Improving human resource management in Chinese healthcare: identifying the obstacles to change

LIKUN PEI, PAULINE STANTON AND DAVID LEGGE

Dr Likun Pei is a Senior Lecturer and Dr David Legge is an Associate Professor in the School of Public Health, La Trobe University; Dr Pauline Stanton is a Senior Lecturer in the Graduate School of Management, La Trobe University.

Abstract

Health sector reform in China has led to increasing responsibility for hospital managers in the management of staff, but constraints continue. New personnel reforms offer new opportunities but face a number of difficulties. Drawing on research in Chinese hospitals in 1997 this paper identifies two major obstacles to improved human resource management: wage policy and lack of control by local managers over staffing.

Context

Prior to the 1980s the health system in China was organised on a centralised model, with finance and personnel functions in health care organisations being directly administered by government agencies. The main role for health service executives was to oversee and administer rules and decisions made by others. The situation was complicated by the parallel Communist Party hierarchy, as at the organisational level the Communist Party secretary often had more influence and control over day-to-day decision-making than the named executives of the institution (Pei, 1998).

The move from a planned economy to a socialist market economy and China's entry into the world market led to rapid economic reform that has involved radical change in all sectors, including China's health sector. These changes include the reduction of government financial support for the recurrent costs of health services and the reform of management systems with increased autonomy for managers at the health care facility level. The introduction of the Contract Management Responsibility System (CMRS) has decentralised decision making from government to the health institutions, increasing the operational responsibilities of senior management. The introduction of the Presidential Responsibility System has also placed greater responsibility on the hospital president relative to Party secretary (Liu, Wen and Liu, 1996).

By the mid 1990s hospital managers had greater responsibility for the management of financial resources and some control over the day to day management of staff, however government bureaux still controlled prices, wages and personnel allocation including the recruitment and selection of staff. Health sector reform had meant that managers had increased responsibilities and were expected to manage rather than administer but they were severely constrained by the continuing central regulation of the personnel function. For hospital managers there was a tension between increasing accountability for efficient and effective resource management and lack of control over wages and conditions and labour recruitment and utilisation (Guo, Wang and Zhao 2002).

In 2000 the Chinese government introduced legislation to encourage greater freedom in personnel management and to improve people management through the application of human resource models and better

organisational policies and procedures (Ministry of Organisation, Ministry of Personnel and Ministry of Health 2000). Recent evidence suggests that these reforms are meeting some difficulties in implementation due to both local lack of knowledge and skills and wider structural constraints (Guo, Wang and Zhao 2002, Li 2002). In this paper we draw upon a study on Chinese hospital managers carried out in the 1990s to cast light on some of the obstacles to reform. We first outline the development of human resource management in modern China, then describe the research study and discuss the relevance of the findings of the study in the present situation.

Human resource management in China

From the establishment of the People's Republic, hospitals in China were either state-owned or enterprise-owned institutions. Until 1979 government authorities were responsible not only for employment policy and planning in such institutions but also for their implementation. Policies relating to wages, housing, and benefits were all determined centrally - a system known as the 'iron rice bowl'. Job allocation was also carried out by central agencies; there was little labour mobility; some areas were overstaffed; and workers had few incentives or rewards (Verma and Tan 1995). There was very little management autonomy in relation to the recruitment and selection process and dismissal of poor quality staff was impossible. People were often promoted according to seniority and 'guanxi' (personal connections) rather than merit (Warner 1993, 1996).

Recent labour market reforms have included the decentralisation of the management of the labour force, a move from an administrative focus to a managerial one, and an emphasis on increasing productivity (Zhu 1997, Zhu and Dowling 2001). Warner (1996) argues that, overall, decentralisation in the state owned enterprises (SOEs) and the development of joint ventures with western companies have given organisations increasing freedom to control their human and financial resources and on the surface many managers appear to be adopting western models of human resource management.

HRM can be described as the use of a proactive, integrative series of interventions, which promote 'organisational fit', the integration of organisational strategy, cultural change and dialogue between key stakeholders at the workplace (Walton 1985). It is a relatively new concept in China introduced through management practices in foreign owned companies and the growth of joint management training courses between overseas and Chinese universities (Braun and Warner 2001). There is evidence that a variety of western human resource management practices are being implemented in China (Zhu 1997, Bjorkman and Lu 1999), although the extent is difficult to establish (McComb, 1999); and because of the influence of Chinese social and cultural principles the impact of these developments in practice is also difficult to ascertain (Whitely et al. 2000). McComb (1999) argues that although many aspects of the Chinese workplace have changed drastically over the last 20 years, the personnel function in most firms has changed little. However, recent research from Braun and Warner (2002) suggests that western multinationals in particular are making notable attempts to introduce high performance human resource practices across their Chinese operations.

In 2000 the National Health Personnel Conference put forward a goal of health system personnel reform. According to the policy within three to five years, the public health care sector will have established a new administrative system supervised by government which will include: increased autonomy by health organisations over the management of personnel; free selection of work units by individuals; open labour recruitment and dismissal; performance based promotion and remuneration; and organisational autonomy in relation to staff establishment (Tu, 2000). Anecdotal evidence suggests that there are some difficulties in the implementation of these reforms at the local level yet there has been no serious systematic study as to why this might be the case. The study reported in this paper, although carried out before the new policy was introduced, identifies a number of important people management problems facing the health sector.

Survey of managers

In 1997, a collaborative research project was undertaken in Yunnan, a South-Western province of China, as part of planning for a health management training program (Pei 1998). The purpose of the research was to document and analyse the training needs of hospital managers in a sample of three teaching hospitals affiliated with the main medical university in the region, two general hospitals with a total of 1,700 beds, and one specialist cancer hospital with 500 beds. The data collection included a self-administered questionnaire survey involving all managers in the three hospitals, interviews with a sub-group of senior managers, and an extensive collection of documentation from the three hospitals and the health bureau.

The questionnaire asked open and closed questions about the managers themselves and their careers as managers; recent improvements in the way their hospital is run; barriers to implementing change; frustrations in their work and reforms which might be needed. There was also a series of questions related to managerial competencies adapted from Rawson's model (1986). The questionnaires were despatched to 342 hospital managers through their institutions, and a total of 242 completed questionnaires were analysed using SPSS, representing 71% of the identified population. Twenty managers were purposefully selected for interviews. The selection criteria for this group (determined by the leadership of the university) included an individual's management record, enthusiasm and capability, career potential as a management leader and teacher. The interview schedule was developed from the issues emerging from the questionnaire survey and was designed to elicit more in-depth information. Interviews were carried out by one of the researchers, who is a native Chinese speaker. They were tape-recorded and transcribed.

The findings suggested that the management of staff was one of the most important areas of concern for hospital managers. Managers complained of the lack of autonomy over what they described as personnel policy or personnel system decisions. Fifty five percent of the survey responses and almost all interviewees identified the 'rigid personnel system' as one of the major problems in their work. Forty two percent of survey respondents cited personnel management problems in responding to the question that asked about frustrations and difficulties, in particular day-to-day staff management problems such as interpersonal issues, and the lack of rules and regulations.

Two major concerns cited throughout the study were problems with staff remuneration, in particular the bonus system, and problems with hiring and firing, including having no power over dismissal or numbers of staff employed, and limited power over recruitment. Thirty eight percent of respondents cited these issues as the priority for reform.

Staff remuneration

Staff remuneration in Chinese hospitals generally includes the basic salary, bonus payments and social welfare benefits such as housing and medical care. The basic salary depends on a person's professional title or grade and experience according to standards which are set by the central government. With the introduction of the CMRS hospitals can now pay workers bonuses on top of their state-determined salaries. There are three main features of the bonus system: first, there is no upper limit on bonus payments; second, bonus payments are not uniform across the hospital but depend on the revenue-raising capabilities of individual departments; and third, bonus payments are not automatic, staff who are not seen as hard working or who work in departments which do not earn much revenue will not necessarily receive bonus payments.

Sixty percent of managers interviewed argued that the responsibility of the work of medical staff compared with other professions is much greater, but traditionally they have actually earned less because basic salaries are so low. To rectify this situation hospital managers have elected to pay relatively large bonuses linked to work performance with a view to creating stronger work incentives. Bonuses have become a large part of salaries in the health sector (in some cases twice the basic salary) and the bonus system has become a major form of staff motivation in Chinese hospitals.

The bonus system aroused the initial enthusiasm of hospital staff as it allowed them to receive a much higher total income, and the principle of bonus payments linked to work performance was supported particularly by departmental managers. All the departmental interviewees stated that the introduction of revenue sharing, at the department level and then to individuals, has put in place strong incentives for increased productivity. The greatest problem in the past was that '*taking patients made no difference to an individual's income*', so no one was willing to take patients, and '*all tried to shift the burden to others*'. There was a change in attitude after the manager made decisions on bonus payments for the medical staff according to quantified standards based on responsibility for groups of patients. One manager argued that everyone now competes to take and discharge patients meaning that patients get treated quickly, leading to improvements in bed turnover and average length of stay.

However, managers also argued that some people sought economic gain at the expense of their professional responsibility and medical ethics. They invested their energy and time in considering ways to maximise their incomes rather than providing high quality medical care or upgrading their professional skills. One manager suggested that some doctors charged more than the standard fee, or organised unnecessary medical tests, with a view to generating more revenue for their department. Also some doctors were unwilling to go for advanced studies because they would have to forego high bonus payments while they were away. Over half of the interviewees suggested that the bonus system had a bad influence on the quality of medical care in the hospitals, leading to a poor service attitude towards patients and a negative impact on staff development. There are also criticisms that the use of bonus payments had exacerbated existing imbalances between wages, costs, prices and fees. Departments which provide services that do not generate revenue are not able to pay bonuses from their basic salary allocation and as a consequence are often unable to attract staff or encourage productivity.

The system also creates perverse incentives. Staff who don't receive large bonuses are under particular pressure to generate commissions, through referrals to private clinics or the purchase of medicines and equipment. One manager argued that staff in departments with lower bonuses '*spend the whole day thinking about how to make money and allocate the bonuses. This has badly affected their work*'. Managers suggested that hospitals should be able to give adequate salaries to staff according to their professional skills and their actual work. They argued that national reform should explore doctors' incomes and increase their salaries directly, so that doctors would spend less time maximising their own incomes and more time and energy on patient care, teaching and research. '*Then hospitals can introduce a better method, which will not put the burden on the department alone to generate greater revenue.*'

However, personnel reform policy does not address these concerns. The Government is committed to linking pay and promotion to performance and there has been no discussion on national salary reform or even recognition that it might be a problem.

Staffing issues

The CMRS had only limited impact on staffing decisions. Government personnel authorities, until recently, retained close control over staffing decisions in the health sector. Hospitals had a fixed quota for staff establishment and hiring and firing had to be authorised by the local personnel bureau and the health bureau. Every year, in addition to accepting college and university graduates, hospitals were required to take personnel from other organisations and retired soldiers. Also hospitals are still responsible for the whole of life and family welfare of their employees; not only paying their salaries, but also providing accommodation, social welfare and medical care.

Managers stated that recruitment and selection took place at the provincial level and that they often had little say in who was chosen. When hospitals needed additional staff the higher authority allocated staff to meet the needs. The extent to which the hospital could choose from the available staff depended on the relationship between the hospital and its higher authority. Sometimes they simply had to accept those people who were allocated. In other cases they were able to look at the files of the potential recruits and have some influence over which ones were accepted. In addition to the normal method of recruitment there were, of course, a number of

informal methods. Pressure was sometimes felt to recruit relatives or other people because of their personal connections.

Managers complained about their limited power over the recruitment of staff, and a number of interviewees identified the problem of nepotism within the Chinese personnel system as an important issue of concern. Managers gave examples of hospitals hiring the children or relatives of staff or hiring other people who had personal connections with higher authorities and senior managers. As the number of staff with personal connections inside a hospital increases, it becomes more difficult to implement reward and penalty policies fairly, to assign jobs to the best person and to manage conflict among staff members. This approach to recruitment cannot ensure the quality of staff; indeed the overall quality of employees might gradually decrease. One manager argued that his hospital had been forced into hiring unqualified medical professionals and administrators leading to many departments literally doing nothing and: '*the burden on the hospital has become heavier and heavier*.' Another manager complained that there were too many people who got into the hospital through their personal relationships: '*If a person is assigned to you, dare you not accept him*?'

The size and makeup of the staff establishment was a related issue. Although managers were responsible for expenditure they had no control over how many staff they employed or the proportion of medical to administrative staff. Hospitals were allocated a fixed number of staff by the responsible government bureau. They were not permitted to discharge staff even if they were over-staffed nor could they recruit new staff if they were short-staffed.

Over half of the interviewees saw the lack of ability to dismiss as a major problem. Dismissing someone meant not only cutting off their income but also their welfare benefits so any dismissal, even for gross negligence or violation of work rules, still required the authorisation of the relevant government authority. There were also interpersonal issues, as one manager stated:

'*We cannot decide to keep or dismiss staff members according to the needs of the hospital and the individual's work achievements. I want to dismiss quite a few unqualified cadres, but I cannot. They are either someone's relatives or another's friends. I have no power to deal with the situation*.'

Twenty seven percent of survey respondents and a third of interviewees commented upon these complex interpersonal relationships often described as 'guanxi'. Quanxi literally means personal connections or relationships and is still very important for 'getting on' in Chinese society even if technocratic qualifications have become more necessary. However, managers felt that too much of their time was spent in dealing with relationships, with superiors, subordinates and government officials. Managers complained about having to be involved in social practices like feasting; meeting demands from superior departments for financial assistance; paying relationship fees in doing official business. One manager stated: '*this takes money from the hospitals. If the hospitals refuse to comply then we don't get things done. It is a big headache for us. We can do nothing about it*.' Managers complained about the time wasted in coordinating interpersonal relationships to make sure that decisions about the hospital's work were not hindered.

In order to deal with these situations there was wide agreement in the survey and the interviews on the importance of having clear and agreed rules and regulations and over 22% of the survey respondents and a third of the interviewees cited clearer rules and regulations as examples of recent improvements in hospital administration. Managers are gradually regularising the hospitals' work and making efforts to enhance the establishment and enforcement of rules and regulations, and they felt that these efforts had proved helpful. However, 19% of survey respondents described how in many areas there was still a lack of documented and authorised rules and often even where there were rules, there were difficulties in achieving compliance because of lack of adequate management and supervision systems. In this context the introduction of formal HRM systems and processes appears to have much to offer and the personnel reform gives some hope. However, a policy decreed on high without leadership, support, training and guidance at the organisational level is likely to flounder, and there is little evidence so far that the reform process has addressed local implementation issues.

Conclusions

This study suggests that there are two major issues that need to be tackled if personnel reform is to be achieved in Chinese hospitals. The first is wage policy. Low basic salary levels and the heavy use of the bonus system creates a strong motivation for all staff to focus on revenue generation rather than also considering the efficient and effective use of resources. The heavy reliance of managers on the bonus system to motivate staff may be due to the limitations on their formal personnel authority. However, there are some quite perverse incentives which arise from the use of bonuses. Employees are very concerned to maintain the revenue that pays their bonus and the hospital and departmental managers depend upon bonus payments to stimulate staff's work motivation. Low salaries supplemented by high bonus payments create incentives for clinical staff to be attracted to some area and not others thus having a direct affect on recruitment strategies.

The second issue is the lack of control by local managers over staff recruitment, promotion and separation which affects the quality and effective distribution of staff. Many people are still promoted according to seniority and connections rather than merit, and permanent staff still enjoy the 'iron rice bowl' advantage. Also hospitals, like many other SOEs in China, have problems of what to with 'displaced' staff, and redeployment is more common than retrenchment. Pressure for hospitals to take new personnel or redeploy staff regardless of their expertise means that many of them have to be appointed as administrators and this reduces the scope for employing more clinicians.

The lack of control by managers over recruitment and dismissal also increases the need for fee revenue to pay salaries. This adds to the pressure to keep salaries low because the total number of staff are in excess of what is needed, in turn, low salaries and excess staffing levels contribute to low morale and productivity.

While personnel reform addresses recruitment and selection it will be difficult to overcome longstanding practice in which the limitations on managers' authority in relation to personnel decision-making has had widespread ramifications. On the one hand, hospital managers expressed concern about the use of guanxi by others in determining appointments and other transactions of personnel, which undermines the credibility of formal systems and distorts the allocation of resources. On the other hand, managers themselves also used guanxi in their own practice. In dealing with government authorities, with peers or with subordinates they have to depend upon their personal credits (and acquire new obligations) in achieving their purposes. Clearly better policies and procedures can limit this reliance but will not eradicate it altogether.

China has a major capacity-building task as it moves away from direct government administration of personnel functions in the health sector to vesting these responsibilities within the health care organisations themselves. Developing effective human resource management within the health system will involve new procedures, rules and norms in human resource planning and personnel management including staff recruitment and termination. This will involve not just documenting and announcing a new set of procedures, but cultivating respect for the efficiency, fairness and accountability of the new arrangements and a general commitment to playing by these new rules. Clearly human resource management techniques and approaches have much to offer in terms of creating a high performance workplace. However, it cannot all be done at local level, and will require some regulatory back up for the new system, including a regulatory framework which is fair, effective and transparent and which can gain and hold the respect and commitment of managers and workforce. Similarly while improved training and development of managers in HRM practices is essential there needs to be a wider approach to workforce planning. A move to improved HRM practices and personnel reform in Chinese hospitals is to be welcomed but it needs to be done in a framework that sets directions centrally, while allowing flexibility at the local level.

References

Bjorkman I and Lu Y (1999) 'The management of human resources in Chinese-Western joint ventures' *Journal of World Business* Vol 34 no 3 pp 306-324.

Braun W. and Warner M (2002) 'Strategic human resource management in western multinationals in China' *Personnel Review*, Vol 31, No 5, pp 553-579.

Guo J, Wang K & Zhao Y (2002) 'Analysis of questions on personnel system reform of hospital in China' *Chinese Hospital Management* Vol 22 No 12 pp1-3.

Li D (2002) 'Challenges and strategies of personnel reform for health institutions' *Chinese Health Service Management*, Vol 163 No 1, p 59.

Liu S, Wen L. and Liu D (1996). *A Complete volume on health care administration and management of China (in Chinese)* Beijing: People's Medical Publishing House.

McComb R (1999). 'China's human resources odyssey' *The China Business Review*, Vol 26 No 5 pp 30-33.

Ministry of Organisation, Ministry of Personnel & Ministry of Health (2000) *Guidance of deepening health personnel reform for health institutions*, Beijing, Ministry of Health.

Pei L (1998). *Hospital management in a time of change: the need for management training (and policy reform) in three teaching hospitals in Yunnan*, Ann Arbor, Michigan UMI.

Rawson G (1986). *Senior health service managers: Characteristics and educational needs*. School of Health Administration, University of New South Wales.

Tu Y (2000). 'All-round start of personnel system reform in health sector'. *Economic Daily*, Beijing, 16 May, p 14.

Verma A and Tan Z (1995). 'The changing face of human resource management in China: opportunities, problems and strategies', Verma A., Kochan T and Lansbury R (eds) Employment *Relations in the Growing Asian Economies*, London Routledge pp: 315 -335.

Walton RE 1985, From Control to Commitment in the Workplace, *Harvard Business Review*, 63, (2), 77-84.

Warner M (1993). 'Human resource management with 'Chinese characteristics' *The International Journal of Human Resource Management* Vol 4 No 1 February pp 45-65.

Warner M (1996). 'Economic Reforms, industrial relations and human resources in the People's Republic of China: an overview' in *The Industrial Relations Journal* Vol 27 No 3 September.

Whitley A, Cheung S and Zhang S.Q (2000) *Human Resource Strategy in China* World Scientific Publishing, Singapore.

Zhu C (1997) 'Human Resource Development in China during the Transition to a New Economic System' *Asia Pacific Journal of Human Resources* Vol 35 (3) pp19-44.

Zhu C and Dowling P (2001) *Changes in Contextual Variables in China's Human Resource Management: Implications for HRM convergence and divergence* Faculty of Business and Economics Monash University Working Paper 84/01 November 2001.