Assessing the support of health leadership for increased Indigenous participation in the health workforce

Christopher Bourke[1,4] BDSc, GDipPubHlth, GradDipClinDent, MBA,
Strategic Programs Director

Julie Lahn[2] PhD, Fellow

Colleen Gibbs[3] BASocSc, BAppSCHlthe, GDipURP, Senior Policy Officer

Natasha Lennard[2] BA(Hons), CAEPR Visitor, Aurora Intern

[1]Australian Healthcare and Hospitals Association, PO Box 78, Deakin West, ACT 2600, Australia.
[2]Centre for Aboriginal Economic Policy Research, Copland Building #24, Australian National University,
  Canberra, ACT 2601, Australia. Email: julie.lahn@anu.edu.au; n.l.lennard@gmail.com
[3]Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Level 1, 15 Lancaster Place,
  Majura Park, Canberra, ACT 2609, Australia. Email: policy@catsinam.org.au
[4]Corresponding author. Email: cbourke@ahha.asn.au

Abstract.
  Objective.   The aim of this study was to assess the strength of leadership statements in Australian state and territory policy documents supporting increased representation of Indigenous people in the health workforce.
  Methods.   Document analysis of leadership statements, prefacing state and territory Indigenous health workforce plans, from a relevant Minister or Head of Department was undertaken to detect the presence and level of 'dependency messaging': did the leadership statement clearly state that an Indigenous health workforce was needed to improve Indigenous health outcomes?
  Results.   Australian health leaders do not routinely use dependency messaging in state and territory Indigenous health workforce plans.
  Conclusion.   Greater alignment of state and territory Indigenous health workforce plans with contemporary diversity management knowledge could improve recruitment and retention of Indigenous peoples and, ultimately, Indigenous health outcomes.

What is known about the topic?   The diversity management and change management literature highlights the importance of demonstrated leadership. Dependency messaging is the clear articulation of the benefit that members of minority and diversity groups bring to an organisation's performance; this is regarded as highly influential for diversity recruitment and retention.
What does this paper add?   Strong 'dependency messaging' in health policy leadership statements could increase the Indigenous health workforce, and ultimately improve health outcomes, but is currently not uniformly used across jurisdictions. State and territory Indigenous health workforce plans were analysed using the diverse literature of change management, diversity management and strength-based approaches to provide recommendations for policy improvement that could lead to better Indigenous healthcare outcomes.
What are the implications for practitioners?   The use of dependency messaging by health leaders could enhance recruitment of an Indigenous health workforce.

Introduction

Australian Government policy strongly supports increased representation of Indigenous people across all health disciplines through the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023.[1] This framework responds to research evidence that Indigenous health professionals deliver better health outcomes for Indigenous patients. Australian states and territories have, in turn, produced their own strategic plans or frameworks to increase Indigenous representation across their health workforce.[2–8]

Each state and territory Indigenous health workforce plan features an endorsing statement from the relevant Minister

and/or Senior Public Servant, often communicating the underlying policy concepts and principles and exhorting those involved in the sector to embrace the policy direction. These succinct statements constitute important leadership direction in a critical area of policy linked to the broader imperatives of better healthcare outcomes for Indigenous people.

Leadership and leadership statements are highlighted in the change management and diversity management literature as key factors for improving recruitment and retention. In particular, 'dependency messaging' (i.e. clearly articulating the valued capacities and abilities that members of minority and diversity groups bring to an organisation's performance) enhances recruitment. In the Australian health care context, this aligns well with a 'strengths-based' approach to the value and contribution of Indigenous employees in delivering better health outcomes for Indigenous people.

The aim of this study was to assess the strength of leadership statements in Australian state and territory policy documents supporting increased representation of Indigenous people in the health workforce. Increasing the number of Indigenous people working in health care is a key strategy in delivering better healthcare outcomes for Indigenous people.

Background

Indigenous health staff benefit Indigenous patients

The assertion that Indigenous health staff help deliver better health outcomes for Indigenous people is central to Indigenous health policy in government and non-government organisations,[1,9–12] and is well supported by contemporary Australian studies.

In primary health care, Aboriginal health workers have built professional partnerships with non-Indigenous allied health professionals that improve outcomes for Aboriginal patients by providing rich local knowledge of the patient, their family and community.[13] Aboriginal health workers enable a culturally safer model of care.[14] Culturally safe health care practice has been defined as ongoing critical reflection by health practitioners of their knowledge, skills, attitudes, behaviours and power differentials in delivering health care free of racism.[15] Partnership with Indigenous health staff is a key component enabling culturally safe care by non-Indigenous health staff. The successful management of an outbreak of acute post-streptococcal glomerulonephritis in an Aboriginal community was because of the partnership with Aboriginal health staff.[16]

In hospitals, Aboriginal health workers improve cultural safety,[17] with consequently fewer Aboriginal patients leaving before treatment is completed and better continuity of care with primary healthcare providers.[18] The poor communication skills of non-Indigenous medical staff were reported to cause Aboriginal in-patients to self-discharge before treatment was completed; Aboriginal health staff overcame this problem and improved cultural safety, producing lower self-discharge rates.[19] In another study, a partnership between Aboriginal health staff and cardiac care nurses improved in-hospital cardiac care and participation in cardiac rehabilitation for Aboriginal patients.[20] Furthermore, Aboriginal cardiac patients at a major metropolitan hospital reported that Aboriginal health staff are very important because they are supportive and can overcome

problems with non-Indigenous hospital staff.[21] Of particular value was the ability to communicate with Aboriginal patients about their condition in a less stressful manner. Aboriginal patients presenting to hospital emergency departments with an acute coronary syndrome are more likely to receive appropriate care if Aboriginal staff are involved due to better coordination and communication,[22] and it has been found that Indigenous cardiac patients highly value Indigenous health staff as a vital support during hospitalisation.[23] In cancer treatment, a study of Australian cancer centres found that the care of Indigenous patients was enhanced by Indigenous staff who enabled cultural safety, negotiated barriers and supported patients.[17]

Strengths-based approach to workforce

Strength-based approaches to providing health care to Indigenous patients is an increasingly familiar idea in health, providing a framework for healthcare professionals that better supports patients in achieving their best health outcomes. Strengths-based practice recognises resilience and focuses on the strengths, abilities, knowledge and capacities of all individuals, rather than on their perceived deficits, limits or weaknesses.[24] Strengths-based practice in health care is a collaborative process between the healthcare professional and the patient that draws on the strengths and assets of the patient, their family and community. It begins with what is working and where the patient, family and community are strong, successful and passionate.[24,25] Issues and challenges are addressed by focusing on what is working well now, what has worked well in similar situations and the individual strengths of the patient and others involved, all of which inform the development of successful strategies for better health outcomes.[26] Working collaboratively promotes opportunities for the patient and healthcare professional to be cocreators in an effective and successful healthcare relationship. An additional benefit of the strengths-based orientation is its effect in 'changing the conversation', acting to transform the broader deficits-based discourse that exists around Indigenous health care.

Applying this approach to Indigenous employment in the health sector workforce raises parallels in practice and effects. It focuses attention on the diverse strengths, abilities, knowledge and capacities that Indigenous people bring to the health workforce. It acknowledges what is working well now (as attested in the research cited above) and builds on these successes to inform and guide collaborative development of organisational strategies supporting better health outcomes. A strengths-based orientation to the Indigenous health sector workforce could deliver the sought-after benefits of increased recruitment and enhanced retention of Indigenous employees. Recent Indigenous public sector employee research highlighted the importance of institutional recognition of the value Indigenous peoples bring to the effectiveness of the organisations to which they are recruited. Indigenous employees also sought a clear articulation of the 'positive case' or 'value proposition' underpinning efforts to employ them.[27,28]

Aboriginal Community Controlled Health Organisations illustrate the strengths-based approach, whereby the community identifies the problems and determines the solutions. This sector provides services that are tailored by the community for the community and covers home and site visits, medical, nursing and allied health services and public and health promotion, as

well as providing assistance with appointments, transport, accessing child care, drug and alcohol services, dealing with the justice system and providing help with income support. For example, the Institute for Urban Indigenous Health (IUIH) in south-east Queensland is a network of 20 multidisciplinary primary health clinics that provide services that have been shaped and informed by the communities to meet their needs. This model empowers the Aboriginal and Torres Strait Islander people living in the region to take responsibility for their own and their communities' health and well-being.

Importance of leadership

Managing change is consistently viewed as the primary task in contemporary organisational leadership.[29] The state and territory health workforce plans[2–8] recognise that increasing Indigenous representation across the health workforce requires policy and practice change. Leadership is vital in managing change.[30,31] Communicating the rationale for change, marshalling support and ongoing appraisal of implementation are all key elements of successful leadership in managing change.[32,33] Leaders need to transform vision into a realisable plan with top-down leadership essential for supporting workforce adaptation during the change process and averting chaos.[34]

The type of leadership is important. A case study of the US Centers for Medicare and Medicaid Services following 20 years of change found extremely low levels of employee satisfaction.[35] This was attributed to a leadership focused on performance and outcome measures at the expense of values. The appointment of a new leadership, with an inclusive and value-driven vision, markedly improved organisational performance.[35] For public organisations, the involvement of politicians, as well as agency heads, in leading change has been strongly linked with successful policy implementation.[36,37]

Institutional leadership is also a key component for success in diversity recruitment, such as increasing the representation of Indigenous people across the health workforce, in both public and private organisations.[38–43] Demonstrated, visible leadership commitment provides direction by example, clear linkage with strategic planning and promotes accountability and measurement.[38] Top leadership commitment to fostering inclusion and supporting diversity can also deliver better organisational performance from a diverse workforce.[44,45]

Dependency messaging

Recruitment is a critical activity for healthcare organisations seeking to attract applicants that contribute to and sustain change processes. In the US, minority jobseekers view potential employers differently to other jobseekers; the impression of support for a diverse workforce created by an employer is an important factor in minority jobseeker decision making.[46,47] Similarly, Australian healthcare organisations seeking to recruit Indigenous people need to develop and maintain an image of engagement with diversity.

An approach linking the institutional rationale for change and the distinctive strengths of Indigenous employees is 'dependency messaging'. Appearing in organisational impression management theory in relation to diversity recruitment, dependency messaging expresses in direct terms an organisation's need for, and valuing of, an Indigenous workforce. Dependency messaging has been termed a 'supplication' tactic.[48,49] Its use by healthcare organisations would involve openly acknowledging shortcomings in delivering healthcare services to Indigenous people and then extending a request for help to Indigenous peoples to use their unique skill sets to foster better health outcomes for Indigenous peoples. In this sense, dependency messaging is consistent with a strengths-based approach to the Indigenous workforce and delivering improved health services to Indigenous people.

Methods

In order to assess the level of support by health leadership for increased Indigenous participation in the health workforce, the present study used document analysis, a qualitative research method that deploys a systematic procedure for reviewing or evaluating documents.[50] 'Document analysis' is a broad term that can include attention to content and/or discourse. Our approach here adopted a form of content analysis to the document by allocating a numerical value to each text analysed.[51] The document analysis method has been well used in health policy research, including the evaluation of mental health strategies in Finland,[52] assessing the extent that Australian health policy addresses the social determinants of health[53] and whether national and state guidelines support breastfeeding in Australia.[54]

In this instance, an evaluation of leadership statements, prefacing state and territory Indigenous health workforce plans, from a relevant Minister or Head of Department was undertaken to detect the presence and level of 'dependency messaging' (Table 1): did the leadership statement clearly state that an Indigenous health workforce was needed to improve Indigenous health outcomes? The indicators were rated on a scale of 1–3 (1, no or not at all; 2, to some extent; 3, yes). For example, 'employment of Aboriginal and Torres Strait Islander people is a fundamental enabler of closing the health gap' would be rated as '3', whereas 'encouraging Aboriginal people into health disciplines will inevitably promote more effective service delivery for Aboriginal people' is more limited in the expression of need and would be rated as '2'. No policy, or a policy that does not include a statement linking an Indigenous health workforce and Indigenous health outcomes, would be rated as '1'.

Data were collected in April 2019 by an online search for state and territory Indigenous health workforce plans. All states and territories had a plan on the internet,[2–8] apart from Tasmania.

Analysis proceeded by JL and CB independently rating each prefacing statement contained in the policy documents. The two researchers then shared their ratings; discrepancies were discussed and a final decision agreed.

Results

The leadership statements contained in state and territory Indigenous health workforce strategies and plans show a lack of consistency in strength of dependency messaging. Just three jurisdictions offered leadership statements that were strongly consistent with the assessment criteria (Queensland, Western Australia and South Australia). Both Queensland and South Australia drew specific attention to the direct role of an Indigenous health workforce in producing improved health outcomes: '*a fundamental enabler* of closing the health gap'[5] from

Table 1.   Strength of dependency messaging by health leaders

Statements were scored as follows: 1, no; 2, to some extent; 3, yes. ACT, Australian Capital Territory; NSW, New South Wales; NT, Northern Territory; Qld, Queensland; SA, South Australia; Tas., Tasmania; Vic., Victoria; WA, Western Australia

State or territory	Document	Statements by Ministers or Department Heads	Strength of statements
ACT	Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018[2]	Employing, recruiting and retaining Aboriginal and Torres Strait Islander people in the health workforce, strengthens our ability to provide an effective, responsive and culturally safe health system which is of mutual benefit to the community and our organisation. [Director-General, ACT Health]	2
NT	Northern Territory Aboriginal Health Plan 2015–2018[3]	No statement about Indigenous Health Workforce by Minister for Health and Chief Executive Officer	1
NSW	Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016–2020[4]	Our commitment to have more Aboriginal people employed by NSW Health is important in frontline services, policy and program development, support roles that leads to better understanding of individual and community needs, better services, better access and better outcomes. [Secretary, NSW Health]	2
		Encouraging Aboriginal people into health disciplines will inevitably promote more effective service delivery for Aboriginal people in NSW. [Secretary, NSW Health]	
Vic.	Aboriginal Employment Strategy 2016–2021[7]	…a diverse workplace will deliver better outcomes for vulnerable Victorians…Increasing Aboriginal employment not only improves health and wellbeing, it is also a key driver for improving access to quality and culturally appropriate health and human services for the Aboriginal community. [Secretary, Department of Health and Human Services]	2
Qld	Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026[5]	The employment of Aboriginal and Torres Strait Islander people at all levels and in all disciplines within Queensland Health's workforce is a fundamental enabler of closing the health gap in Queensland. [Director-General, Queensland Health]	3
SA	SA Health Aboriginal Workforce Framework 2017–2022[6]	A significant enabler to reducing the disparity in health outcomes is building the capacity and capability of our workforce to deliver quality care to Aboriginal people. We know that having skilled Aboriginal staff makes a difference to Aboriginal patients and families…We know too that cultural safety and clinical safety are both essential for delivery of high quality care. [Chief Executive, SA Health]	3
WA	WA Health Aboriginal Workforce Strategy 2014–2024[8]	More Aboriginal staff are needed to help address the significant health issues faced by Aboriginal people. [Acting Director General, Department of Health]	3
Tas.	–	Workforce plan under development	1

Queensland and '*a significant enabler* to reducing the disparity in health outcomes'[6] from South Australia (italics added). Both policy leadership statements also articulated, to a degree, particular attributes brought by Indigenous employees to the health workforce, notable the ability to facilitate required levels of 'cultural responsiveness'[5] and 'cultural safety'.[6] The Western Australian leadership statement cites more specific skill sets, including 'the ability to break down barriers to access, and bring cultural perspectives'.[8] The Western Australian statement's proposition that 'more Aboriginal staff are needed to *help address* significant health issues'[8] (italics added) is less direct than the Queensland or South Australian statements in acknowledging the vital role played by an Indigenous health workforce. However, the Western Australian message was a more direct example of dependency messaging through the use of the phrase 'are needed'.[8]

The New South Wales leadership statement offers a strong message in relation to the 'importance' of increasing Aboriginal employees in NSW Health linked to improving service delivery in a range of areas (access, understanding, outcomes).[4] However, it is weakened by an insufficiently explicit communication

of specific strengths possessed by the Indigenous health workforce linked to 'inevitably promoting' better Indigenous health-care outcomes.[4]

Statements from health policy leaderships in Victoria and the Australian Capital Territory point to the benefits of an Indigenous workforce in broad terms (e.g. citing diversity, community and employment rates), but make no direct link to improved health outcomes or to the specific skills and abilities offered by the Indigenous workforce.[2,7] The statements communicate relatively weak dependency messaging, with implicit rather than explicit acknowledgement of an institutional need for increasing the recruitment and retention of an Indigenous workforce.

The Northern Territory plan offered the weakest leadership statement among those assessed,[3] with no statement concerning the Indigenous workforce. Tasmania was the only jurisdiction lacking an Indigenous health workforce plan.

Discussion

The health sector has been a large employer of Indigenous people over an extended period relative to other sectors, but

challenges remain in terms of attracting, recruiting and retaining Indigenous people in the health workforce.

Although all states and territories (except Tasmania) have Indigenous health workforce plans and strategies in place, the analysis here suggests the policy leadership statements that accompany those documents do not present uniformly consistent and clear expressions of dependency messaging, despite contemporary research evidence attesting to the value of an Indigenous health workforce in improving outcomes for Indigenous health.[13,14,16–23]

This represents a significant missed opportunity for health policy leadership across Australia to collectively articulate and disseminate a powerful institutional message, one that would work to both entrench a strengths-based approach to Indigenous health and support further growth of the Indigenous health workforce.

The current lack of consistency suggests uneven engagement by state and territory health workforce policy leadership with current approaches to diversity management. It also reflects broader policy approaches to Indigenous recruitment in the public sector that tend to be framed largely in terms of commitments to equity as a fundamental value and Indigenous employment as a social and economic good in and of itself (whether for the individuals involved or their communities), but gives relatively little attention to the benefits Aboriginal and Torres Strait Islander employees bring to public sector work.

Dependency messaging alone is unlikely to deliver improved outcomes in Indigenous employment statistics. Further research is required in understanding what works in the recruitment and retention of Indigenous employees, not just in health but across a range of sectors. However, dependency messaging is a powerful tool for signalling to the health sector, and to prospective and current employees, that in delivering better health outcomes to Indigenous patients an Indigenous workforce is not just desirable, but a necessity.

Conclusion

There is clear and growing research evidence that Indigenous health professionals deliver improved healthcare outcomes for Indigenous patients.[13,14,16–23] This is a direct consequence of the range of unique skill sets and insights that Indigenous peoples bring to their roles in the health workforce. Studies of Indigenous patient experience clearly demonstrate the positive effect the Indigenous health workforce has on supporting better care outcomes.[21,23] Non-Indigenous staff deliver better outcomes when they work in partnership with Indigenous staff.[13,16,20] Such findings illustrate the critical effect of the culturally informed and committed care Indigenous health professionals are able to provide in reducing institutional racism and improving cultural safety.[17,19,55] In practice, however, this potential for improving health service delivery and better health outcomes for Indigenous peoples cannot be fully realised without greater support in promoting and growing the Indigenous workforce.

Better alignment of leadership in Australian state and territory health workforce policy areas with contemporary diversity management is needed. Leadership that reflects the current evidence concerning the value and unique strengths of the Indigenous health workforce, through strong statements using dependency messaging, could improve Indigenous representation in the health workforce with better outcomes for Indigenous patients. Developing and supporting this health workforce is a critical step towards achieving national 'Close the Gap' objectives. The analysis provided here of leadership statements accompanying current state and territory Indigenous health workforce plans suggests that stronger policy leadership is required to enable change.

Competing interests

One author, Christopher Bourke, is a member of the *Australian Health Review* Editorial Advisory Board. There are no other competing interests to declare.

Acknowledgement

References

1   Australian Health Ministers Advisory Council (AHMAC). National Aboriginal and Torres Strait Islander health workforce strategic framework 2016–2023. Canberra: AHMAC; 2017.

2   ACT Health. Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018. 2013. Available at: https://www.health.act.gov.au/sites/default/files/2019-02/Aboriginal%20and%20Torres%20Strait%20Islander%20Health%20Workforce%20Action%20Plan%202013-2018.pdf [verified 1 April 2020].

3   Northern Territory Government. Northern Territory Aboriginal Health Plan 2015–2018: improving Aboriginal health outcomes: closing the gap in health and wellbeing between Aboriginal and non-Aboriginal Territorians. 2015. Available at: https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/798/1/Northern%20Territory%20Aboriginal%20Health%20Plan%202015%20-%202018.pdf [verified 1 April 2020].

4   NSW Government, Ministry of Health. Good health – great jobs: Aboriginal workforce strategic framework 2016–2020. 2016. Available at: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_053.pdf [verified 1 April 2020].

5   Queensland Health. Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026. 2016. Available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0023/628340/aboriginal-torres-strait-islander-workforce-framework.pdf [verified 1 April 2020].

6   SA Health. SA Health Aboriginal workforce framework 2017–2022. 2017. Available at: https://www.sahealth.sa.gov.au/wps/wcm/connect/a986c5c3-5d95-4a9a-b7da-ec07a5352d22/SA+Health+Aboriginal+Workforce+Framework+2017-2022.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-a986c5c3-5d95-4a9a-b7da-ec07a5352d22-mMyTiMn [verified 1 April 2020].

7   Victoria State Government, Department of Health and Human Services. Aboriginal employment strategy 2016–2021. 2016. Available at: https://www.dhhs.vic.gov.au/publications/aboriginal-employment-strategy-2016-2021 [verified 1 April 2020].

8   Government of Western Australia, Department of Health. WA Health Aboriginal workforce strategy 2014–2024. 2014. Available at: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Aboriginal%20health/PDF/workforce_strategy.pdf [verified 1 April 2020].

9   Australian Health Ministers Advisory Council (AHMAC). Aboriginal and Torres Strait Islander health performance framework 2014 report. Canberra: AHMAC; 2015.

10   Lowitja Institute. Workforce. 2019. Available at: https://www.lowitja.org.au/page/research/research-categories/health-services-and-workforce/workforce [verified 30 June 2019].

11 Australian Indigenous Doctors' Association (AIDA). Policy statement: the role of doctors in Closing the Gap. Canberra: AIDA; 2016. Available at: https://www.aida.org.au/wp-content/uploads/2017/08/FINAL-The-Role-of-Doctors-in-Closing-the-Gap.pdf [verified 30 June 2019].

12 Mohamed J. Growing the Aboriginal and Torres Strait Islander nursing and midwifery workforce. Canberra: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; n.d. Available at: https://www.naccho.org.au/wp-content/uploads/Congress-of-Aboriginal-and-Torres-Strait-Islander-Nurses-and-Midwives-CATSINaM.pdf [verified 30 June 2019].

13 Hooper K, Thomas Y, Clarke M. Health professional partnerships and their impact on Aboriginal health: an occupational therapist's and Aboriginal health worker's perspective. *Aust J Rural Health* 2007; 15: 46–51. doi:10.1111/j.1440-1584.2007.00849.x

14 McDermott RA, Schmidt B, Preece C, Owens V, Taylor S, Li M, Esterman A. Community health workers improve diabetes care in remote Australian Indigenous communities: results of a pragmatic cluster randomized controlled trial. *BMC Health Serv Res* 2015; 15: 68. doi:10.1186/s12913-015-0695-5

15 Cox L, Best O. Cultural safety history repeats: why are we taking the redefinition road? *Croakey* 2019; 2019: 18.

16 Custodio J, Kelly G, Haenga M, Bell C, Bond T, Prouse I, Eastwood A. Working in partnership with communities at risk: the potential of integrated public health action during an outbreak of APSGN in remote Australia. *Aust Indigen Health Bull* 2016; 16: 1–10.

17 Taylor EV, Haigh MM, Shahid S, Garvey G, Cunningham J, Thompson SC. Cancer services and their initiatives to improve the care of Indigenous Australians. *Int J Environ Res Public Health* 2018; 15: 717. doi:10.3390/ijerph15040717

18 Taylor KP, Thompson SC, Wood MM, Ali M, Dimer L. Exploring the impact of an Aboriginal Health Worker on hospitalised Aboriginal experiences: lessons from cardiology. *Aust Health Rev* 2009; 33: 549–57. doi:10.1071/AH090549

19 Einsiedel LJ, van Iersel E, Macnamara R, Spelman T, Heffernan M, Bray L, Morri H, Porter B, Davis A. Self-discharge by adult Aboriginal patients at Alice Springs Hospital, Central Australia: insights from a prospective cohort study. *Aust Health Rev* 2013; 37: 239–45. doi:10.1071/AH11087

20 Daws K, Punch A, Winters M, Posenelli S, Willis J, MacIsaac A, Rahman MA, Worrall-Carter L. Implementing a working together model for Aboriginal patients with acute coronary syndrome: an Aboriginal Hospital Liaison Officer and a specialist cardiac nurse working together to improve hospital care. *Aust Health Rev* 2014; 38: 552–6. doi:10.1071/AH13211

21 Worrall-Carter L, Daws K, Rahman MA, MacLean S, Rowley K, Andrews S, MacIsaac A, Lau P, McEvedy S, Willis J. Exploring Aboriginal patients' experiences of cardiac care at a major metropolitan hospi3tal in Melbourne. *Aust Health Rev* 2016; 40: 696–704. doi:10.1071/AH15175

22 Tavella R, McBride K, Keech W, Kelly J, Rischbieth A, Zeitz C, Beltrame J, Tideman P, Brown A. Disparities in acute in-hospital cardiovascular care for Aboriginal and non-Aboriginal South Australians. *Med J Aust* 2016; 205: 222–7. doi:10.5694/mja16.00445

23 Mbuzi V, Fulbrook P, Jessup M. Indigenous cardiac patients' and relatives' experiences of hospitalisation: a narrative inquiry. *J Clin Nurs* 2017; 26: 5052–64. doi:10.1111/jocn.14005

24 Hammond W, Zimmerman R. A strengths-based perspective. Resiliency intiatives. 2012. Available at: https://shed-the-light.webs.com/documents/RSL_STRENGTH_BASED_PERSPECTIVE.pdf [verified 30 June 2019].

25 Alliance for Children and Youth of Waterloo Region. Strength-based approaches: improving the lives of our children and youth. Kitchener, ON: Alliance for Children and Youth of Waterloo Region; 2009. Available at: http://www.healthyllg.org/_resources/Strength-Based_Approaches_Backgrounder.pdf [verified 30 June 2019].

26 Congress of Australian and Torres Strait Islander Nurses and Midwives (CATSINaM). Participant handbook, cultural safety and quality health service standards training. Canberra: CATSINaM; 2018.

27 Faulkner S, Lahn J. Navigating to senior leadership in the Australian Public Service: identifying barriers and enablers for Aboriginal and Torres Strait Islander people in APS employment. Canberra: Australian Public Service Commission; 2019.

28 Lahn J. Being Indigenous in the bureaucracy: narratives of work and exit. *Int Indig Policy J* 2018; 9: 3. doi:10.18584/iipj.2018.9.1.3

29 By RT. Organisational change management: a critical review. *J Change Manag* 2005; 5: 369–80. doi:10.1080/14697010500359250

30 van der Voet J. The effectiveness and specificity of change management in a public organization: transformational leadership and a bureaucratic organizational structure. *Eur Manage J* 2014; 32: 373–82. doi:10.1016/j.emj.2013.10.001

31 Nadler DA, Tushman ML. Beyond the charismatic leader: leadership and organizational change. *Calif Manage Rev* 1990; 32: 77–97. doi:10.2307/41166606

32 Battilana J, Gilmartin M, Sengul M, Pache A-C, Alexander JA. Leadership competencies for implementing planned organizational change. *Leadersh Q* 2010; 21: 422–38. doi:10.1016/j.leaqua.2010.03.007

33 O'Shea JA, McAuliffe E, Wyness LA. Successful large system change: at what cost? *J Change Manag* 2007; 7: 107–20. doi:10.1080/14697010701531723

34 Smith AD, Rupp WT. An examination of emerging strategy and sales performance: motivation, chaotic change and organizational structure. *Mark Intell Plann* 2003; 21: 156–67. doi:10.1108/02634500310474

35 Kellis DS, Ran B. Effective leadership in managing NPM-based change in the public sector. *J Organ Change Manage* 2015; 28: 614–26. doi:10.1108/JOCM-11-2013-0229

36 Kuipers BS, Higgs M, Kickert W, Tummers L, Grandia J, Van Der Voet J. The management of change in public organizations: a literature review. *Public Adm* 2014; 92: 1–20. doi:10.1111/padm.12040

37 Xerri MJ, Nelson SA, Brunetto Y, Reid SRM. NPM and change management in asset management organisations. *J Organ Change Manage* 2015; 28: 641–55. doi:10.1108/JOCM-11-2013-0222

38 Wyatt-Nichol H, Antwi-Boasiako KB. Diversity management: development, practices, and perceptions among state and local government agencies. *Public Pers Manage* 2012; 41: 749–72. doi:10.1177/009102601204100409

39 Martins L-P. HR leaders hold the key to effective diversity management. *Hum Resour Manage Int Dig* 2015; 23: 49–53. doi:10.1108/HRMID-05-2015-0093

40 Lafever-Ayer L. Making diversity business critical. *Strategic HR Rev* 2013; 12: 145–50. doi:10.1108/14754391311324507

41 Kramar R. Diversity management in Australia: a mosaic of concepts, practice and rhetoric. *Asia Pac J Hum Resour* 2012; 50: 245. doi:10.1111/j.1744-7941.2011.00010.x

42 Chiappetta Jabbour CJ, Serotini Gordono F, Caldeira de Oliveira JH, Martinez JC, Gomes Battistelle RA. Diversity management. *Equal Divers Incl* 2011; 30: 58–74. doi:10.1108/02610151111110072

43 Choi S, Rainey HG. Organizational fairness and diversity management in public organizations: does fairness matter in managing diversity? *Rev Public Person Adm* 2014; 34: 307–31. doi:10.1177/0734371X13486489

44 Sabharwal M. Is diversity management sufficient? Organizational inclusion to further performance. *Public Pers Manage* 2014; 43: 197–217. doi:10.1177/0091026014522202

45 Carstens JG, De Kock FS. Firm-level diversity management competencies: development and initial validation of a measure. *Int J Hum Resour Manage* 2016; 28: 2109–35.

46 Thomas KM, Wise PG. Organizational attractiveness and individual differences: are diverse applicants attracted by different factors? *J Bus Psychol* 1999; 13: 375–90. doi:10.1023/A:1022978400698

47 Lievens F, Slaughter JE. Employer image and employer branding: what we know and what we need to know. *Annu Rev Organ Psychol Organ Behav* 2016; 3: 407–40. doi:10.1146/annurev-orgpsych-041015-062501

48 Avery DR, McKay PF. Target practice: an organizational impression management approach to attracting minority and female job applicants. *Person Psychol* 2006; 59: 157–87. doi:10.1111/j.1744-6570.2006.00807.x

49 Windscheid L, Bowes-Sperry L, Jonsen K, Morner M. Managing organizational gender diversity images: a content analysis of German corporate websites. *J Bus Ethics* 2018; 152: 997–1013. doi:10.1007/s10551-016-3292-6

50 Bowen GA. Document analysis as a qualitative research method. *Qual Res J* 2009; 9: 27–40. doi:10.3316/QRJ0902027

51 Given L. Document analysis. In: Given L, editor. The Sage encyclopedia of qualitative research methods. Los Angeles: Sage Publications; 2008.

52 Vähäniemi A, Warwick-Smith K, Hätönen H, Välimäki M. A national evaluation of community-based mental health strategies in Finland. *Int J Qual Health Care* 2018; 30: 57–64. doi:10.1093/intqhc/mzx166

53 Fisher M, Baum FE, MacDougall C, Newman L, McDermott D. To what extent do Australian health policy documents address social determinants of health and health equity? *J Soc Policy* 2016; 45: 545–64. doi:10.1017/S0047279415000756

54 Esbati A, Barnes M, Henderson A, Taylor J. Legislation, policies and guidelines related to breastfeeding and the Baby Friendly Health Initiative in Australia: a document analysis. *Aust Health Rev* 2018; 42: 72–81. doi:10.1071/AH16067

55 Bourke CJ, Marrie H, Marrie A. Transforming institutional racism at an Australian hospital. *Aust Health Rev* 2019; 43: 611–18. doi:10.1071/AH18062