

## Chapter 5

# Human Resource Management's Contribution to Healthy Healthcare



David E. Guest and Annet H. de Lange

**Abstract** The aim of this chapter is to outline and evaluate the role of human resource management (HRM) in contributing to healthcare provision and to the well-being of those working in healthcare. To achieve this, the chapter is divided into three main sections. The first section describes the nature and importance of HRM, highlighting some of the main theoretical and conceptual debates and some of the research evidence. The second section reviews and evaluates research on HRM in healthcare, illustrating how it has been associated with positive outcomes such as lower mortality rates, better continuity of care and higher patient satisfaction. The third section presents an outline of a distinctive employee-centred approach to HRM that focuses more explicitly on employee well-being and sets out a future research agenda.

**Keywords** Human resource management · Employee well-being · Performance · Ageing · Burnout · Bullying

### 5.1 What is Human Resource Management and Why does it Matter?

This first section describes the nature of HRM, outlines some of the core research findings and highlights some of the challenges in implementing HRM in context. We start

---

D. E. Guest (✉)

Emeritus Professor of Organizational Psychology and Human Resource Management, King's Business School, King's College London, 30 Aldwych, London WC2B 4BG, UK  
e-mail: [david.guest@kcl.ac.uk](mailto:david.guest@kcl.ac.uk)

A. H. de Lange

Department of work and organizational psychology, Open University, Heerlen, The Netherlands  
e-mail: [annet.delange@han.nl](mailto:annet.delange@han.nl)

Department of HRM at the Academy of Organisation and Development, HAN University of Applied Sciences, Arnhem and Nijmegen, The Netherlands

Norwegian School of Hotel Management of the University of Stavanger, Stavanger, Norway

© Springer Nature Switzerland AG 2020

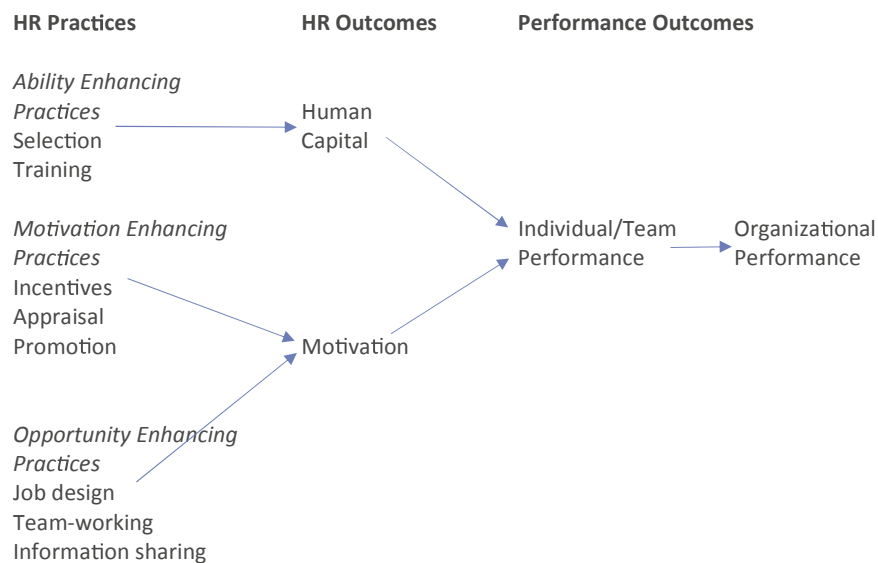
L. T. Løvseth and A. H. de Lange (eds.), *Integrating the Organization of Health Services, Worker Wellbeing and Quality of Care*,  
[https://doi.org/10.1007/978-3-030-59467-1\\_5](https://doi.org/10.1007/978-3-030-59467-1_5)

109

by defining the nature and content of HRM. In simple terms, human resource management (HRM) is concerned with the management of people in organizations. Boxall and Purcell (2013) suggest it is “All those activities associated with the management of work and people in organizations”. Since effective healthcare provision depends on the performance of its staff, HRM has a potentially valuable contribution to make to effective healthcare provision.

HRM addresses the development and implementation of a wide range of policies and practices affecting the management of people. An influential analysis by Appelbaum, Bailey, Berg, and Kalleberg (2000) proposed that the core role of HRM is to ensure the ability and motivation of employees and to provide them with opportunities to contribute to organizational goals.

Ability depends on careful recruitment and selection and training and development. Motivation depends on providing appropriate goals and incentives. In healthcare, financial incentives are unlikely to be appropriate so the focus needs to be on intrinsic motivation through the nature and challenge of the work. Motivation will also be enhanced through careful goal-setting, ideally in the context of performance management where developmental appraisals can include jointly agreed goals and priorities. Opportunity to contribute can be achieved by providing sufficient autonomy and responsibility to ensure that a contribution is possible, complemented by effective two-way communication, including an opportunity to suggest improvements, as well as voice mechanisms to express concerns. This approach, sometimes simply described as the AMO model, has provided a popular basis for research since it points to a range of HR practices that should be measured. Figure 5.1 provides an illustration of the content and assumptions of this model.



**Fig. 5.1** The AMO model of HRM and performance

The content and focus of the HR practices outlined above will depend in part on the strategic goals of the organization. In the private sector, this may be a function of the competitive environment and therefore involve judgements about how to compete in a challenging market. One of the influential perspectives on strategy is what is termed the resource-based view of the firm (Barney, 1991). This makes the point that many resources that matter to organizations such as finance and technology can be quickly copied but this is more difficult to achieve with human resources and organizational culture. Therefore, one way to gain competitive advantage is to focus on investing in human resources. This give greater prominence to HRM as a strategic priority (Barney & Wright, 1998), although it may be a message that falls on deaf ears in many organizations. In healthcare, and particularly in public sector healthcare organizations, the strategic challenges can be rather different to those of the private sector. They may reflect choices about healthcare priorities, about expansion or contraction of specific services and specialties or about finance. These in turn will affect the HRM priorities.

Schuler and Jackson (1987) suggest that the choice of strategic priorities facing an organization about how to compete, for example through high quality or cost control, will help to determine the kind of people who need to be in key positions in the organization and how employees need to be managed to achieve the strategic goals. This in turn shapes the HR policies and practices required to manage the workforce to achieve these goals. This suggests a form of strategic determinism, in effect a contingency approach. It implies that there will be a variety of ways of managing human resources.

In considering the broad strategic choice about how to manage the workforce, a distinction has been drawn between a high commitment and a high control approach (Walton, 1985). High commitment implies a trusting environment where staff are given autonomy to undertake their work. In contrast, a control environment implies lower trust and tight monitoring of performance by the organizational hierarchy. The temptation for management in challenging times is to seek to exercise tighter control. This may not be compatible with the traditions of professional autonomy or with a healthy organization as experienced by the workforce. This implies that there can be conflicting priorities so that even with the best of wills it is difficult to implement the kind of HRM that might be associated with healthy organizations and with ensuring employee well-being.

One way of beginning to address some of the challenges in creating healthy organizations is to adopt a stakeholder perspective to HRM (Beer, Spector, Lawrence, Quinn Mills, & Walton, 1985). Indeed, one definition of a healthy organization is that it is able to satisfy the goals and concerns of the relevant stakeholders. In the context of healthcare, these stakeholders can include patients and their families, management, staff, trade unions, the government and the local community. Professional bodies might also claim to be legitimate stakeholders. Nevertheless, in the specific context of HRM, the main stakeholders are likely to be management and staff; but in shaping HR policies and practices it is important to take account of other stakeholders, most notably patients.

In addition to the challenge of developing a sound HR strategy, there is a further hurdle to overcome with the need to ensure its effective implementation. One reason why this can be a problem is the limited commitment to HR priorities among many managerial and professional staff allied to the potentially limited power and influence of the HR function. A second is the difficulty of developing and implementing HR strategy when it competes with other priorities. Production managers in industry may prioritise production while hospital consultants may prioritise patient care over the well-being of their staff. Addressing the first issue, the HR function has a largely advisory role. Therefore, while HR staff may act as people champions in the organization and develop policies and practices that reflect this, it is the line managers who have to implement these policies on a day-to-day basis. The HR function can develop a sophisticated appraisal system but it is line managers who have to carry out the appraisals and if they do this in a half-hearted way, then the quality of the appraisals will suffer. HR professionals need to exercise sufficient influence to ensure that HR concerns are treated seriously and given sufficient priority in the face of competing priorities which may be considered more important by line managers.

As interest in HRM has grown over recent decades, there has been a vast amount of research, much of it exploring the link between HRM and organizational performance. Initial reviews after the first major decade of research (see, for example, Boselie, Dietz, & Boon, 2005; Combs, Liu, Hall, & Ketchen, 2006) revealed an association between the presence of more HR practices and higher organizational performance, typically indicated by productivity or more usually financial results. The authors also highlighted a number of problems including the large variety of measures of HR practices and of performance as well as the cross-sectional nature of almost all the studies, making it difficult to establish any causal relationship. There was also quite considerable variation in the effect sizes. However, one possible explanation soon became apparent. Khilji and Wang (2006) and Wright and Nishii (2013) highlighted a gap between intended and implemented HR practices. This was reflected, for example, in a persistent finding that employees reports of their experience or perceptions of HR practices were lower than the management accounts of the practices they claimed were in place (Liao, Toya, Lepak, & Hong, 2009). This has led to studies exploring the implementation process (Guest & Bos-Nehles, 2013; Purcell & Hutchinson, 2007). One major consequence of this has been to place employees at the centre of analysis on the grounds that the process whereby HRM is intended to have its impact is largely through its effect on the attitudes and behaviour of employees.

One stream of research has built on the AMO model to explore the extent to which HR practices associated with ability, motivation and opportunity to contribute have their intended impact on employee competence and on their attitudes and behaviour. Once again, there have been many studies exploring this question and these have been brought together in meta-analyses (see for example, Jiang, Lepak, Hu, & Baer, 2012; Subramony, 2009). Using the Jiang et al. paper as an example, the authors show that adoption of careful selection and extensive training is associated with greater competence among the workforce, providing the organizations with more valuable human capital. Secondly, careful use of rewards, particularly financial rewards, is



associated with higher motivation. Less attention is paid to opportunity to contribute, partly because it is less frequently covered in the papers that were reviewed for the meta-analysis and partly because it is sometimes seen as less central. The evidence indicated that competent, motivated staff are associated with higher unit or organization performance. This has led to an increased focus on human capital and incentive systems in much of the contemporary research on HRM.

A second stream of research seeking to understand the challenge of effective HRM implementation has explored the processes whereby HRM might have an impact. A significant amount of research has considered the role of line management in the HRM implementation process. Research by Purcell and Hutchinson (2007) and by Townsend, Wilkinson, and Allen (2012) confirms the important role of front-line managers in HRM implementation. However, Townsend et al. found that ward managers in healthcare were not trained for managing human resources and in the UK, McGovern, Gratton, Hope Hailey, Stiles, and Truss (1997) found that line managers were neither willing nor able to manage human resources effectively. Studies confirm that more effective HR implementation by line managers, usually reflecting practices within the AMO model, is associated with positive outcomes including engagement and individual performance (see, for example, Alfes, Truss, Soane, Rees, & Gatenby, 2013; Bos-Nehles, van Riemsdijk, & Kees Looise, 2013; Fu, Flood, Rousseau, & Morris, 2020). Sikora, Ferris, and Van Iddekinge (2015) explored perceptions of the effectiveness of line management implementation of HRM and showed that this mediated the relationship between HRM and outcomes reflected in their performance, participation in decision-making and lower intention to quit. In summary, line managers have an important role to play in HRM implementation but for various reasons they have not always risen to this challenge.

One way of addressing this challenge has been presented by Bowen and Ostroff (2004). They utilise attribution theory (Kelley, 1973) to advocate the case for what they term a strong HR system. Attribution theory is primarily concerned with how people explain past events. They suggest that a strong HR system should send signals that are consistent over time, there should be consensus about its application and it should be distinctive in so far as it recurs across different contexts. These signals are intended to send a clear message throughout the organization about what is expected. Bowen and Ostroff outline nine ways in which this can be achieved. Subsequent research shows that there is an association between the presence of more characteristics of a strong HR system and a range of positive employee attitudes (Hewett, Shantz, Mundy, & Alfes, 2018). To take one element of the model, Fu et al. (2020) have shown that consistency of implementation by line managers is associated with superior employee performance. As a process theory, Bowen and Ostroff's concept of a "strong" HR system has little to say about the content of the HR practices. They may be intended to enhance control or commitment, depending on management priorities. However, the research indicating an association between indicators of a strong HR system and positive employee attitudes and behaviour suggests that it is likely to enhance rather than detract from employee well-being.

A different dimension of attribution theory (Kelley, 1973; Weiner, 1985) has been utilised by Nishii, Lepak, and Schneider (2008) to explore what they term HR

attributions. They argue that the way in which employees respond to HR practices depends to an important extent on their beliefs about why they have been introduced by management. They hypothesise that if employees perceive that practices have been introduced to facilitate higher quality performance or to enhance employee well-being, the response will be positive. On the other hand, if they view them as being introduced to enhance control over employees or to cut costs, then they are likely to be poorly received. A growing body of research confirms that positive HR attributions are associated with positive attitudes on the part of employees while negative attributions have either little effect on attitudes or, more likely, a negative effect (Hewett et al., 2018).

Both of these approaches utilising attribution theory to explore the process whereby HRM and various outcomes may be linked reveal that much of the responsibility for effective HRM implementation depends on line management and the signals they provide. Nishii and Paluch (2018) identify four ways in which line managers can influence subordinate performance with respect to HR practice as well as more generally. These are articulating the intended HR practices, role modelling, reinforcing expectations about the kind of behaviour required and checking employees understanding of the HR messages. One integrating feature of all these approaches to understanding the role of line management in effective implementation is the role of signalling theory. At a straightforward level, signalling theory focuses on the role of the signaller, the message and medium and the receivers, as well as providing a feedback loop.

However, it can also be considered at higher levels of complexity (Connelly, Certo, Ireland, & Reutzel, 2011). In the present context, the critical factor is the content of the messages sent by the management hierarchy about people and HR management and how these filters down to front line managers. Importantly, as Nishii and Paluch (2018) note, the signals may not always be conscious or intended but they are nevertheless likely to influence the response from employees as the receivers.

Drawing this review together, there are two further important issues that need to be addressed. The first reflects the concern outlined by Beer, Boselie, and Brewster (2015) that most of the research on HRM has focused on organizational performance as a main dependent variable. This leaves open the question of whether high organizational performance and high well-being go hand-in-hand or whether one squeezes out the other. The concern about the ability of HRM, particularly when it is labelled high performance management to achieve both high organizational performance and high employee well-being lies in the concern that extracting high performance may come at a cost of stress and burnout. Over the years there have been relatively few publications that have explicitly explored this question. They have been brought together in a recent review by Peccei and Van De Voorde (2019). Across 46 studies, they found strong evidence for mutual gains. However, more-27-assessed individual performance outcomes while only 20 included organizational outcomes. These results look very encouraging. But the authors are careful to refer to “happiness well-being” as opposed to health well-being because most of the studies measured either job satisfaction, organizational commitment or engagement while only eight

studies included any measure of health-related outcomes such as stress and anxiety. We return to this issue in Sect. 5.3 of this chapter.

The second issue that needs to be addressed concerns the role of individual differences. Lepak and Snell (1999) advocated selective HRM investment based on an assessment of the value to the organization of various types of work. A rather different perspective recognises the wider range of differences within the workforce and the need to take account of these. Organizations in general and healthcare organizations in particular employ a diverse range of staff and good HRM practice will recognise this. For example, there are likely to be differences based on permanent versus temporary employment, on disability, on ethnicity and on age. Each of these topics has generated a considerable amount of research and to illustrate this, we turn now to a review some relevant work on HRM and aging.

A growing body of research pays attention to the role of HR practices in sustaining aging workers at work (De Lange, Kooij, & Van der Heijden, 2015; Pak, Kooij, De Lange, & Van Veldhoven, 2019). For example, Kooij, Jansen, Dijkers, & De Lange (2014) formulated four bundles of HR practices (e.g. developmental, maintenance, utilization and accommodative practices; see Table 5.1) based on the Selection Optimization and Compensation (SOC) model (Baltes, Staudinger, & Lindenberger, 1999). The SOC model suggests that employees allocate their resources in line with four major life goals namely; growth, maintenance, recovery, and the regulation of loss. HR practices can be bundled according to these goals. Employees of different ages and at different stages in their careers are likely to welcome and utilise HR practices that fit their goals. First, developmental practices aim to aid workers in improving their performance (e.g. training and promotion). These practices are mainly related to advancement and satisfy the need for growth and development (Pak et al., 2019). As such they are important job resources which can in turn help employees generate additional person and job resources. For example, De Lange, De Witte, and Notelaers (2008) showed that employees gained autonomy and departmental resources after receiving a promotion. As developmental practices are

**Table 5.1** Overview of the HR practices included in the questionnaire (cf. De Lange et al., 2015; Kooij et al., 2014)

Accommodative practices	Utilization practices	Maintenance practices	Developmental practices
Long career break Early retirement Reduction of tasks and/or responsibilities Additional leave Demotion Early retirement Exemption from working overtime/night shifts Reduced workload	Participation Task enrichment (knowledge transfer) (Partial) change in tasks or responsibilities	Flexible benefits Performance pay Compressed workweek Health promotion Ergonomic adjustments to the workplace Adjustments to work tasks due to illness	Career planning Promotion Continuous training or instruction on the job

classified as job resources and can help workers generate additional job resources, we argue that they will be beneficial for successful aging at work. In line with this expectation, the review of Pak et al. (2019) revealed significant relations between developmental practices and work outcomes like employability and work motivation.

Second, maintenance practices facilitate workers to sustain their performance in spite of (age-related) loss of resources (e.g. declines in physical capabilities). These practices are mainly focused on security and protection of personal resources (e.g. health) (Kooij et al., 2014; Veth, Korzilius, Van der Heijden, Emans, & De Lange, 2017; Veth, Van der Heijden, Korzilius, De Lange, & Emans, 2018). Examples of maintenance practices are health checks and performance appraisals (Kooij et al., 2014). Maintenance practices can help individuals increase their job and personal resources. For example, Robertson and O'Neill (2003) showed that ergonomic adjustments made to the workplace can reduce the number of work-related disorders (and thus increase health). Moreover, Pak et al. (2019) showed in their review of 110 empirical studies that maintenance practices (especially health promotion) was significantly positively associated with work ability.

Third, utilization practices make use of the experience, knowledge, and competencies of older workers (e.g. mentoring roles and participation in decision-making) thus optimising these personal resources. These practices can be used to assist workers in regaining performance after having experienced a drop in performance. They usually make use of lateral development in which job demands that do not fit the coping resources of the employee are replaced by other demands that fit better with the existing personal resources of the individual (Zaleska & de Menezes, 2007). For example, through mentoring an older worker may be better able to use his or her resources (e.g. knowledge and skills of the company and the profession). Nonetheless, the current evidence on relations between utilisation practices and work outcomes like work ability, employability and motivation to work is still inconclusive (Pak et al., 2019) and requires more research attention.

Fourth, accommodative practices (e.g. demotions and receiving an exemption from overtime) are used when an employee can no longer regain previous levels of performance and needs to be assisted in functioning at a lower level. According to Kooij et al. (2014) this type of practice helps to regulate the loss of resources; by reducing demands there is less strain on the available resources of the employee. To illustrate, a worker who has experienced burnout can be offered a demotion to a less challenging position which reduces the strain on the resources that the individual has available allowing this worker to continue working until the retirement age. Indeed, Josten and Schalk (2010) found that demotions can reduce exhaustion among older workers when they start working in less physically challenging positions. Earlier research has found that accommodative practices like workplace rehabilitation, reducing the number of working hours, and getting exemptions from evening and night work were found to have a positive effect on work ability (Pak et al., 2019; Van der Meer et al., 2016). An overview of all HR practices that are included in the different bundles can be found in Table 5.1.

Drawing this section together, what we have argued is that HRM is a major organizational responsibility that can have a considerable bearing on the performance

of organizations and on the well-being of their employees. It has been a topic of extensive research and one of the important contemporary debates is about whether it is possible to identify HR practices and specific contexts that achieve both high performance and high well-being. The risk is that there may be pay-offs between the two. Much depends on the type of HRM that is applied, as well as the way in which well-being is defined in the research, limiting the scope for generalisations. However, there is evidence that while high performance and both job satisfaction and organizational commitment may go hand in hand when HRM is applied (Peccei & Van De Voorde, 2019), the association between performance and health-related indicators of well-being such as stress and burnout is less clear. One explanation for this may be the impact of work intensification and work demands associated with the pressure for higher performance. Since many healthcare organizations are high demand environments, this is something to bear in mind as we turn to the next section which reviews the evidence about HRM in healthcare.

## 5.2 Research on HRM in Healthcare

Our analysis of research on HRM in healthcare will be divided into two broad categories. First, there is research that emulates the research in other sectors exploring the link between HRM and performance. Secondly, there is research that is mainly concerned with the role of HRM in relation to its impact on specific aspects of employee well-being which have been particularly associated with the healthcare context. We will look at each in turn and outline illustrative research.

### 5.2.1 *HRM and Performance in Healthcare*

As noted in the previous section, research exploring the relationship between HRM and performance has burgeoned and findings generally confirm an association between the presence of more HR practices and various indicators of organizational performance (Boselie et al., 2005; Combs et al., 2006; Jiang et al., 2012; Paauwe, Guest, & Wright, 2013). The amount of variance in outcomes explained by HRM varies and is generally fairly small but is nevertheless significant. This raises the question of whether this general finding will be replicated in the public sector and in particular in healthcare.

One of the first studies to explore the role of HRM on healthcare outcomes was reported by West and colleagues (West et al., 2002; West, Guthrie, Dawson, Borrill, & Carter, 2006). Both papers are based on the same data except that the second has a fuller set of HR practices and performance data, in this case mortality indices, spread over a greater time. The 2002 study is based on 61 acute hospitals in England. Information on HR practices was collected from HR directors and addressed five practices, namely, appraisals, training, team-working, centralization and possession



of a kite mark, *Investors in People*, which mainly assesses training and communication. The choice of variables was based on “theory and statistical robustness” (2002, p. 1303). The analysis reported a negative association between appraisal, training and team-working, considered as individual practices, and patient mortality rates. However, these results have to be treated with considerable caution since the measures of the HR practices were weak, there was a lack of control variables and the data are cross-sectional.

The follow-up study (West et al., 2006) remedied some of these deficiencies. The sample was reduced to 51 of the hospitals, the HR practices were combined into a single index and a number of relevant controls were introduced such as the ratio of doctors to beds. Prior mortality rates were also controlled for. The analysis confirmed that there was an association between greater use of HR practices and lower mortality rates. These results appear encouraging but still need to be viewed with caution due to the limited measure of HR practices.

A more comprehensive study has been reported by Givan, Argar, and Liu (2010). They adopted a stakeholder approach, recognising that relevant actors include staff and patients and that a broader range of outcomes beyond mortality are important for most patients. The research was again conducted in England with a sample of 173 acute and teaching hospitals. The wider set of hospital performance indicators included incidence of MRSA and hospital acquired infections, errors and near misses and readmissions. Data was also collected on patient and staff satisfaction as well as staff intention to quit. HR practices were grouped into broad categories; one addressed high involvement HRM and included employee participation and voice, communication and teamworking; the other was described as employee development and consisted of training and appraisal. It was hypothesised that some HR practices would be associated with some but not all of the stakeholder-related outcomes. This is, indeed, what was found, but not always in the expected way. For example, high involvement practices were associated with higher employee-reported errors and near misses but also with higher staff satisfaction and lower intention to quit. Higher use of participation and voice practices was associated with more reported errors and near misses, higher surgery deaths and lower patient satisfaction. More use of communication practices was associated with more emergency readmissions but also less MRSA and fewer errors and near misses. In summary, the results present a mixed bag implying that different stakeholder outcomes are related in rather unpredictable ways to various HR practices. In doing so, they highlight the challenges in seeking to satisfy the different stakeholders with their often different interests and priorities. Once again, we must exercise caution in interpreting the results since they were cross-sectional and some of the HR measures are not strong.

Further evidence of the complexity of the link between HRM and outcomes in healthcare is provided in a study by Ogbonnaya and Valizade (2018), again using the British national survey data. They report an association between HRM and both job satisfaction and engagement as reported by staff. Both of these are associated in turn with aggregated hospital level evidence of lower absenteeism. However only job satisfaction and not engagement is associated with patient satisfaction. The rationale behind these differing findings is not clear.



A final study based on English data is reported by Piening, Baluch, and Salge (2013) utilising national survey data across 167 acute hospitals. They reported an association between employee perceptions of HR practices and patient satisfaction. The authors argue that it is implemented HR practices, as perceived by employees that provide the most relevant measure of HRM and that patient satisfaction, covering a sample of all types of patient, is a particularly useful outcome measure. The analysis identified a path from employee perceptions of implemented HR practices, integrated into an HR system, to lower intention to quit and then to higher levels of employee civility to patients which in turn was linked to patient satisfaction. Despite the sophisticated analysis, this study shares with others the problems of a limited measure of HRM and use of cross-sectional data. However, like the other studies using this large annually collected English data set, the results confirm an association between HRM and various outcomes and suggest that staff attitudes and behaviour are important intervening variables. In these respects, the evidence from these studies, although seemingly somewhat inconsistent, largely reflect the findings from the private sector in revealing an association between HRM and performance.

Townsend, Lawrence, and Wilkinson (2013) report a study that used data from the Australian Healthcare Standards Authority to explore the role of HRM within a systems context. All the data were based on the judgements of teams of experts who inspected the hospitals using a standard set of indicators for each variable. In a sample of 465 acute hospitals, including fairly equal proportions of both public and private hospitals, they found that high quality HRM was associated with better continuity of patient care. However, this outcome was also associated with higher quality strategic and operations management, information management and quality of health and safety. They also noted interactions between HRM and some of the other management activities showing that HRM could either complement or compensate for them. This supports the view that HRM should not be viewed in isolation and that its impact can depend, at least in part, on the quality of, and relation to other systems within healthcare. Another interpretation might be that organizations blessed with competent management across the various functions will display more positive results.

Ang, Bartram, McNeil, Leggat, and Stanton (2013) have addressed the question of HR implementation in healthcare. Based on a survey of 193 staff and 58 matched managers in a single Australian hospital, they found that HRM was only associated with positive employee outcomes such as job satisfaction, engagement and lower intention to quit, when the HR practices reported as implemented by their manager matched their own accounts of implementation. This confirms the importance of implementation and also of consensus on implementation.

The studies reported above all address HRM as a set of practices but have little to say about the role of the HR department. This omission is addressed in a paper by McBride and Mustchin (2013) who studied the role of the HR function in introducing a specific change, namely the introduction of what was termed a skills escalator in the English healthcare system. The aim was to provide staff with opportunities for advancement by gaining greater skills. The government, through a paper "HR in the NHS Plan" had anticipated a major role for the HR function in driving through

the changes. Through a series of case studies, McBride and Mustchin (2013) found that in most cases the role of the HR function was very limited. As they summarise, “the inactivity of HR can be explained by a failure of actor capacity or insufficient resources” (2013, p. 3141). Using the concept of regulatory space, the research found that many of the required changes were operational and required technical expertise which resided with clinical staff or local management and professionals. HR had a role in dealing with pay and union negotiations and in resourcing some of the training. But it was generally a support role. Essentially, the HR function in these healthcare organizations lacked the expertise to manage change, lacked influence to demand a greater say, and lacked the time and resources to act as change agents. These findings are similar to those reported by Guest and Peccei (1994) who also noted the limited impact of the HR function in healthcare in England in influencing HR effectiveness. There are echoes in this of research by Buyens and De Vos (2001) who showed that in the context of strategic change, the HR function was typically involved at the later stages of implementation rather than in shaping the changes.

Research on the role of the HR function raises the important and under-researched question of who initiates and implements significant change in HR practices in healthcare. It seems likely that we have to look beyond the HR function to the role of the top management team or to external pressures from government and other institutional forces. The research outlined above reveals considerable differences in the application of HRM. We also need to know more about what determines these differences in a context such as healthcare where the strategic challenges appear to be similar across organizations.

As well as general studies exploring the relation between HRM and outcomes in healthcare, there are also many studies that explore the role of HRM in relation to specific topics directly affecting staff. These include studies of selection, socialization, team-working and labour turnover as just some examples. Here we will explore two topics, selected because of their links to employee well-being and therefore of direct relevance to Healthy Healthcare. They are burnout/engagement and bullying at work.

### ***5.2.2 HRM, Burnout and Engagement***

Burnout is a chronic state of disaffection with work characterised by emotional exhaustion, depersonalisation and a sense that work an individual does is not worthwhile. Schaufeli, Leiter, and Maslach (2009) trace the history of the concept of burnout highlighting its role as a public service phenomenon partly resulting from a challenge to professional autonomy and also arising from the increasing demands placed on public sector employees, especially those in healthcare. Since 1997 in Sweden, it has been an accepted clinically diagnosable illness. With the growth of positive psychology there has also been considerable interest in engagement as the other end of a continuum from burnout (Schaufeli, Taris, & Van Rhenen, 2008). Since

burnout seems to be more a feature of the organizational context than determined by individual factors, it should be something that can be addressed by HRM.

A typical study is presented by Bartram, Casimir, Djurkovic, Leggat, and Stanton (2012) who explored the proposition that HRM buffers the relationship between job demands—in this case emotional labour—and burnout. Their research, with a sample of 183 Australian nurses confirms this proposition. They find, in a cross-sectional study, that burnout fully mediates the relationship between emotional labour and intention to quit while HRM reduces burnout. While the Bartram et al. study explores an integrated set of HR practices, another study by Holland, Allen, and Cooper (2013), based on a sample of 762 Australian nurses, looks at two more specific practices, namely voice and management responsiveness to employee concerns. Voice was measured on three characteristics, firstly whether there were regular meetings between management and all staff, secondly, the presence of a formal employee involvement programme, reflected, for example in quality circles; and thirdly the presence of semi-autonomous work groups. Responsiveness was measured through staff perceptions of management on eight dimensions including showing concern for staff, providing support for them and valuing their contribution. The results revealed that greater voice was associated with lower burnout and that management responsiveness mediated this relationship and, by implication, reduced burnout further.

Both the studies described above are cross-sectional and as such are typical of many that are reported. This makes it difficult to be confident about causal relationships. A study by Kilroy, Flood, Bosak, and Chenervert (2017) adopted a cross-lagged methodology and gives us greater confidence about causality. With a sample of 185 healthcare staff in a Canadian hospital, at Time 1 they collected staff data on perceptions of high involvement HRM and a measure of person—environment fit. Their logic was that HRM can help to align staff and their working environment by providing signals about what is offered and what is expected. This can occur, for example, through selection, socialization and communication of values. In the event they found that staff reporting the presence of more HR practices also reported better fit with the organization. A follow-up three years later linked these responses to burnout. As expected, they found that those reporting more HR practices at Time 1 reported lower burnout at Time 2 and this relationship was mediated by person—environment fit.

The three studies briefly described above are typical of a number of studies in healthcare exploring the relationship between HRM and burnout, sometimes extending to include the link between burnout and intention to quit. Most report samples of nurses and most are cross-sectional. The analytic framework is invariably the job demands—resources model (Bakker & Demerouti, 2007). The Kilroy et al. study is a welcome exception to this on all these counts. The studies confirm the pattern of research in a range of settings. When employees report the presence of more HR practices, burnout is lower and this feeds through to lower intention to quit. Because the data are invariably cross-sectional, the link between intention to quit and actual labour turnover cannot be established. But other research (Hom, Mitchell, Lee, & Griffeth, 2012) confirms this association in most research settings.

The explanation for the positive effect of HRM is usually explained through its role in either reducing demand or increasing resources although the study by Kilroy et al. also points to a role for person—environment fit.

As noted above, employee engagement has been presented as the positive alternative to burnout and it has attracted a considerable amount of research attention. There are different approaches to, and definitions of engagement but the most popular is associated with Schaufeli and colleagues. They define engagement as consisting of vigour, dedication and absorption (Schaufeli, Salanova, Gonzalez-Roma, & Bakker, 2002). Most research utilises the job demands—resources model (Bakker & Demerouti, 2007) and explores either the causes or the consequences of engagement. For example, Laschinger and Leiter (2006) found that higher employee engagement among a sample of 8597 hospital nurses was associated with safer patient outcomes. A typical healthcare example is provided by Shantz, Alfes, and Arevshatian (2016). Based on the English National Health Service survey of 2011 they utilise a sample of 69,081 nurses and administration workers. They explored the relationship between four HR practices that are relevant to job resources, namely, training, participation in decision-making, opportunities for development and communication and quality of care and safety. They find an association that is mediated by engagement.

Reflecting the job demands—resources model, studies of engagement often explore a few selected HR practices as antecedents rather than considering an HR system and most of the research is cross-sectional. However, there have been a number of interventions attempting to enhance engagement. Reviewing these studies, Knight, Patterson, and Dawson (2017a) identify four types of intervention targeted at personal resource building, job resource building, leadership training and health promotion. They find that the results are very mixed but, on balance, are positive rather than negative. More recently they have reported their own intervention (Knight, Patterson, Dawson, & Brown, 2017b) involving teams of nurses working in the acute care of the elderly. Their study was longitudinal and utilised experimental and control groups. The intervention consisted of five participative workshops. The results showed no change in engagement and a deterioration in some work-related needs in the experimental group. The authors attribute these results to the major difficulties in seeking to introduce change in the highly pressured context of acute care, especially when there is a lack of top management support. More generally, the findings indicate that while research tells us quite a lot about the antecedents and consequences of employee engagement, we still have a lot to learn about how to improve engagement levels, particularly in the challenging context of healthcare organizations.

### 5.2.3 *HRM, Bullying and Harassment*

There is extensive evidence that workplace bullying has harmful effects on the well-being of those exposed to it (Nielsen & Einarsen, 2012). Healthcare organizations with their high-pressure work environments and strong professional hierarchies have long been associated with bullying and harassment which in turn has been associated

with reduced levels of employee well-being. One indication of its severity comes from a study by Woodrow and Guest (2012), based on a national sample of nurses in England who found that the experience of bullying and harassment had a more severe and longer-lasting effect on well-being than the experience of violence from patients or patients' family and friends. One reason for this is that violence is often visible and therefore can be dealt with whereas bullying can be invisible to all except the perpetrator and victim and, by its standard definition, persists over time. As a result of concern about the causes and consequences of bullying and harassment (described in some countries as mobbing) HR policies have been advocated to seek to limit its occurrence.

There have been several reviews of the literature to identify relevant policy and practice designed to minimise bullying. For example, Fox and Cowan (2015) have outlined policies that might be applied in the USA while Rayner and Lewis (2010) have provided a comprehensive list in the UK. There is therefore no shortage of guidelines for HR departments to follow. To explore the effectiveness of recommended HR practices, Woodrow and Guest (2014) examined levels of bullying and harassment in a number of large London-based hospitals in a period following pressure from the government's Department of Health to take action to reduce levels of bullying. They found that all the recommended HR practices to minimise bullying were in place; but they also found that they had made no difference to levels of bullying as reported in annual staff surveys. In exploring the reasons for this, they found that the policies and practices had not filtered down to the local level where much of the bullying seemed to be occurring. Furthermore, those who tried to use the HR system to complain about being bullied often found the process to be cumbersome and ineffective and the surveys identified a general lack of faith in the effectiveness of the system. Reflecting the research cited earlier by Khilji and Wang (2006) and Wright and Nishii (2013), there was a gap between intended and implemented practices.

A somewhat similar picture emerges in a study by Timo, Fulop, and Ruthjerson (2004) among staff responsible for care of the aged in Australia. They found that bullying was associated with poorly articulated HR policy and practice, lack of effective follow-up and poor communication. A major international study by Salin et al. (2018) may help to explain why policy and practice to address bullying and harassment does not always lead to improved well-being among staff. Across 14 countries, they found that the main motivation among managers to address bullying was to improve productivity and minimise costs. To achieve this, the preferred practice was to provide more training.

Some studies offer insights into ways in which HR policy and practice might help to reduce bullying. One example is the study by Cooper-Thomas et al. (2013) conducted in New Zealand. In a sample of 727 staff in nine healthcare organizations, 133 reported bullying, defined as two negative events per week over six months. Comparing those who had and had not experienced bullying, they found, based on correlations, that bullying was negatively associated with constructive leadership, perceived organizational support and the presence of organizational anti-bullying initiatives. Perceived organizational support buffered the relationship between bullying and self-rated performance while anti-bullying initiatives



buffered the relationship between bullying and employee well-being and organizational commitment. Despite this, those who had been bullied gave lower ratings of the effectiveness of the anti-bullying initiatives than those who had not experienced bullying and, perhaps not surprisingly, the bullied reported poorer support and lower well-being. It seems important that leadership and organizational support result in direct action to prevent or deal with bullying rather than serving as mainly as palliatives to aid coping with the experience of being bullied.

The question of leadership was addressed in a paper by Woodrow and Guest (2017) who explored a number of critical incidents of bullying, based on either the accounts of those who had been bullied, those who had observed bullying or those who had sought to address it. Their specific focus was on the role of leadership which had played a small part in the study reported by Cooper-Thomas et al. (2013). What they found was a continuum of leader roles in relation to bullying. At the negative end were those leaders who were the perpetrators of bullying. Next in line were those who decided that addressing bullying was not their problem, and by those who buried their head in the sand and did their best to ignore the problem. They were followed by those who made a formal attempt within the system to respond to bullying but it was often a ritualised attempt and they were happy to pass the problem up the line or to HR. Towards the more positive end were those who made a genuine attempt to address the problem but often only when it had become a serious problem while the best managers were those who kept an eye out for any evidence of bullying and sought to nip it in the bud. This study suggests that for many managers, bullying is a problem that they do not want to deal with so they either try to ignore it or to pass the problem on to others as quickly as possible. Reflecting the analysis of Bowen and Ostroff (2004) described earlier, this indicates a weak HR system where line managers can evade their responsibilities on issues about which they feel uncomfortable or refuse to recognise as their responsibility. This raises questions about the management of the HR system within hospitals where this occurs.

Several of the papers exploring HR policy and practice relating to bullying identify the failure to implement them effectively as a major limitation explaining their lack of impact. This issue is addressed in a study of Irish nurses and midwives reported by Sheehan, McCabe, and Garavan (2020). Their study surveyed 1507 staff in 47 hospitals, 53% of whom had experienced bullying in the previous six months and interviewed matched HR directors. As in almost all studies, experience of bullying is associated with lower job satisfaction and higher intention to quit. However, they found that this association is partly mediated by the perceived effectiveness of the implementation of the anti-bullying policies. Furthermore, the impact of bullying is moderated by line management anti-bullying training. This suggests that anti-bullying policies can have some effect if they are carefully implemented.

There is general agreement that pervasive bullying is incompatible with a Healthy Healthcare organization, as demonstrated by its association with lower well-being. Yet the evidence suggests that the experience of bullying remains worryingly high, even in organizations that appear to have good, evidence-based policies and practices in place to address the problem. Drawing these illustrative studies of research on HRM and bullying together, it seems that the HR function is often failing to address



the problem effectively because of poor implementation. As Woodrow and Guest (2014) note, it is not enough to have impressive policies and practices in place if staff are largely unaware of them and little serious attempt is made to implement them. The study by Salin et al. (2018) is also of concern in indicating that in addressing bullying, senior managements priority is to improve productivity and minimise costs. We might expect the well-being of the workforce to be a higher priority. This implies that we need to rethink the HR priorities and the role of HRM in seeking to ensure that healthcare organizations minimise problems such as burnout and bullying which will otherwise continue to be endemic features of contemporary healthcare. A potential approach that seeks to achieve this goal is set out in the final section of this chapter.

### 5.3 Designing HRM for a Healthy Healthcare

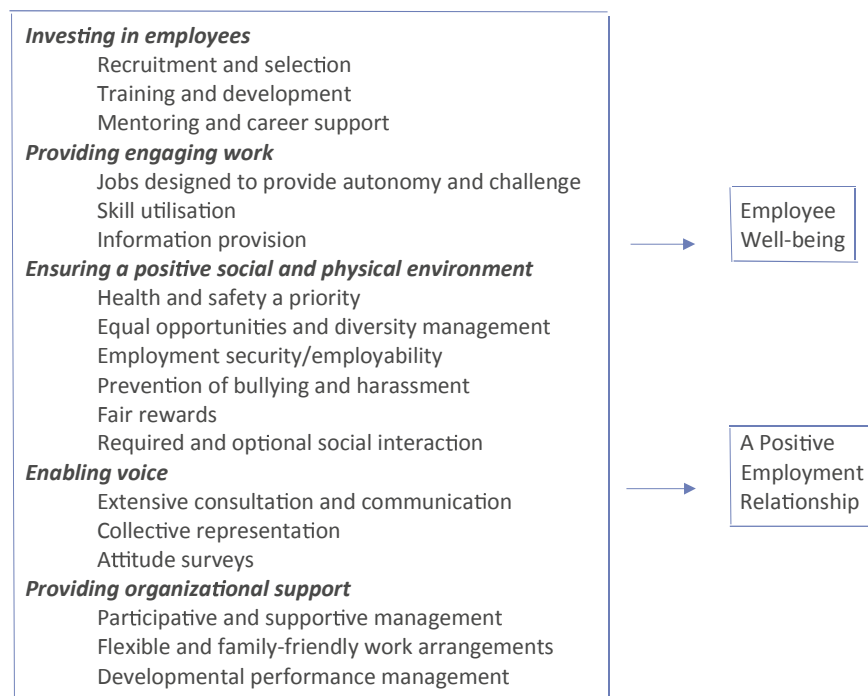
The challenges of designing a system of HRM that gives greater emphasis to the well-being of staff in healthcare organizations has elements which are similar to those in any organization. However, there are some additional factors that need to be taken into account. The first is the number of important stakeholders including not only staff, management and patients but also the public, government and local authorities as well as powerful professional bodies and trade unions. A second is the size of many healthcare units. Hospitals can employ up to 15,000 staff or more, sometimes on a single site. While many private sector organizations outside healthcare may employ more staff, they often work in much smaller units. In healthcare, it is feasible to subdivide into units of, for example, types of clinical practice; but account then must be taken of a third factor, namely the interdependence of sub-units such as radiology or pharmacology that operate across the clinical units. A further important factor in healthcare is the power of the professions who seek to guard their professional autonomy. These factors combined with the pressures of financial constraints that place a focus on costs and can result in heavy workloads create pressures that present a major challenge in providing an effective HRM system. With all this in mind, what can we say about the characteristics of a healthy HRM system?

The early section of this chapter outlined how HRM has been analysed and applied across organizations. As Beer, Boselie, and Brewster (2015) observed, the dominant approach, reflecting in particular the views of scholars in the USA, has prioritised the kind of HRM viewed as most likely to improve financial performance. While employee attitudes and behaviour are sometimes treated as mediators, relatively few studies pay serious attention to employee well-being. The review by Peccei and van de Voorde (2019), cited earlier, is encouraging in showing that HRM can simultaneously be associated with both performance and happiness well-being. As the authors note, only a few studies explore health-related well-being. Furthermore, most of the studies use a narrow set of HR practices sometimes drawing on the AMO model and often captured in the popular concept of the high-performance work system. There have been attempts to go beyond this rather narrow view of HRM. For example, Walton (1985) offered the idea of high commitment HRM while Lawler (1986) and Boxall

and Macky (2009) have advocated high involvement HRM. Both of these approaches give much greater priority to staff concerns and in particular to greater staff autonomy and involvement in local decisions that affect them. This is helpful but may not go far enough; for example, they have little to say about HR practices to minimise bullying and harassment or about flexible work arrangements. What is needed is a broader view of HRM that takes account of the diverse workforce found in healthcare and which also prioritises well-being the major outcome.

An approach to HRM that explicitly seeks to promote employee well-being has been proposed by Guest (2017). Drawing on evidence about the antecedents of well-being at work and utilising both social exchange theory (Blau, 1964) and job demands—resources theory (Bakker & Demerouti, 2007), it places the employment relationship at the centre of the analysis. In this context, a positive employment relationship is characterised by fairness, trust, a positive and fulfilled psychological contract, a sense of security and a high quality of working life.

To achieve this, and simultaneously to promote high work-related well-being, five broad categories of HRM are identified, as illustrated in Fig. 5.2. The first is investing in employees through careful selection, training, developmental performance management and provision of mentoring and career support to maintain



(Adapted from Guest 2017)

**Fig. 5.2** HR practices to promote employee well-being. Adapted from Guest (2017)

employability. The second is provision of engaging work, reflected in the design of jobs to provide autonomy and challenge, in enabling full use of skills and in providing sufficient information provision and scope for feedback. The third component is a positive social and physical environment. This is a feature that is often neglected in other models of HRM. It includes a safe and healthy working environment, including zero tolerance for bullying and harassment, opportunities for social interaction, equal opportunities and a concern for diversity, ensuring a sense of employment security, perhaps reflected in employability, fair collective rewards and high basic pay. The fourth component is voice. This implies extensive two-way communication, use of surveys to seek representative staff views and also collective representation. Finally, there is a need for organizational support. This will be reflected in supportive management, a climate of involvement and debate and flexible family-friendly work arrangements. These HR practices are set out in Fig. 5.2.

The assumption behind the kind of HRM outlined above is that it will promote high employee well-being and a positive employment relationship. Employee well-being is an important end in its own right and should be an ethical priority, particularly in healthcare organizations to reflect their primary mission. However, to be taken seriously by an often-financially pressured top management, it greatly helps if it can demonstrate its cost-effectiveness. This can be achieved in two ways. First, there is evidence, drawing on social exchange theory, that employees will respond to well-being-oriented HR policies and practices by being more highly motivated and committed (Tsui, Pearce, Porter, & Tripoli, 1997). Secondly, it is important to draw on evidence that higher well-being is associated with higher performance (Brockman, Bryson & Ilmakunnas, 2012; Bryson, Forth and Stokes et al., 2014; Daniel & Harris, 2000). To achieve positive outcomes for all stakeholders from well-being-oriented HRM, greater emphasis needs to be placed on the quality of management in healthcare. As the research cited previously has revealed, it is possible to have impressive HR practices in place to address topics such as bullying, yet they often have little impact. To address this, Bowen and Ostroff (2004) have advocated a strong HR system. This requires that HRM is owned by top management who signal to their managerial staff that HR policy and practice needs to be taken seriously and implemented properly. This can be a tall order when faced at the same time with the competing challenges of prioritising patient care and minimising costs. One way in which HR departments can begin to address this is through improved data analytics. For example, labour turnover and sickness absence are persistent problems in healthcare organizations. Implemented well-being policies should help to reduce these, thereby reducing the costs of staff replacements and employment of temporary staff. Good analytics may first be able to highlight the problems and secondly show that the effective implementation of a well-being-oriented form of HRM brings multiple benefits.

## 5.4 Discussion and Conclusions

This chapter has outlined the nature of HRM and illustrated some of the main streams of research, many of which are focused on the relationship between HRM and organizational performance. It has also placed emphasis on the challenges of HRM implementation and the actors involved in this process, since this has a major bearing on outcomes including both performance and employee well-being.

Turning specifically to the healthcare environment, we have reported a number of studies, many based on the large data sets collected in England, which consistently show an association between HRM and positive patient outcomes. In doing so, these studies are mirroring the bulk of the wider research on HRM which explores the link to organizational performance. The constraints of the data mean that these studies use a limited number of HR practices and also tend to focus on a variety of patient-related outcomes. While some included information on staff attitudes and behaviour, this was rarely central to the study. Better information about staff concerns can be found in studies looking at specific well-being-related problems such as burnout and bullying. Although they tend to use a piecemeal set of HR practices, they do confirm that HR practices can affect employees well-being if they are properly implemented. Set against this, most of the reported studies are cross-sectional making it difficult to demonstrate causation.

A distinctive feature of HRM is that it is viewed as a system in which there are synergies between the various practices. To take a simple example, there is no point in enhancing competence if staff are not motivated; nor is there value in offering an opportunity to contribute if staff lack the ability or motivation to contribute. Within the AMO model, it is therefore necessary to ensure that the bundle of HR practices address ability, motivation and opportunity to contribute rather than focusing on one or the other. The Guest (2017) model indicates that if the goal is employee well-being then it is necessary to extend the coverage to include a positive physical and social working environment, voice and organizational support. Neglecting any of the sets of HR practices could be costly for employee well-being. It is ironic that in many healthcare organizations, most of the practices outlined in the Guest model are in place. However, it is not enough to have an impressive set of HR practices. They have to be effectively implemented.

The challenge of HR implementation seems to be particularly acute in healthcare for reasons already outlined including size, professional autonomy and competing stakeholder interests. Furthermore, healthcare often employs highly diverse workforces with a range of sub-groups who may be particularly responsive to specific HR practices, as illustrated in the case of aging. This places emphasis on the role of top management and the goal of developing a strong HR system. Here, signalling theory has an important role to play. The importance of taking HRM seriously needs to be conveyed down the organizational hierarchy. Using findings from HR attribution research, care needs to be taken to explain, initially to line managers and senior professional workers, why HR practices are being applied and do so in a convincing way. One of the lessons of this review of HRM in healthcare is that implementation

is perhaps the greatest challenge. This challenge is reinforced by the recognition that the HRM system must fit with other systems operating alongside it.

The challenge of implementation raises questions about the role of HR specialists. The study by McBride and Mustchin (2013) implies that they can get squeezed out of organizational and HR change initiatives. There has been much debate about the appropriate structure of the HR function (Ulrich, 1997) and its relation to line management. Guest and Bos-Nehles (2013) set out areas of responsibility and demarcation between the HR department and line management, though in practice the boundaries are unlikely to be clear-cut. One role for HR specialists is to develop high quality HR policies and practices. A second is to support implementation by working closely with line managers. This requires change management and consultancy skills as well as considerable personal credibility and capacity to exert influence. These roles are very different from the more administrative activities such as management of selection and training, ensuring appraisals are completed and dealing with grievances; they require a different skill set. Indeed, they may need behavioural science skills more commonly associated with Organizational Development (OD). An alternative might be to recruit into the HR function from other roles in healthcare. Senior clinical consultants might become excellent HR champions!

Finally, we need much better-quality research on the impact of HRM in seeking to create Healthy Healthcare. In this chapter, Healthy Healthcare has been defined from a stakeholder perspective but has given primacy to the health and well-being of the workforce. Neither the studies of HRM and patient outcomes, nor the narrower focus on specific topics such as burnout and bullying, provide the kind of coherent programme of longitudinal research that will provide a more convincing evidence base for policy and practice. We also need case studies of changes in HRM that attempt to enhance employee well-being and Healthy Healthcare. There is a rich and important research agenda to be pursued.

## References

- Alfes, K., Truss, C., Soane, E., Rees, C., & Gatenby, M. (2013). The relationship between line management behaviour, perceived HRM practices, and individual performance: Examining the mediating role of engagement. *Human Resource Management*, 52, 839–859.
- Ang, S., Bartram, T., McNeil, N., Leggat, S., & Stanton, P. (2013). The effects of high-performance work systems on hospital employees work attitudes and intention to leave: A multi-level and occupational analysis. *International Journal of Human Resource Management*, 24(16), 3086–3114.
- Appelbaum, E., Bailey, T., Berg, P., & Kalleberg, A. (2000). *Manufacturing advantage: Why high-performance work systems pay off*. Ithaca, NY: ILR Press.
- Bakker, A., & Demerouti, E. (2007). The job demands—resources model: State of the art. *Journal of Managerial Psychology*, 22(3), 309–328.
- Baltes, P. B., Staudinger, U. M., & Lindenberger, U. (1999). Lifespan psychology: Theory and application to intellectual functioning. *Annual Review of Psychology*, 50, 471–507. <https://doi.org/10.1146/annurev.psych.50.1.471>