CASE STUDIES

# Human resource management in hospitals: A contested arena for jurisdiction

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## Abstract

*During the past 10 years, financial pressures on health service providers have led to a quest for more efficient service delivery and many consequential changes to the organisation and utilisation of staff. This study investigated the organisational responses to such pressures by four major South Australian hospitals and the level of involvement of hospital human resource staff in the staffing issues associated with strategic planning. With one exception, there was little contribution from qualified human resource professionals to staffing decisions involving medical and nursing personnel and little value was placed on their potential input by other professional groups. If, as suggested by writers on strategic human resource management, human resource practice is moving toward a more strategic approach, then there is a large credibility gap for human resource staff to overcome within the South Australian health service.*

## Introduction

Australia's system of health care delivery typifies the pressures facing all industries in the 1990s, since it is driven largely by the need to contain costs and improve service, in addition to specific health system pressures to achieve better national

health returns. Health care developments include major changes in the structure and funding of public and private health care delivery in the hope of achieving more cost-effective and higher quality services. Such changes have included the use of casemix in funding arrangements and moves to restructure the public health system by separating funders, purchasers and providers.

The majority of South Australian public hospitals have responded to financial constraints by re-evaluating their own structures and accountability systems so that they incorporate both clinical and financial criteria. Restructuring has included outsourcing components of non-core activities and devolving authority for decision-making on budgetary and resource matters closer to the level of clinical decision-making. Financial systems have been enhanced to incorporate the collection and dissemination of information to ensure that treatment decisions can be fully costed. These changes are turnaround in their focus and substantive in their magnitude and are designed to have significant impact on hospital management practices. They indicate that governments at both federal and State levels are no longer seeking to achieve efficiencies by introducing incremental types of change which leave the hospital structure and decision processes basically untouched. Rather, they are moving towards a more radical outcome whereby health activities, including many of those once thought to be havens of secure job tenure, are now being contracted out to private providers.

In such a turbulent political, industrial and financial environment, health service managers have become increasingly conscious of the need to apply a strategic focus to managing their human assets. Simultaneously, developments in professional human resource management practice have emphasised a strategic focus for staffing issues (for example, Guest 1987). As a result there have been increasing pressures to integrate corporate strategy with human resource management (for example, Marchington & Parker 1990; Storey 1992) and thus facilitate the effective achievement of corporate goals. For example, pressures to increase efficiency have led to large-scale downsizing in both the public and the private sector; pressures to improve quality standards and customer services have placed greater emphasis on performance and its measurement.

The impact of these changes has been the focus of research in health service management both here and overseas. The authors are members of an international research team seeking to gather information on the processes by which health services achieve more efficient outcomes with fewer resources. Our early findings (Barnett et al. 1994; Buchanan et al. in press; Patrickson & Maddern 1995) indicated that decision-making structures in hospitals were becoming more decentralised, whilst central administrative bodies which controlled funding allocations were simultaneously increasing control over resource utilisation through additional accountability mechanisms. The present

study focuses on whether there has been a changing role for human resource practitioners in hospitals to reflect the changing focus of administration.

## The sample

Four hospitals participated in the study. They represented a variety of hospital management arrangements for comparison. Three were large metropolitan public hospitals and the fourth (Hospital C) was a large metropolitan private not-for-profit hospital. Two (Hospitals A and B) of the three public hospitals were managed by public sector staff. The third (Hospital D) was managed and staffed by a private provider (since February 1995), the first contract of its kind in South Australia and, as such, closely monitored by both government and community bodies.

## Research questions

In gathering information, we sought answers to the following questions.

1. Who, in the hospital (department), is involved in:
    - 1.1 Designing reporting relations for top management, middle management and other employees?
    - 1.2 Making decisions on staff numbers, and staff mix?
    - 1.3 Setting budgets and monitoring financial performance against the budget?
    - 1.4 Making treatment decisions which have staffing implications?
    - 1.5 Conducting staff performance reviews?
2. How has this changed in the last two years?
3. What factors influenced the locus for these human resource activities?

Permission was given by the chief executive officer at each hospital to conduct semi-structured interviews with senior staff. These followed an information capture menu, and were subsequently recorded, transcribed and analysed. This information was augmented with copies of relevant documents, including annual reports and some relevant internal documents.

Seven interviews were conducted in each of the three public hospitals and six in the private not-for-profit hospital. This provided five interviews with chief executive officers, six interviews with medical administrators, and 16 with representative professional staff employed at the next level.

## Results

Input into strategic decision-making by human resource specialists was remarkably lacking in the hospital system in South Australia, as evidenced by the following information.

### Designing reporting structures

In all institutions, primary input into the system of reporting relationships between functions was the prerogative of the chief executive officer. Limited advice was sought from colleagues at the immediate reporting level, but only at Hospital B did this level contain any representative from human resources. Consequently, in no case was the structure influenced by those with professional training in organisational design. However, it was customary in public hospitals for all major structural changes to be vetted and ratified (and at times proposals considered to be innovative were vetoed) by a centralised authority such as the Health Commission and thus it could be argued that professional assistance was available at this level.

The privately operated hospitals (Hospitals C and D) did not employ human resource specialists but accessed industry representative bodies and networks of private human resource consultants when there was an identifiable need, such as in occupational health and safety. At these hospitals, structural decisions were handled by senior executive staff, a number of whom had acquired significant experience in the field and had established credibility with others in the senior management team, for example, the director of corporate services and the director of nursing at Hospital C. In addition, Hospital D had access to senior managers within other hospitals managed by the same group. None of these contributors were human resource specialists.

Traditional influences operated strongly in all four institutions to ensure that nurses administered nurses and doctors administered medical staff. Hospital C varied slightly in this respect because the director of corporate services was responsible for the employment of medical staff. Nevertheless, the medical staff had reporting lines through the Medical Advisory Committee and access to the Board of Management via medical representatives on the board.

Though two public hospitals employed human resource staff, their responsibilities and authority differed. In Hospital A, human resource staff had no direct input into structural design at the senior level. However, in Hospital B, the human resource manager had input at the strategic level via membership of the senior management group. This was interpreted by respondents as being associated with the expertise of the job holder, who had been recruited from a

senior post outside the health sector in 1994. Since being appointed to the hospital, this individual had exercised direct influence on the structure of clerical and administrative areas. New human resource approaches, such as multi-skilling of ancillary staff, were implemented and staff (including 'personnel' staff) with commercial knowledge bases and experience were hired from outside the health industry.

Thus hospital administrators or executives, aided by senior staff from medical and nursing administration, designed the reporting structures in all hospitals in our sample. For all hospitals, major changes would also be approved by their Board of Management.

## Decisions on staff numbers and staff mix

Decisions on staffing levels were strongly governed by available funding and hospital funding has been steadily reducing for the last five years. Consequently, all four institutions were seeking alternative ways to reduce costs and increase productivity and, in the private sector, to improve their competitive edge by attracting high profile specialists who would bring business to the hospital. These included various methods of staffing current functions, use of technology, alterations in clinical practice such as day surgery, and introduction of new services in the private sector, for example, cardiac surgery and emergency services.

Alternative ways to provide non-core services other than by full-time employees were also being considered. In the public sector the South Australian Health Commission had introduced an open tendering process in which targeted staff groups could lodge in-house bids in competition with external private service providers. Initially targeted for potential outsourcing were catering services, gardening and maintenance services, cleaning, and even some medical and nursing services for which demand was spasmodic rather than constant. The private operators were already contracting external organisations to provide non-core activities at specified levels of quality and efficiency.

At Hospital A, staffing plans were developed by the members of the clinical directorate team in consultation with each other, in general with nurses speaking for nurses and doctors speaking for doctors, but nonetheless requiring coordination at the level of directorate management. Any changes to existing practice were then negotiated with more senior staff such as the director of nursing and the medical director. An example of changes undertaken in the last two years was grouping patients according to the degree of nursing required, thus allowing staffing ratios and experience to be more appropriate to the care and clinical requirements of the patients. Where possible, only seriously ill patients

were kept in hospital over a weekend to avoid paying higher penalty rates over that period. Nurses maintained that only qualified medical or nursing staff were able to make such decisions, which required a high level of clinical judgement. In this way they were able to ensure that control over staffing remained in medical/nursing hands.

At Hospital B, staffing requirements were initially developed by heads of sections and then submitted to the executive committee for approval. In recent years, however, most staffing decisions have involved staff reductions rather than additions. Human resource staff had been responsible for reducing numbers in many non-medical areas but medical and nursing staff had each held jurisdiction over staffing decisions in their own clinical fields. As the management teams for the divisions are developed further, it is intended that these decisions also be devolved to the divisional team.

At Hospital C, staffing plans were considered by the divisional directors and discussed at the executive management meetings. Decisions to reorganise or reduce staff were also made by the executive management team. Established practices according to patient dependency were in place for nursing staff requirements at any particular time. With the radical reorganisation of the nursing and administrative structures to provide divisional management teams, more of the responsibility for such decisions will be devolved as in the public hospitals. The executive team, however, is still likely to maintain oversight of staffing.

Staffing decisions in Hospital D were made at the executive level, with input from the various divisions and oversight by the regional manager. This hospital had achieved a great deal of flexibility in recruitment and staffing processes compared to its previous arrangements when it was tied to public sector practices.

## Budgeting and financial control

Some devolution of authority in financial matters had occurred in all hospitals in recent years. At two public hospitals (Hospitals A and B) there was widespread recognition by senior staff that devolution of financial management was needed if staff were to be held accountable for financial performance. Consequently, clinical directorates at both hospitals each developed operating budgets and were responsible for ensuring cost containment. Senior managers cited that the devolution process could only work effectively if there were well-developed information systems to assist them and more divisional involvement in the financial management systems.

Hospital C had developed detailed financial and costing information systems in preparation for casemix-based funding and in response to the need for more and more information required in negotiations with the health insurers. Budgets were developed, monitored and controlled by the divisional directors and their managers in close consultation with the finance director. A significant educative process had been undertaken to ensure that managers understood the process and participated in it. The budgets were further fine-tuned by the executive management team. With the change in structure, nurse managers who were previously responsible for financial control will assume more of a supportive function, passing the monitoring and control to the clinical managers who are responsible for the decisions which drive the costs.

Hospital D was in the process of changing financial and reporting systems to the model used by the private provider. Budgeting and financial control was primarily the responsibility of the senior management team, including the finance manager. At the time, the clinical areas did not have to focus on these tasks and in the near future were unlikely to be asked to take as much responsibility in this area as in the other hospitals. Nevertheless, they will be involved in discussions/consultation on cost control as the need arises. The philosophy of the management team seemed to be to provide the management and financial support for clinical practice without expecting professional staff to spend large amounts of time involved in financial and budgetary processes.

### Reviews of staff performance

Performance review was undertaken under several umbrellas, thus broadening the potential jurisdiction over the activity. Clinical practice was generally assessed by quality assurance practices entrenched as part of standard operating procedures in most hospitals. All four hospitals had appraisal systems operated by the various professions and departments. In addition, the private operators used performance contracts for their executive managers.

Generally, appraisal systems were profession-specific and there was little evidence of human resource specialist involvement in the development and implementation of these processes. In the public sector, the Health Industry Development Centre had developed a resource package and conducted appraisal courses, but attendance at these was purely voluntary.

In summary, performance appraisal systems existed in all organisations but these were largely profession-specific, with a variety of purposes from identifying individual development and training needs to being more performance and outcome-focused. The research team is still unclear as to the details of how these

integrate with the organisations' strategic directions, priorities or human resource plans and will be conducting further research to clarify this. Thus it would be premature to comment on the level of sophistication of these systems.

## Changes in the last two years

Major changes in all hospitals were associated with the financial cutbacks and the increasing stringencies which these placed on senior staff. Almost all interviewees reported increased stress levels, both their own, and an increasing level of stress amongst staff generally. Two public hospitals (Hospitals A and B) had been driven by having to absorb dramatic reductions in funding, associated bed closures and the introduction of the tendering policy for non-core activities. These had hastened the moves towards further devolution of decision-making and accountability, consideration of alternative clinical practice, multi-skilling of ancillary staff and moves to outsource non-core activities. Only Hospital B had recruited a human resource specialist to assist with the strategies and the processes for change.

At Hospital C the biggest changes had been associated with the construction of the new wing and the related treatment and staffing changes, and a major review and reorganisation of the nursing structure. As a consequence, other areas of the hospital will be reorganised to provide a greater focus on customers.

At Hospital D the change to private sector management and service provision and the associated staffing issues had resulted in major upheavals within both the hospital and the surrounding community.

## Major influences on the locus of human resource management activities

Public hospitals in South Australia have a long tradition of human resource issues being handled by centralised authorities such as the South Australian Health Commission and the Commissioner for Public Employment. The Health Commission formerly permitted little latitude to individual hospitals to vary staff mix, negotiate individual variations in employment contracts, set pay levels or implement professional human resource practices at the local hospital level. Rather, such decisions were seen as the prerogative of the central authority, which employed personnel at head office to provide a moderating staff management function to each State-funded hospital. The aim was to safeguard comparability across the various State-based hospitals, all of which were being funded from public money.

At the hospital level, human resource management, or 'personnel' as it is often still called, has traditionally been exercised as a regulatory function rather than a strategic one. Human resource staff in many public hospitals have largely been restricted to interpreting industrial relations and guidelines, arranging recruitment for some groups of staff and keeping records of pay and leave entitlements. In the organisational hierarchy, human resource staff were located lower than most other senior staff. In terms of Storey's (1992) distinction between strategic and tactical roles, their focus has been predominantly tactical.

Given that this became entrenched over many years, it was difficult to change. Few, including human resource staff, saw the need. Consequently, chief executive officers, planning officers, directors of nursing, medical directors and finance directors were those concerned with staff deployment, as such matters were considered to be critical to economic operations and required handling at the most senior level.

## Have human resource managers lost influence?

Influence seems not to have been lost as such. Rather, the window of opportunity which restructuring presented to adopt a more strategic approach to human resource management within South Australian hospitals has been seized by others. Such an outcome contrasts with emergent practice in other industries, here and interstate, where human resource staff have been struggling to define a new and more strategic role for their professional jurisdiction and have strongly advocated that their input into strategic operations is necessary to ensure human talent is effectively utilised in a more competitive environment. Supporters of strategic human resource management emphasise that one major way to highlight the strategic nature of this new role is to ensure that the senior human resource person has direct access to the chief executive officer through a direct report relationship – that is, their location in the structure is at the most senior level. Cascio (1995) reports that this has already occurred in some 70 per cent of United States companies. Rough Australian figures, though difficult to acquire with any degree of reliability, indicate that the proportion would be a lot less than this.

While there is less evidence of human resource management becoming more strategic in Australia than elsewhere (Limerick 1994; Purcell 1994), the move towards a more strategic approach has certainly opened up an arena for debate which is summarised by Legge (1995, p 103):

> *arguably the act of consciously matching HRM policy to business strategy is only relevant if one adopts the rational 'classical' perspective. From the point*

*of view of the processual perspective, there may be no clearly articulated business strategy with which to match HRM policy.*

The human resource group is not the only or even perhaps the most credible professional group to seek jurisdiction over the strategic human resource management agenda. Other contenders in business settings include strategic planners and senior marketing and finance staff. Their claims for jurisdiction over the human resource agenda rest on their professional judgement of the number and types of individuals necessary to achieve marketing targets and the resources available for their remuneration. Differences are resolved through a combination of negotiation and coordination at corporate level.

Though hospitals in our sample differ marginally in the ways they have approached this dilemma, they nonetheless agree in that they do not accord human resource specialists with the necessary expertise to be part of a negotiated decision process. One public hospital, where the human resource manager was recruited from outside the health industry, is the only exception.

Awareness that human resource staff have a potential to contribute to the strategic agenda was poor. In the words of some participants:

*'…they're not seen as an expert resource that can be relied on and they've just lost it as far as I'm concerned.'*

*'…useful contributing resources in the past but…hadn't recognised today's needs…or simply weren't capable of doing what had to be done today…'*

*'…the strategic side of it…has to come from within the departments…'*

Human resource departments were largely viewed as fulfilling a bureaucratic role rather than a strategic one:

*'…are they just there to serve the political masters at the time…or are they there as professionals who are expert in the area of personnel relations?'*

*'…they've got to make a case and prove the case that they have a contribution to make…but if they can't do that and if people can't see how putting money into other areas will increase throughput…people aren't going to put money into that area.'*

In referring to a strategic focus being assumed by human resource specialists:

*'…a personnel area here which doesn't have a lot of impact in that regard.'*

*'…they're highly unlikely to ever have it, because the budget cuts are such that you can't put money into that.'*

## Strategic human resource management: The rhetoric, the reality and the options for change

A significant gap appears between the urgings of human resource writers on strategic human resource management and the practice. Kramar (1992) remarked on the emerging gap in commercial organisations. In the health sector, historical factors have contributed to a widening of the gap to the extent that few strategic activities are being undertaken by human resource staff. Unless pressure is applied, either from human resource staff themselves or from senior managers, there is little incentive for change. Our evidence suggests that, not only are there few such pressures, but that alternative pressures to enhance the contribution of other staff groups operate strongly (American Organization of Nurse Executives 1992; Bruhn, Levine & Levine 1993).

Moreover, human resource staff have contributed to their own disenfranchisement and, without their agitation and the necessary competence to have an input into strategic decisions, any future change may disenfranchise them even further. By contrast, the other contenders for strategic power, the planners, the senior medical, nursing and finance staff, and heads of institutions, appear to have gained in strategic stature as a consequence of having to maintain services in an environment of financial cutbacks and reduced resources.

Competence in confrontational industrial matters, in demand in the 1980s, has reduced. The 1990s demand skills in staff deployment, separation initiatives, outsourcing negotiations and internal political activity. Yet the majority of human resource staff have not responded by developing a more relevant skill portfolio. Nor have they been assisted to do so.

Watson (1986) pointed out that many human resource staff find themselves in a double bind, running the risk of being overloaded if they collect too many activities or else being scapegoated if they tackle messy problems and fail. Clearly human resource management is experiencing a credibility problem which can only be resolved if individual human resource staff begin to exhibit increasing skills, not only in the emergent human resource agenda but within each hospital, in the political process of a negotiated advisory role. The people management expertise needed in the 1990s may not necessarily be the prerogative of any specific discipline or individual, but open to negotiation between the competent, the desirous and those with a strong compelling argument underlying their claim. If human resource staff are to have any input to strategy, then they need to advance on all three fronts.

Training programs which update skills and have a heavier emphasis on external recruitment are two possible activities to enhance human resource input. A surge

in the desire to be part of the strategic process on the part of human resource staff and a willingness to seek their advice on the part of other professionals are two others. Without such developments, it is likely that the strategic human resource management agenda will continue to elude human resource staff.

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