like to open up education opportunities to allow AHWs to have a better understanding of health determinants. Clapham and Gosden believe that incorporating AHW training into tertiary education programs will allow other health practitioners to access the courses and lead to a better understanding of the role of AHWs. Specifically, they are interested in an integrated model of traditional and western medicine to achieve better health outcomes. An important focus for education and training is argued to be a management vocational outcome. Tregenza and Abbott (1995) for instance suggest that AHWs should be the team leaders in their own community as they are responsible to the community especially in terms of the success or failures of health outcomes.

AHWs surveyed from community controlled health services reported more control over their situation in relation to balancing the expectations of the health service, family and community as these services take into consideration these aspects of their role and attempt to assist by offering leave without pay and other structures.

There is much evidence in the literature of uncertainty about the AHW role in the 90s. No new literature has emerged that resolves this uncertainty satisfactorily. There is a need therefore still to define the role for AHWs; some argue that this is a major contributor to tensions that lie between AHWs and nurses in some health services. Tregenza and Abbott (1995) offer up a number of elements of the role that AHWs they are currently (at least in 1995) playing:

- clinical care/western medicine;
- traditional medicine;
- cultural broker – translator but also provide orientation to the community for doctors / nurses;
- health educator and promotion;
- environmental health – determine aspects of health – look to social determinants of health to extend on this idea;
- community care – elderly/counselling etc;
- administration, management and control of clinic; and
- policy development and program planning.

It is likely that solutions will need to be multi-faceted. Research by the Centre for Socially Responsible Mining (CSRSM) at the Argyle Diamond Mine which aimed to identify the influences on the employment of Indigenous employees found the employees generally had a positive experience working at the mine and attributed this to the ability to increase their skill levels and create and maintain good working relationships with their fellow workers. The main reasons identified for ceasing their employment were attributed to family issues, communication barriers, discrimination and management issues. The suggestions made to improve the retention of Indigenous workers were:

- implement culturally appropriate and family friendly employment practices, improving on site facilities and services;
- improving human resource *development* practices;

- ensure supervisors and managers are trained in cross-cultural communication and supervision;
- provide support for career development opportunities;
- seek opportunities to hire former employees;
- provide external mentoring services;
- provide numeracy and literacy training.

Tiplady & Barclay found that cultural awareness training was evident in most companies with successful indigenous employment strategies as their cultural and transitional values were respected by non indigenous employees. They went on to propose strategies for increasing retention of indigenous employees such as:

- providing mentoring and support
- flexible work rosters
- career development
- family support
- identifying sources of discrimination and racism

## **More comprehensive approach**

Increasingly in regard to recruitment and retention issues best practice organisations are moving increasingly towards more comprehensive and integrated human resource management approaches such as 'employer of choice' and 'attractive workplaces' methodology.

For instance Ridoutt and Santos (2006) identified 16 elements of an attractive workplace for health services in Victoria as follows:

- Attractive Compensation / Benefits Package
- Recognition program
- Professional development
- Work organisation
- Organisation structure
- Leadership
- Management style
- Change management
- Work-life balance
- Interdisciplinary relationships /Social Support
- Open Communication
- Social responsibility
- Fairness
- Inclusiveness
- Safety and Well-being
- Workspace and supportive technology

They were able to relate the 16 elements systematically into three easily recognisable 'clusters' of elements viz.:

- One involving attractive compensation / benefits package, recognition program and professional development which they termed 'Job Future';

- A second network involving organisation structure, work organisation, leadership, management style, change management and work-life balance which was called 'People management'; and
- The third group of elements which prescribed the quality of worker to worker and worker to immediate supervisor relationships and which they called 'Organisational climate'.

They further analysed this network of attractive workplace elements to identify several key elements which they argued:

*" ... could return a greater (or faster) return on investment than others and whose absence from any constructed model [of an attractive workplace] would significantly diminish the potential of the model to deliver desired outcomes." (p.20)*

The key elements they identified were:

- **work organisation**, effort to design work and workforces in such a way that satisfies the needs of health professionals to practice in a way that best utilises their skills, affords them maximum control over their own work and the clinical judgements they make.
- **management style and leadership**, which may vary depending on the stage of maturity of the organisation, but is likely to be based on providing a clear and attractive work vision, engage workers in participative processes, demonstrate an on-going valuing of the worth of human resources, and promote an open, fair and supportive environment.
- **strong job futures**, where compensation for the level of work required is competitive, a clear career pathway is evident and support, including professional development, is available to progress, and where job security is strong for persons who perform to expectations.
- **workplace social relationships** that reflect mutual respect between different worker categories and between workers and management.

It is interesting to compare this set of elements with the list of solutions developed in the previous section of this report gathered from the AHW literature as shown in the box below.

work organisation	<ul style="list-style-type: none"> <li>▪ defining better the role of AHWs</li> <li>▪ improving the status of AHWs vis a vis other health workers</li> </ul>
management style and leadership	
strong job futures	<ul style="list-style-type: none"> <li>▪ enhancing the education and training of AHWs to improve their chances of progressing within and beyond the AHW classification</li> </ul>
workplace social relationships	
	<ul style="list-style-type: none"> <li>▪ improving basic human resource management practice.</li> </ul>

Work organisation and job futures elements are common (although Ridoutt and Santos focus as much on pay and conditions as professional development in job

futures) while management style / leadership and workplace social relations (which could possibly be argued to link with status issues) are not prominent in the AHW literature. In the case of management style and leadership, other reports in the series of Review reports will explore this issue and indicate that it is a major determinant on AHW retention behaviour and too the way they perform in the workplace.

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# Appendix A: Outline of findings of Schoo, Stagnitti, Mercer & Dunbar (2005)

## Optimising workforce recruitment for members of three generations: Baby Boomers, and Generation X and Y<sup>6</sup>

Baby Boomers	Generation X	Generation Y
Value experience and maturity	Making a difference as an individual	Emphasise the mission and actively demonstrate it
Support professional development and acquiring new skills	Balance, time off and support are important	Value multiple career opportunities
Desire to get ahead	Fun in work environment	Value making daily differences in the lives of others
Desire to achieve balance in the job	Value technology and autonomy	Forefront of technology

## Optimising workforce retention for members of three generations: Baby Boomers, and Generation X and Y

Baby Boomers	Generation X	Generation Y
Provision of mentoring	Provision of quality training that is easily accessible	Competing in pay and benefits
Recognition of contributions	Encouragement of working independently	Demonstrating ways to progress
Creating harmony in the workplace	Pointing out project opportunities	Desire to speak up and take part in projects
Name recognition	Provision of direct feedback	Teamwork and inter/intra departmental collaboration
Flexible working hours	State of the art technology	State of the Art technology
Point out value to organisation	Recognition of balance as an important factor in life	Dislike for corporate politics
Recognition of achieving balance in life	Recognition of the need for job / career changes	Value optimism, diversity and updates on status quo

<sup>6</sup> They in turn adapted their tables from the work of McKenna (2003) and Spin Communications and Sweeney Research (2004).