

## ORIGINAL RESEARCH

# Extrinsic and intrinsic factors impacting on the retention of older rural healthcare workers in the north Victorian public sector: a qualitative study

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*Submitted: 26 June 2013; Revised: 10 January 2014; Accepted: 10 January 2014; Published: 27 August 2014*

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*Rural and Remote Health 14: 2721. (Online) 2014*

Available: <http://www.rrh.org.au>

## ABSTRACT

**Introduction:** Workforce shortages in Australia's healthcare system, particularly across rural areas, are well documented. Future projections suggest that as the healthcare workforce ages and retires, there is an urgent need for strategies to retain older skilled employees. Very few qualitative studies, with theoretical underpinning, have focused on the retention of older rural nurses and allied healthcare workers. This study aimed to address these gaps in research knowledge.

**Methods:** This qualitative study is phase 2 of a large mixed-methods study to determine the factors that impact on the retention of older rural healthcare workers across northern Victoria, Australia. The initial phase, drawing on the effort–reward imbalance model found high levels of imbalance across a large sample of this population. The present study builds on these findings to explore in more depth the organisational (extrinsic) and individual/social (intrinsic) factors associated with retention.

A purposeful stratified sample was drawn from participants at the survey phase (phase 1) and invited to take part in a semistructured telephone interview. A diverse group of 17 rural healthcare workers (nurses and allied health) aged 55 years or more, employed in the north Victorian public sector, were interviewed. The data were transcribed and later analysed thematically and inductively.

**Results:** Data were categorised into extrinsic and intrinsic factors that influenced their decisions to remain in their roles or leave employment. The main extrinsic factors included feeling valued by the organisation, workload pressures, feeling valued by clients, collegial support, work flexibility, and a lack of options. The main intrinsic factors included intention to retire, family influences, work enjoyment, financial influences, health, sense of self, and social input. Given the noted imbalance between (high) effort and (low) reward among participants overall, strategies were identified for improving this balance, and in turn, the retention of older rural healthcare workers.



**Conclusions:** Study outcomes provide important insight into factors that impact on the retention of older rural healthcare workers, and, importantly, the imbalance in effort and reward participants experience in their current workplace. Use of a theoretical approach, and a two-stage methodology, enables a deeper understanding of these factors and the strategies needed to address them. Further research is now needed to test the effectiveness of these strategies in the older rural healthcare workforce.

**Key words:** effort–reward imbalance, healthcare workers, older aged, retention, workforce shortage.

## Introduction

Workforce shortages in Australia's healthcare system are well documented, and appear more evident in rural and remote areas than metropolitan areas. Furthermore, people living in rural and remote areas experience poorer health outcomes, a higher rate of morbidity<sup>1,2</sup>, and reduced access to healthcare services compared with metropolitan residents<sup>3</sup>.

The projected ageing of Australia's population over the next 40 years will drive future demand for healthcare services, with evidence highlighting that older people generally require additional treatment by healthcare professionals and more hospital care<sup>2,4</sup>. Patterns of migration from metropolitan to rural areas, including in-migration of retirees as sea or tree changers, and out-migration of younger populations, including young healthcare professionals, suggests the increasing demand for healthcare services is likely to be further pronounced in rural areas<sup>5-7</sup>.

Numerous government reports have drawn attention to the inevitable strain placed on current and future health budgets<sup>8,9</sup>, and the shrinking pool of younger employees as the healthcare workforce ages and retires. Specifically, baby boomers comprise approximately 57% of Australia's current health workforce, and their impending retirement will inevitably create shortages in almost every sector of health<sup>8,9</sup>. It appears highly unlikely that younger healthcare professionals entering the workforce will make up sufficient numbers to replace baby boomers as they retire<sup>2,10</sup>. For example, according to Australia's Health Workforce 2025 projections, workforce shortages will be significant,

particularly for nurses (109 000 or 27%) and doctors (2700 or 3%)<sup>11</sup>. Additionally, there is a shortage in the allied health workforce, particularly in rural areas of Australia<sup>12,13</sup>. Similarly, estimates of shortages for allied health professionals are also expected, with numbers less certain due to the diversity of allied health professionals and the difficulties of collecting such data<sup>14</sup>. However, the overall evidence suggests that relying only on recruitment strategies to meet future demand will not suffice. Strategies to retain older skilled employees are also urgently needed. This is the focus of the present article.

### *Critical gaps in research knowledge*

Awareness of the current and impending workforce crisis has led to a number of policy responses<sup>11</sup>, and a considerable body of literature devoted to the retention of rural healthcare workers and healthcare workers more generally<sup>15-17</sup>. Although much progress has been made concerning ways to best deal with the impending workforce demand and shortage facing rural communities, as outlined below, critical gaps in research knowledge remain. These gaps relate to the lack of health workforce retention research that has taken into account specific health professions (eg nurses and allied health professionals) or certain geographic locations (eg rural areas), or particular age groups (eg older workers). Additionally, little is known about retention strategies specific to older rural nurses and allied health professionals, and there is a dearth of qualitative research, grounded in theory, focused on health workforce retention.

With regard to health workforce retention, most research to date has focused on the retention of medical professionals (eg



doctors, general practitioners, specialists) in rural areas. Very few studies have focused on other rural health workers, namely nurses and allied health professionals, who provide integral services to both patients and communities<sup>18,19</sup>. The need to focus on retention in specific health professions, rather than generalising findings across all health professions (eg medical, nurses, allied health) is critical. For example, in the current Victorian public health system, different pay structures exist for medical practitioners (contract pay structure) and allied health staff and nurses (salary-based packages). These differences may influence employees' retention decisions and, in turn, impact on study results. Additionally, existing evidence shows substantial differences in workforce retention rates in a wide range of health professions, particularly among older workers. Outcomes from one Australian study showed that 40% of general practitioners were aged 65–69 years, compared to only 9% of general nurses being in the same age bracket. Thus, this disparity reinforces the contention that issues impacting on workforce retention are profession specific<sup>16</sup>. Geographic location also impacts on retention. Consistent with other developed countries, in Australia, retaining healthcare professionals is particularly problematic in rural areas compared to metropolitan areas<sup>20–24</sup>. This all suggests that there are likely to be different issues associated with retaining older nurses and allied health professionals in rural areas, yet there is very little Australian research focusing specifically on these groups.

Additionally, the majority of existing relevant literature on retention has not taken age into account<sup>25</sup>. When age has been considered, age is likely to be a control variable, and older workers (aged 50–55 or more) are generally shifted into the domain of retirement. Some recent research has explored factors relating to the recruitment and retention of allied health professionals<sup>20</sup>. However, while this study contributes to knowledge of this professional group, it did not focus specifically on the older rural workforce, despite the fact that far less is known about the needs of this specific group.

There are also unanswered questions concerning effective retention strategies for older rural nurses and allied healthcare workers. Outcomes from existing research have identified various retention strategies, yet very few studies have evaluated the effectiveness of any particular strategy<sup>19,26,27</sup>. With regard to retaining older workers, outcomes from general workforce literature highlight the need for organisations to reorient workforce strategies, including the organisation culture and management practices, to capitalise on and retain their older workforce<sup>27</sup>. Similarly, qualitative nursing workforce literature in the UK and USA identifies a range of factors influencing older nurses' decisions to remain in the workforce, despite numerous job stressors faced on a daily basis. These factors include (although are not limited to) altruistic reasons (eg caring nature, job satisfaction), flexible hours, and professional development<sup>28,29</sup>. Thus, on the basis of available evidence, there is no 'one size fits all' approach to retention strategies. Rather, it seems that what is needed is the development and prioritising of 'bundles of strategies' that are individual-, discipline- and geographic location-specific, to ensure retention of different healthcare workers in different settings<sup>12,19,21,26</sup>.

Furthermore, although there is a body of quantitative research that provides critical trends in understanding the retention of healthcare workers, most of this work is atheoretical<sup>9,15,30</sup>. There is a lack of qualitative research, grounded in theory, to provide a richer, in-depth understanding of health workforce retention. The present study, located as it is as the second stage in a broader program of research, draws on the effort–reward imbalance (ERI) model<sup>31</sup> as the theoretical framework. This phase of the study explores what underpins the high levels of effort–reward imbalance found among participants in the initial quantitative study (for more details, see Hodgkin and Warburton<sup>32</sup>). The intent of this stage is to understand better the perceptions of older healthcare workers relating to their retention in the workforce. The present article contributes to knowledge as it provides a strong empirical and theoretical approach to understanding this under-researched but critical area of health provision.



Outcomes from this qualitative study have specific and timely relevance to older healthcare workers, management of rural healthcare organisations, and individuals interested in improving the wellbeing and retention of older rural healthcare workers, and thus the sustainability of quality healthcare services in rural communities.

## *Theoretical framework*

This program of research utilises the ERI model as its theoretical framework, an approach designed to assess the deleterious health effects of experiences at work. While largely untested in an Australian population, the ERI model has been used extensively in European studies to examine how work stress impacts on workers in the human services sector<sup>33</sup>. The fundamental tenet of the ERI model is that imbalance between a high amount of effort and low rewards represents a deficit between ‘costs’ and ‘gains’, which in turn leads to stress. A further key concept of the model is over-commitment, which accounts for individual personality characteristics. In short, the greatest amount of stress is experienced if an employee perceives their work situation as being high cost and low reward, and particularly if they feel over-committed.

European research has shown that imbalance in effort and reward has been linked to numerous health problems, including burnout in nurses<sup>34</sup>, lower job satisfaction and increased mental distress<sup>33</sup>, and sleep disturbance and fatigue<sup>35</sup>. In addition to health impacts, high ERI has also been associated with poor work quality, and intentions to retire early<sup>36,37</sup>. All of these factors are highly concerning in a workforce struggling to maintain sufficient workers.

Furthermore, and consistent with the ERI model, the qualitative phase reported in this paper draws on a similar approach to Campbell, McAllister and Eley<sup>38</sup>, who explored both recruitment and retention of rural allied health professionals. Thus, the qualitative interviews in the present study are analysed through using motivation theory and Herzberg’s extrinsic and intrinsic classifications as an analytical framework<sup>38,39</sup>. This enables a much deeper

understanding of the impact of effort–reward imbalance if more older workers are to be retained in the rural healthcare workforce.

## Methods

The aim of this qualitative phase of the research is to address gaps in research knowledge by using qualitative methods to explore the factors associated with retention of older (≥55 years) nurses and allied health workers across northern Victoria. The specific aim was to identify potential strategies to improve effort–reward balance and, in turn, retention of older healthcare workers.

This qualitative study comprised phase 2 of a large mixed-methods study of nurses or allied health workers located in northern Victoria and aged over 55 years. Participants in this stage of the research had taken part in a previous linked study (phase 1) conducted by the authors, at which time they had indicated their willingness and consent to participate in further research. Participation was voluntary and all participants provided informed consent. Eighteen participants were interviewed and one later withdrew, making a total of 17 participants reported here. At phase 2, participants were informed that interviews were audio recorded for transcription purposes, with their identity remaining anonymous, and pseudonyms being used instead of real names.

A semistructured interview schedule was designed to explore two main themes of interest. Specifically, open-ended questions focused on: (1) identifying factors that differentiate perceptions between participants experiencing ERI and those who are not (eg questions about participants’ workplace and role; and work-related factors that make them feel like a valued staff member); and (2) identifying factors that influence participants decision to stay in employment (eg questions about participants’ work and retirement plans, and factors that might influence these plans; and any factors that the workplace could do, which would influence their decision



to leave or retire). Clarification and elaboration probes were used to explore issues raised throughout the interview<sup>40</sup>.

A total of 299 participants aged over 55 years completed the initial survey. This specific age cut-off was included to represent older workers who are the most likely cohort to be looking to the future in terms of retirement and plans for later life. Of these, 161 participants expressed interest in being interviewed at phase 2 via their returned, completed consent form. Briefly, phase 1 participants were recruited anonymously through the payroll department of 17 rural public healthcare facilities under the jurisdiction of the Victorian Government Department of Health, in the Hume catchment region. Health facilities were predominately local health services and hospitals. Paper surveys (including a demographic information sheet, a psychological wellbeing questionnaire, ERI questionnaire, and a consent form for participants interested in participation in further research) were attached to payslips of individuals identified to fit the inclusion criteria (healthcare professional but not medical professional, aged over 55 years, and currently employed in any of the 17 public healthcare facilities in the Hume region).

Recruitment for phase 2 involved purposeful stratified sampling procedures from the original database of 161 participants. As the data were linked, demographic and workplace variables were able to be accessed for participants. Sampling was deliberative to ensure representation of both high and low scoring participants with regard to the ERI scale reflective of the original (phase 1) cohort. Also, because the study cohort reflected the national rural health workforce with relation to gender spread and discipline mix (ie predominantly female nurses), the decision was made to over sample for males (2/17) and allied health professionals (4/17) to ensure some level of representation. This avoided an overly gendered discussion that may have focused on issues perhaps specific to nursing. The final sample largely comprised nurses ( $n=13$ ; 76.5%), while the remainder of the sample were in varied positions within the allied health field (eg social worker, physiotherapist, diabetes educator, and aged care services co-ordinator), reflecting the structure and composition of Australian public hospital system<sup>41</sup>. Table 1

displays participants' descriptive statistics obtained, including demographic data, employment status, potential retirement age, and ERI score. Any ERI ratio score over 1 indicates the presence of effort-reward imbalance.

Prior to the commencement of interviews, the researcher contacted interested participants from phase 1 to see if they were still willing to participate. Audiotaped, semistructured phone interviews were then conducted with participants, following a brief initial conversation to build rapport, as recommended by DiCicco-Bloom and Crabtree<sup>42</sup>. Each interview covered the same topics, as indicated by the interview guide, and ranged in time from 15 to 70 minutes. Interviews continued until theoretical saturation had been reached; that is, similar themes were being repeated by participants<sup>43</sup>.

Data were entered into NVivo v9 (QSR International; [www.qsrinternational.com/products\\_nvivo.aspx](http://www.qsrinternational.com/products_nvivo.aspx)), and inductive thematic analysis was used to analyse the data, following guidelines put forth by Braun and Clarke<sup>44</sup>. Thus, specific themes were not pre-determined; rather, they emerged from participants' data<sup>45</sup>. In presenting the data, the authors have used Herzberg's extrinsic and intrinsic classifications as an analytical framework<sup>38,39</sup>, and the ERI model as a context for the interviews and interpretation of the results. Strategies were employed to ensure rigour throughout the research process, including the attainment of truth value (credibility), applicability (transferability), consistency, and neutrality<sup>46-48</sup>. Specifically, credibility was obtained through the use of a semistructured interview tool to ensure consistency, independent analysis of data by two authors, and use of verbatim quotes to represent key themes. Furthermore, NVivo was used to establish a decision trail in terms of coding and analysis<sup>46,47</sup>. Finally, to avoid ambiguity, enhance clarity of study outcomes, and allow for comparisons with similar research, key concepts in this study are defined in Table 2.

### ***Ethics approval***

Ethical approval was obtained for the study from the Human Research Ethics Committee of the Faculty of Health, La Trobe University (FHEC10/187).



**Table 1: Participant descriptive statistics**

Variable	Category	Participants (N=17)
Gender	Female	15
	Male	2
Age (years)	Mean	58.24
	Range	55–70
Hours worked	Mean	30.65
	Range	13–48
Employment status	Full time	5
	Part time	10
	Casual	2
Employment general	Nursing	13
	Allied health	4
Age (years) at which they plan to retire	Mean	63.69
	Range	56–68
ERI ratio score	Mean	1.67
	Range	0.83–2.69

ERI, effort–reward imbalance.

**Table 2: Definition of key concepts<sup>19,38,39,49,50</sup>**

Key concept	Definition
Retention	Operational definitions of the concept retention have varied <sup>49</sup> . In this study, retention refers to ‘the length of time between start and finishing employment with a particular organisation’ <sup>19</sup> .
Extrinsic and intrinsic motivation	Similar to Campbell, McAllister and Eley <sup>38</sup> , definitions of extrinsic and intrinsic motivation used in this study are taken from Frederick Herzberg’s influential framework of motivation at work <sup>39</sup> . Extrinsic motivation (also termed ‘hygiene factors’) refers to factors/incentives that are within direct control of the workplace, and act to prevent job dissatisfaction. Examples include tangible rewards such as salary, work status and security, leave allowances, supervision and professional development. Intrinsic motivation (also termed ‘growth needs’) refers to incentives/factors that come from within the individual, and contribute to job satisfaction. These factors make a person ‘feel good’ about their work. Examples include autonomy, challenge and responsibility, opportunity for advancement, and perceived significance of the work <sup>50</sup> .
Allied health professional	For this study, allied health professionals were defined as individuals who fulfil important roles in patient care and day-to-day duties within the public health system. Examples are dieticians, occupational therapists and physiotherapists.
Rural and remote	There is no single definition of ‘rural and remote’ that has been used by researchers in the field, but, consistent with Campbell, McAllister and Eley <sup>38</sup> , ‘rural and remote’ in this study was broadly defined as a range of communities beyond major metropolitan areas.

## Results

Findings here report the perceptions of a sample of older rural healthcare workers in relation to the extrinsic and intrinsic factors that impact on their work retention. As

noted, these factors are a mix of extrinsic (work and client issues) and intrinsic (personal values, assessment of finances and views of significant others). These factors are summarised in Table 3 and then discussed briefly.





**Table 3: Extrinsic and intrinsic factors influencing intentions re retention by older healthcare workers in the Hume region of Victoria**

Themes	Participants (N=17)	Reference frequency
Extrinsic factors	17	552
Valued by the organisation	17	162
Workload pressures	17	207
Feeling valued	16	49
Support	14	60
Flexibility	11	32
Lack of options	9	20
Interpersonal conflict	5	13
Interpersonal practice	3	9
Intrinsic factors	17	334
Intention to retire	17	72
Family influences	16	66
Enjoyment of current work	15	68
Financial influences	14	42
Health	13	22
Sense of self	11	31
Social input	10	18
Adjustment to change	8	16

### Extrinsic factors

Extrinsic factors refer to factors that organisations have direct control over, and thus can be manipulated by management to enhance employee retention. Participants discussed several extrinsic factors that impact on their decisions to remain in their current role. These themes included: feeling valued by the organisation, workload pressures, feeling valued by clients, collegial support, work flexibility, a lack of options, interpersonal conflict, and interpersonal practice.

**Valued by the organisation (17/17):** The importance of feeling valued by the organisation (or lack thereof) was mentioned by all participants. In particular, there was a shared sense of disconnect between clinicians engaged in day-to-day care of health consumers, and upper levels of local management and/or government bodies. In general, participants felt there was a lack of understanding of the physical and emotional requirements of providing high-quality health care to an ever-expanding client base in a continually resource-constrained environment, as the following comment indicates:

*Well maybe some of them need to go into a hospital and see how hard we work and that we all don't just sit on our bums all day and smoke and drink coffee (Stella).*

However, those in a more senior role were less likely to report this disconnect with senior management, as they felt more in control of their work environment. For example, one participant (in a senior role) said 'I do feel valued. I get good feedback from the boss ... at the moment we're going through a difficult time financially, she calls upon me for opinions' (Yusaf).

Yet recognition from the organisation was noted as critical, providing staff with what one called 'positive reinforcement' (Quentin). When asked what their organisation could provide by way of recognition, participants mentioned both tangible and non-tangible rewards. The most obvious issue of remuneration was often raised. Almost all participants (particularly those in aged care) highlighted the inequity of pay scales for healthcare professionals in light of the critical nature of their work. Summed up by one participant:



*It's a lousy pay for what is absolutely the maximum that you can do for any living human being. I mean I look after [those who've] lost part of their brain, a lot of their faculties and in that sense it is 24 hour nursing in its true terminology. It's just – it is so undervalued and we all get extremely het up about it [laughs] ... (Louise).*

Similarly, many participants identified funded professional development as a reward they valued highly. As one participant noted, 'It's about continuing to have the freedom and flexibility to manage my own ongoing learning ... just because I'm 60 I don't think I know it all' (Yusuf). Yet as several others noted, professional development had limited availability in regional areas. By contrast, others noted that organisations need to be very careful in terms of rewards, not to appear insincere and tokenistic. For example, one participant suggested that a staff voucher offered to those who did not take time off sick 'showed almost disrespect for people' (Ursula).

**Workload pressures (17/17):** All participants also referred to workload pressures, and the negative effects it can have on their intentions to stay in the workforce. Different workload pressures were noted. In particular, the increasing demand to attend to administrative tasks (eg documentation) was a commonly expressed concern. Participants felt that tending to administrative obligations drew them away from their primary focus of patient care. For example, one participant commented 'there's so much paperwork to do' (Ursula). Similarly, another participant believed:

*I wasn't doing enough clinical work and spending all my time worrying about the things that were not clinical. Such as, you know, accreditation and quality assurance ... I believe that they're important – however, I think that we have to look very closely at how much time is spent doing those sorts of activities – the workplace demands versus what's your core responsibility as a clinician (Quentin).*

This pressure was compounded by the need expressed by participants (in clinical roles) to expedite patient discharge, although they felt that this may not be in the best interests of

patients. One participant said 'staff are expected to be on call and have recall after hours ... in a rural context, you don't have a pool of people that you can call upon to help with that burden of work' (Yusaf).

The physical and emotional toll of working in health care was also noted. Generally, there was a realisation that clinical care became more difficult as they aged. For example, one participant said 'even though I adore them and enjoy looking after them but – yeah I think the main thing would be the physicality of it because it is a very heavy load' (Louise). Another participant mentioned:

*Another thing that was prompting me to get out of shift work was that I used to get migraines a lot, and just the – I found that the stress and irregular hours – I felt that I was becoming quite unhealthy and wearing out quickly (Xavier).*

Furthermore, financial considerations also caused work stress, with some noting they had to continue working to optimise potential superannuation as most were not in a position to retire. Thus 'working is a security' (Wanda).

**Feeling valued by clients (16/17):** Nearly all participants mentioned the sense of value and personal satisfaction they derived from their patients or clients. One participant said 'We just love it when we get the feedback saying that people have felt ... nurtured and cared for and everything. So we take great pride in that' (Harriet). It became clear from participants' (clinicians') discussions that their patient–client interaction was the most common reason why they remained in the workforce and that this would be greatly missed if they left. As one participant commented:

*Yes I do feel valued because I feel valued as far as the clients go. Because even though they suffer – and some of them severely from dementia – I see recognition in their eyes when they see me. Which is – that's a miracle in its own right. So I feel valued in that sense and yes I feel valued because ... I'm told quite often that I'm a very good nurse which makes me feel valued, yes. (Louise)*





Most participants noted the importance of feeling valued by clients, and how this made them feel positive about their work environment despite other pressures.

**Support (14/17):** Similarly, many participants stated they valued the support they gained from interactions with their peers and colleagues at work. For example, one participant mentioned 'The things that would make me stay would be the support of my fellow workers – which I think is good' (Tanya). Additionally, some participants outlined the restorative nature of this interaction in the light of sometimes difficult work environments. Another participant noted the importance of 'education, the discussions that you can have with other staff members about different problems' (Quentin).

**Flexibility (11/17):** Many participants stated the importance of work hour flexibility, with some seeking more flexibility in a less responsible role. For example, one participant highlighted 'What's important to me, certainly as an older person, is being able to have flexibility to work particular days' (Wendy). Another participant said she would consider working beyond retirement 'if it was casual work or part time or something like that' (Xanthe). However, she did not feel that this was available. Having flexibility in days/hours worked was generally seen to balance the negative effects of the physical and emotional workload they experienced as healthcare workers.

**Lack of options (9/17):** A number of participants mentioned their inability to seek an alternative workplace, with some suggesting that this was due to a lack of employment options in rural settings. One participant acknowledged that 'for me, I have choices [but others face] the huge fear of losing jobs when people are getting older, and a lot of people haven't allowed for retirement' (Wendy).

### ***Other extrinsic factors***

Other factors influencing retirement/resignation decisions noted by fewer than half of the participants were 'interpersonal conflict' (5/17) and 'interdisciplinary practice' (3/17). For those who mentioned conflicts, the negative

effects were, at times, all consuming, and the toxicity of unresolved inappropriate behaviour had a direct negative impact on their willingness to remain either in their current workplace or in the workforce at all: 'There was a bullying issue some time earlier, which I hadn't even been aware of, that had never been addressed properly and that still affected people' (Nuala). In contrast, the positive contributions that comes from working in either multidisciplinary teams or in an environment where interdisciplinary discourse was encouraged was noted by a few participants. While a relatively small number of participants referred to this theme, the overall focus was in relation to enhancing patient outcomes through interactions with other professionals with varying perspectives: 'I think for me, individually, just I reckon my knowledge basis expanded. That leads, I think, to better outcomes' (Moir).

### ***Intrinsic factors***

Intrinsic factors are those that participants were most able to influence and adjust themselves, not necessarily affected directly by the workplace. They are still important considerations in terms of retention. Factors here included: intention to retire, family influences, work enjoyment, financial influences, health, sense of self, social input, and adjustment to change.

**Intention to retire (17/17):** In response to questions about retirement plans, all participants stated they had either considered retirement, or had a firm date in mind. It is important to note that, for most participants, retirement was a fluid concept dependent on many factors and open to change at any time. An intended retirement date was largely dictated by feelings of financial preparedness.

**Family influences (16/17):** Issues related to family were a common discussion topic for most participants. Participants talked about the caring needs of children, grandchildren or ageing parents. For many, there was a need to attend to someone from each category: 'everyone in our age group has family issues of one way or another. If it's not kids or grandkids or ageing parents, it's something' (Harriet). Of



particular concern for many was the potential conflict between a caring role and that of an employee. As one participant commented 'what we really need is a crèche for the elderly' (Moir).

**Enjoyment of current work (15/17):** Despite the numerous work-related difficulties they had identified, the majority of participants stated they generally enjoyed their work. One participant said 'I just love my work and I just wish more people would do it, because it is rewarding' (Stella). Many identified the conflict they experienced as they considered retirement and the potential loss of this enjoyment. Some were reluctant to leave, and as one noted, 'it's a simple task that I do and I can see myself doing it for another 20 years if need be' (Xavier).

**Financial issues (14/17):** Financial issues were another commonly mentioned theme. Almost exclusively, participants stated their acute awareness of the need to optimise the amount of their superannuation, and that this became increasingly urgent as they neared retirement age. For example, one participant stated 'I have to work financially as long as possible, and so I will be doing whatever I can to try and facilitate that' (Harriet). Furthermore, most participants wanted to be 'self-funded' with little or no mention of a dependency on government-provided retirement benefits. They sought the finances to be able to enjoy retirement and sought '...to have money for travel, that sort of thing' (Xanthe).

**Health (13/17):** More than two-thirds of participants spoke about physical or psychological health issues as being a major contributor to their ability to continue working. One participant said 'As long as my health stands up I'll probably retire when I'm about 70. If I'm feeling really good then I probably won't do it then either' (Louise). Discussion was generally focused on the effects of workload pressures and the confounding issue of failing health. For example, the thought of retirement for one participant was 'a great bone of contention because it depends on physically and mentally, how long I can keep doing it [work]' (Harriet).

**Sense of self (11/17):** Participants often talked about their 'sense of self' and how this was related to their work. Some participants described how the way their work contributed to how they constructed their identity: 'I need to work for me as much as I need the money' (Stella). Another participant while reflecting on her retirement intentions, described it as similar to 'separation anxiety' (Terese).

**Social input (10/17):** Not surprisingly, there was a degree of overlap between sense of self and social input. It was the group dynamic that often contributed to some of the indecision participants felt about leaving the workplace. For example, one participant mentioned:

*Perhaps I should move on but I like where I work and I like the girls I work with so I think that's half the battle and if you're happy in your job ... (Xena).*

### **Other intrinsic factors**

One other intrinsic issue noted by fewer than half of participants were those relating to 'adjustment to change' (8/17). For participants who referred to this topic, discussions revolved around their personal reaction to the often changing environment that is health care, and the effect this had on their sense of security and ultimate longevity in the workforce. For example, one participant said 'They just transferred me over. Yes, but they did make my immediate boss at that stage redundant and then they sacked another one. It was very disruptive' (Wanda).

## Discussion

Currently there is a scarcity of research focused specifically on factors that influence the retention of older healthcare workers in rural settings. This information is becoming more urgent in view of the current and impending workforce shortage in Australia's healthcare services, coupled with the ever-increasing demand on health services, particularly in rural communities<sup>3,5,6</sup>. Therefore, outcomes from this study provide timely and important knowledge about the factors



affecting retention among older, rural healthcare workers, and, in turn, highlight several strategies that may assist with retention of these older workers.

It is important to note that each participant discussed a variety of factors that were unique to their lifestyle, health and circumstances. While these have been presented under specific categories, many are linked to each other. Hence, for example, intention to retire is linked to financial issues. Nevertheless, using extrinsic/intrinsic categorisation as a framework allowed the authors to understand the perceptions of participants in relation to their retention as a healthcare worker. This therefore provides some useful insights for rural healthcare organisations wanting to improve the retention of their skilled older workforce, and thus build the future sustainability of their health services.

Using the ERI framework as a theoretical lens made evident an imbalance between high effort and low reward in all participants' discussion. Regarding factors that contributed to a perceived high level of effort, as mentioned, a noted finding was that participants did not single out any one factor. Rather, each participant highlighted numerous compounding factors, including the physically and emotionally demanding workload, increasing requirements to attend to clerical or administrative tasks, and lack of physical resources. By contrast, participants frequently talked about the low levels of both tangible and intangible rewards they received for their exerted effort. This lack of reward contributed to the ERI they seemed to be experiencing. Given the older age and length of service these participants have given in their healthcare role, it is reasonable to assume that these participants are experiencing, or at greater risk of, the numerous health problems ERI has been linked to, such as increased mental distress<sup>33</sup> decreased wellbeing<sup>51</sup>, sleep disturbance<sup>35</sup> and perceptions of work–life conflict<sup>39</sup>. The qualitative nature of this analysis prevents the identification of causal relationships between ERI and health problems. Nevertheless, the detrimental impact of ERI on older employees' health remains an important topic for future investigation.

It is clear from the data that strategies are urgently needed to reduce this noted effort–reward imbalance, and improve the

retention of older rural healthcare workers. These strategies are presented in Table 4. Strategies such as reducing administrative tasks, and increased open communication between employees and management are relatively achievable, could reduce stress experienced by older workers, and allow them to concentrate on providing care to clients (a primary motivation for working in health care noted in this study cohort). In turn, this would provide older workers with more opportunities to receive some of the more intrinsic rewards as valued in both our data and in other studies, such as feeling satisfaction from helping others, and feeling valued by their clients and organisation<sup>29</sup>.

Additionally, open communication with receptive management is critical to achieving positive outcomes. It should be noted here that workers were clearly articulate about the range of intrinsic and extrinsic factors that impacted on their worklife and potential for retention. While the authors did not ask specifically, many participants suggested how they dealt with the challenges they faced, and with thoughts about needed changes to work conditions. This emphasises the need for management communication, particularly as many participants had experience and knowledge gained from many years of professional practice.

Findings suggest that management needs to understand better individual employee motives, skills, and needs (eg access to professional development, an important consideration in rural areas). It would also enable older workers to have a better opportunity to discuss their job roles (eg flexible work hours, less physically demanding tasks). Opportunities for more open communication would help maximise the intrinsic rewards noted by participants, which are as important as financial ones. At the same time, it would also enable management to consider and utilise much more of the experiences of these long-term experienced staff. It is a concern that participants report a lack of acknowledgement or feeling valued by the organisation, and felt overlooked in making clinical decisions. Findings such as these support Campbell, McAllister and Eley's review, where they noted that a lack of personal recognition and respect has a negative impact on the retention of rural and remote allied health workers<sup>38</sup>.



**Table 4: Suggested strategies for retention of older aged healthcare workers in rural settings**

Strategy focus	Strategy description
Reduce workload	Streamlining, or possibly outsourcing, administrative tasks, allowing workers to concentrate on providing care to clients
Communication	Increased, open two-way communications between management and clinicians working on the 'ground floor'. Greater communication between all levels of employers and employees is likely to have numerous benefits, including: <ul style="list-style-type: none"> <li>• enhanced employee morale (eg working towards a common goal, support networks) a greater sense of feeling valued and appreciated</li> <li>• opportunities for employees to share their ideas with management</li> <li>• opportunities for employers to assess employees' needs (eg flexible work hours, modified job roles, professional development)</li> <li>• a greater understanding of employees' motives (and, in turn, matching job roles accordingly).</li> </ul>
Financial remuneration	Increased financial remuneration to reflect the physical and emotional demands of the job
Professional development	Access to quality (fully or partly funded) professional development opportunities

While these issues are critical, at the broader policy level it is also important to note that financial remuneration is also very important, particularly for this group planning for their retirement. It is well known that those working in health care receive some of the lowest earnings compared with other industries, with the Australian Bureau of Statistics (ABS) recently reporting health care as the fourth lowest paying industry out of a total of 18 industries<sup>52</sup>. It was evident in the present study that low remuneration contributed to the stress of funding retirement, and the sense of needing to continue working. Therefore, findings from this study support literature indicating the benefits of increased financial remuneration on aiding the retention older rural healthcare workers, for example, by reducing financial stress<sup>19,53</sup>.

However, findings from the present study show that there is a need for effective incentive schemes for recruiting and retaining healthcare workers, particularly older workers, which need to incorporate *both* financial and non-financial strategies, as noted by other literature<sup>19,29,54</sup>. This finding is in contrast to research indicating younger healthcare workers, who are at a different life stage than older healthcare workers, may be more motivated by financial incentives, and opportunities to advance their career<sup>6</sup>. Considering the natural course of ageing and the workforce lifecycle,

differences in motives between generations reinforce that there is no 'one bundle of strategies' that will suit all workers<sup>12,19,21,26</sup>. Instead, strategies have to be tailored to individual workers and workplaces in order to meet the challenges of maintaining an adequate healthcare workforce<sup>15,19</sup>. The present study, by focusing on efforts and rewards, and exploring the intrinsic and extrinsic factors that impact on older, rural healthcare workers, makes a further contribution to understanding what is needed for valued and experienced older workers to be retained.

## Conclusions

This study seeks to provide some important insights into a critical workforce issue. The strength of the study lies with its location within a broader program of work exploring the effort–reward imbalance experienced by older, rural healthcare workers. These findings are part of a larger mixed method study and build on previous survey data<sup>31</sup>. The intent of the present study was to explore from the perceptions of workers themselves why they were experiencing high levels of effort–reward imbalance.



The authors also acknowledge the study's limitations. It is based in one large health region of one Australian state, which may limit the generalisability of these findings to other states and regions. As a qualitative study, it inevitably comprises only relatively few participants. Despite these limitations, the findings here suggest the need for both a bundle of strategies, and more specifically, a series of strategies that will address identified issues associated with workforce retention. Furthermore, while there are studies exploring recruitment and retention issues associated with healthcare workers, the authors propose that this study contributes to this literature because of its specific focus on retention and pre-retirement age groups; on public sector healthcare workers (nurses and allied health); in a rural/regional context. All of these factors are important in view of the potential crisis facing rural health services. It is proposed that this bundle of strategies be investigated more fully and tested across rural healthcare workplaces.

## Acknowledgements

The authors would like to thank Fleur St Armand for her initial work on this study. This project was funded by the Victorian Government Department of Health and the John Richards Initiative (La Trobe University).

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