Human Resource Management tools in healthcare: are they driving change?

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Track - People: Human Resource Behaviors and Practices

1. INTRODUCTION

In order to meet the drastic reforms that have interested the healthcare sector in Italy, healthcare organizations are facing a strategic change by assuming a new identity and adopting entrepreneurial values. This, in turn, implies structural changes such as, in the first place, the adoption of the clinical directorate model, which was introduced by law in the system. However, it is likely that such change will require, in turn, a cultural one, overcoming a number of factors, such as a lack of capacity of action and the presence of consolidated routines, that may reduce the potential for organizational changes to become fully implemented in clinical directorates (BRAITHWAITE et Al., 2008; MCNULTY and FERLIE, 2004; MASCIA et. Al. 2013). Specifically, the risk of encountering resistances to change bring to a risk of incurring in the so called decoupling phenomenon.

This work wants to spread light on to the still poorly explored issue about whether clinical directorates have really fostered change in line with the objectives of their organizational model, which include the ambition of pursuing greater efficiency without sacrificing the quality of services provided. To do this we suggest to explore the extent of adoption and actual implementation of innovative human resource management tools in clinical directorates, and present a model to do so.

The study's aim, therefore, is to provide answers to the following two research questions:

- Is it possible to identify different approaches in managing human resources, or are approaches generally uniform across clinical directorates?
- What are the enablers/barriers to a concrete implementation of innovative human resource management tools?

2. THEORETICAL BACKGROUND

From the 90s on, the Italian healthcare sector has faced a number of relevant reforms that have transformed deeply the identity of healthcare organizations. Among other aspects, reforms aimed at fostering a deep change in healthcare organizations' "identity", with a switch from typically public bureaucratic organizations to entities that, just as private ones, are directly accountable for the quality of the services offered as well as the degree of efficiency reached in doing so.

These drastic strategic transformations have required deep structural changes. Specifically, the greater accountability of organizations, as well as the strong pressures they had to meet, required them to adopt new organizational structures, able to allow them to pursue quality and efficiency in an effective way.

The main solution to these challenges has been sought in the clinical directorate model. Clinical Directorates are semiautonomous hospital divisional units in which several clinical wards are integrated or merged (LEGA, 2008; BRAITWAITE et al., 2006). Although wards may be aggregated on the basis of different criteria, the main intent of the law is clearly to assign responsibility to organizations by creating subunits that are accountable for their own activities.

The clinical directorate model has important managerial implications. Clinical directors cover an intermediate managerial role between top management on one side and clinical wards on the other. Top management can now focus on setting strategic results and measuring their achievement, while delegating coordination and operational control activities to clinical directorates (FONTANA, 2012).

What emerges, therefore, are new organizations with non bureaucratic features and a decentralized decision-making scenario, which is combined to the historical professional autonomy typically found in health care organizations. Clinical directorates therefore, seem to have deeply affected organizations' structure, but are also likely to affect the set of responsibilities and of managerial tools adopted. It seems reasonable to believe that since a great number of responsibilities are delegated and decentralized, intermediate managerial levels must become responsible of the adoption and, especially, the correct implementation of managerial tools.

It is clear, therefore, that to the difficulty of designing new strategies and organizational models, one has to consider the difficulty of managing the actual implementation of change by adopting the necessary processes, mechanisms and managerial tools (COLLIS, MONTGOMERY, 1998).

Achieving change seems to be one of the most difficult challenges management can face. The risk is to incur into the so called decoupling phenomenon, that is responsible of the adoption and of the contextual not implementation of the organizational models and practices within organizations, (MEYER, ROWAN, 1977; HALLET, VENTRSCA, 2006; WESTPHAL, ZAJAC, 2001). In presence of decoupling, although we assist to a structural change, this may not be translated into concrete changes in terms of behaviors and ways of working.

Moreover, studies have shown how organizational transformation has often failed because of inabilities to face a limited motivation to change among health professionals (GOES, 2011). Indeed, structural changes may not be accompanied by cultural ones and may create misalignments between leadership goals and workforce goals. It is not at all obvious that employees should share the same understandings (BALOGUN AND JOHNSON, 2004; BARTUNEK et al., 2006) or feelings (GEORGE AND JONES, 2001) as their managers toward change.

What seems to be a common conclusion of most studies in this field, is that the support of employees is crucial for the successful implementation for organizational change (Bartunek et al., 2006; Herold et al., 2007). Moreover, it seems that people's will to contribute to organizational change not only depends on the content of change (what changes), but also, and in a resolute way, on the process of change through which organizational change takes place (Armenakis and Bedeian, 1999; Self et al., 2007). It is therefore essential to correctly manage organizational change.

Change management studies have proposed a number of approaches, strategies, interventions and actions through which change can be implemented (e.g. Burke, 2010). However, the most common distinction is perhaps between planned and emergent processes of change (Bamford and Forrester, 2003; By, 2005). In particular, planned change consists in rationally setting specific objectives and implementing change in a top-down manner. To do so the organization must go through a number of phases in order to successfully change to a desired future state (Burnes, 1996, 2004). On the contrary, the emergent approach to change consists in a bottom-up way and more devolved way of implementing change (By, 2005). Change does not hold on its starting point, as is the case in the planned approach, but instead on the outcome of an emergent change process. Employees are not considered and treated ad passive recipients of change, but are asked to assume an active role in its process (Russ, 2008).

A top-down bureaucratic management style is associated with planned change, while a more decentralized, flexible management style corresponds to emergent change (Burnes 1996). The unique features and complexity of healthcare organizations (CICCHETTI, 2004) make it reasonable to believe that they will have to adopt an emergent approach in change implementation. This not only in reason of their new "identity" which, as mentioned, casts away the old bureaucratic stereotype, but also because the strong autonomy its professionals hold is in stark contrast with top-down approaches. Organic philosophies, therefore, seem to be a lot more appropriate and coherent with the delegation of responsibilities to clinical directorates.

Consequently, it is clear that clinical directorates (and directors) assume a fundamental role in the implementation of change. What however has been poorly explored is how to measure the effectiveness of their ability to implement change. The approach suggested in this work consists in analyzing the adoption and the degree of concrete implementation of the most innovative human resource management tools in clinical directorates, holding on the assumption that in order to change how people work one must change the way of managing them. Previous literature has explained how managerial accountability, evaluation of managers and reporting systems, if well designed and used, are all enablers of a correct and effective implementation of the clinical directorate model (FONTANA, 2012). However, what is still unknown is to what extent, after around 15 years from their introduction in the system, clinical directorates have been able to

innovate their human resource management system and foster an effective implementation of the organizational model, in coherence with its objectives. In other words, this work holds on the assumption that scenarios characterized by innovative and lively human resource management systems have most likely been able to truly implement the model, avoiding the presence of decoupling phenomena and overthrowing barriers and people's resistances to change.

3. MATERIALS AND METHODS

3.1 Sample and data collection

During on- site visits in Italian health care organizations we collected data through around 50 questions about the development of HRM tools, by conducting semi-structured interviews with Clinical Directors. Our sample is composed of 65 clinical directorates, belonging to 33 Italian health care organizations, that we have selected on the basis of on their homogeneity in terms of number of staffed beds and clinical activities performed.

3.2 Variables

Dependent variable

Clinical directorate HRM approaches: We focused our attention on the presence and concrete degree of application of three different kinds of HR managerial tools (COSTA, GIANECCHINI, 2005): *control-related, training-related and objectives-related* tools. In particular, control-oriented tools include forms of control of human resources in terms of process evaluation and in line with a need of standardization, in such a way to reduce the variability of results and to uniform procedures. The training-oriented tools are aimed at fostering professional growth in terms of knowledge, skills and organizational behaviors. Finally, the objectives-oriented tools are related to the measurement of the results achieved by employees in a management-by-objectives perspective (COSTA, GIANECCHINI, 2005).

In order to measure these dimensions, we investigated the presence/absence of the three types of HRM tools in each clinical directorate, as well as their degree of concrete adoption, through some of the questions of the questionnaire. We translated the results in percentage scores and calculated, for each of the three typology of tools, the mean value of implementation across clinical directorates. The resulting three values represent the final indexes adopted in the regression analyses.

Independent variables

In order to investigate the features that affect the development and the implementation of control-, training- and objectives-related managerial approaches within clinical directorates, we used the following independent variables in the regression analyses.

Departmental decentralization: measures the degree of autonomy and responsibility assigned to Clinical Directors from top management, through some of the questions of the questionnaire. In line

with previous research (CICCHETTI, 2012), we consider two perspectives of decentralization: the *administrative decentralization* and the *clinical decentralization*.

Administrative decentralization: this variable has been analyzed by exploring the degree of clinical directorates' autonomy in administrative decision-making processes and in the elaboration of a budget, the frequency of administrative reports requested from top management and the type of administrative tasks delegated to directorates. This dimension has been surveyed through a checklist validated by experts. Each item has been weighed from 1–5, in order to capture its contribution to the total degree of administrative decentralization. These scores were summed and rescaled (divided by 100) to obtain the final index adopted in the regression analyses.

Clinical decentralization: this variable analyzes clinical directorates' degree of autonomy in clinical decision-making and in the adoption and creation of clinical guidelines; the typology of clinical tasks on which clinical directors are held responsible (clinical audits, risk management, continuing medical education, etc.). Each item has been weighed from 1–5, in order to capture its contribution to the total degree of clinical decentralization. These scores were summed and rescaled (divided by 100) to obtain the final index adopted in the regression analyses.

Institutional profile: Health care organizations in Italy are classified into five main institutional categories, each of which comprises similar organizations with respect to legal form, ownership structure, institutional objectives and types of services provided. Therefore, "Hospital Trusts" are public hospitals that provide highly specialized (tertiary) care and are characterized by high levels of entrepreneurial autonomy. Local Health Units (LHUs) are publicly owned organizations that are directly responsible of providing community healthcare. Hospital Teaching Trusts are linked to universities and provide highly specialized care, and National Institutes for Scientific Research are research-oriented hospitals that provide a limited number of highly specialized services (MASCIA et al., 2014 b). In the present study, four dummy variables were used to identify the different institutional categories of hospitals: Hospital Trust, LHU, Hospital Teaching Trust, and Research Hospital, with LHUs used as base line.

Clinical directorates typology: This set of dummy variables captured the different criteria according to which clinical wards were grouped together into newly formed directorates. These criteria were labeled "Process-Integration", "Specialty-Integration", and "Mixed-Integration" (MASCIA et al., 2014). "Specialty Integration" was used as a baseline in regression models.

Geographical localization: We used a three-category variable that includes Northern, Central, or Southern Italy. Southern Italy was used as base level.

Clinical directorate complexity: The variable complexity counts the number of hospital wards merged into the clinical directorate.

Clinical directorate size: The variable size counts the number of staffed beds belonging to the clinical directorate.

4. RESULTS

Our analysis has been conducted following two levels. In the first level of analysis we performed a pairwise correlation in order to understand if the degree of implementation of each set of HRM tools is related to the implementation of the other two sets. The second level of analysis, given the continuous nature of the dependent variable used in this study, is represented by a linear regression model. This allows us to explore the institutional, organizational, and departmental features able to affect the implementation of each set of tools. We analyzed three different models. In Model 1, 2 and 3 the dependent variable consists of, respectively, control-related, training-related and objectives-related HRM tools. To ensure that our results are robust in reference to methodological choices and in order to offer further assurance against the lack of independent observations because of nestedness of sampled clinical directorates in hospitals, we adjusted the standard errors for the clustering of clinical directorates within hospitals.

The sample is made up of 65 clinical directorates staffed in 33 healthcare organizations belonging to the I-NHS. 37% of the sample belongs to teaching hospitals, 31% to trust hospitals, 24% to LHUs and 8% to research hospitals. The geographical localization is distributed as follows: 45% in Northern, 31% in Central and 24% in Southern Italy. In terms of complexity the average number of ward units is 7 and the average number of staffed beds is 112.

Table 1 provides pairwise correlations among the three sets of tools.

Table 1: pairwise correlations results

			Control	Training	Objectives
Spearman's rho	Control	Correlation Coeffic. Sig. (2-tailed) N	1,000 . 65	,491** ,000 65	,577** ,000 65
	Training	Correlation Coeffic. Sig. (2-tailed) N	,491** ,000 65	1,000 . 65	,435** ,000 65
	Objectives	Correlation Coeffic. Sig. (2-tailed) N	,577** ,000 65	,435** ,000 65	1,000 . 65

**. Correlation is significant at the 0.01 level (2-tailed).

The analysis of coefficients reveals a positive association between each pair of dimension. In particular, there exists a positive and significant correlation between the implementation of control-related tools and of training-related ones (ρ =0,49, p-value=0,000) as well as between control-related and objectives-related tools (ρ=0,58, p-value=0,000). Finally, the trend is confirmed by the positive and significant correlation between the adoption of training-related and objectives-related ones (ρ =0,44, p-value=0,000).

In Table 2 the results of the regression analyses are presented.

Table 2: Linear regression analysis results

	Model 1 **Control tools**		***Model 2*** **Training tools**		***Model 3*** **Objectives tools**	
Admistrative decentralization	-.004	*	-.005		.001	
	(0.002)		(.003)		(.002)	
Clinical decentralization	0.012	***	.011	***	.006	*
	(0.002)		(.003)		(.002)	
Hospital trust	-0.007		.080		-.034	
	(0.041)		(.082)		(.061)	
Hospital teaching trust	-0.018		.046		-.045	
	(0.030)		(.064)		(.058)	
Research hospital	0.019		-.066		-.059	
	(0.038)		(.104)		(.065)	
Process integration	0.006		-.113		.015	
	(0.033)		(.058)		(.039)	
Mixed integration	0.004		-.065		.026	
	(0.063)		(.062)		(.044)	
Northern Italy	-0.014		.033		.049	
	(0.040)		(.058)		(.059)	
Central Italy	-0.026		-.020		.051	
	(0.038)		(.073)		(.063)	
Complexity	-0.012	**	-.007		-.006	
	(0.004)		(.005)		(.003)	
Size	0.000		-.001		-.000	
	(0.000)		(.000)		(.000)	
Cons.	0.234	***	0.488	**	.287	*
	(0.049)		(.172)		(.114)	
N° of observations	65		65		65	
R square	0.658		0.336		0.426	
Sig.	0.000		0.005		0.008	

*p ≤ .05. **p ≤ .01. ***p ≤.001.

Findings document a slightly negative effect of administrative decentralization on the implementation of control-oriented tools (β=-0.004; p≤.005).

On the other hand clinical decentralization exerts a positive and significant effect on the implementation of all HRM tools' typologies. In particular control-related tools present a coefficient of 0.012 (p≤.001) while training-related ones of 0.11 (p≤.001). Finally the objectives-related tools present a coefficient of 0.06 (p≤ .05).

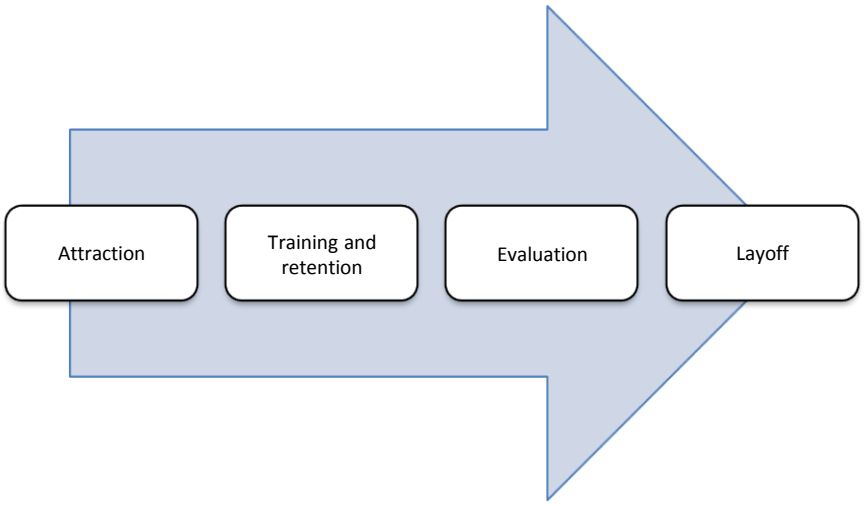
Moreover, the clinical directorate's complexity negatively affects its tendency to adopt control-related tools (β= -0.012p ≤ .01).

Finally, in all of three models of the regression analysis, characterized by 65 observations each, there seems to be a reasonable goodness of fit with R^2 values ranging from 0.336 in the "training model" to 0.426 in the "objectives model", to 0.658 in the "control" one.

5. DISCUSSION

The different set of tools explored in this study reflect the different phases of human resource management. These include people's: selection and hiring; training and retention; evaluation; layoff (COSTA and GIANECCHINI, 2005).

Figure 1: HRM phases



However, in the Italian public healthcare system phases such as hiring and layoff are strongly regulated and leave little flexibility to managerial subjectivity. Therefore, it seems reasonable to expect that concrete change may be fostered through the introduction and effective implementation of HRM tools attributable to the following two phases:

- Training and retention: tools aimed at fostering professional growth in terms of knowledge, skills and organizational behaviors in order to uniform problem solving approaches within clinical directorates (CICCHETTI, 2004);
- Evaluation: tools aimed at assuring that the goals set are concretely achieved by people and teams. These can include forms of control in terms of process evaluation (due to the difficulty of measuring outputs and outcomes of healthcare processes, it becomes necessary to standardize them in order to reduce variability of results and to uniform procedures and tools), or tools aimed indeed at measuring the results achieved in a management-by-objectives perspective (which has to do with the recognition of an economic incentive in reference to the achievement of preconceived objectives) (COSTA AND GIANECCHINI, 2005).

What emerges from the study is that these three set of tools seem to benefit from given contexts, in which it appears they will all be generally fostered. In particular, it would seem that there isn't a tendency to adopt one set of tools at the expense of the others, but rather that favorable scenarios

encourage the development and implementation of an innovative and comprehensive set of managerial tools.

This favorable scenario appears slightly hindered by the degree of administrative decentralization but highly encouraged by the degree of clinical decentralization. It seems, therefore, that the modalities of delegation of responsibilities, as well as their contents, clearly affect the degree to which clinical directors will actively translate their responsibilities in concrete managerial actions. The results of the study might confirm the belief that clinical directors, who are by definition physicians, are hesitant to endorse administrative responsibilities and tasks, which are often felt to be in contrast with medical ethics, but strongly believe in their own ability to actively organize and manage the clinical activity of their directorate. In other words, the tendency that emerges sees clinical directors scarcely inclined to invest effort in administrative matters, preferring to confirm the implementation of possibly dated managerial tools designed at the central level, but highly interested and involved in clinical matters, with a clear orientation to exploit any responsibility in this area through the adoption of an innovative managerial approach. Top management should therefore be aware of the aforementioned risk of decoupling phenomena through which professionals might carry out their work in a different manner from what is expected, creating a lack of compliance between what managers think that professionals are doing and what they are really doing. This seems particularly plausible in reference to the delegation of administrative responsibilities.

A further result of the study shows how the degree of complexity of a clinical directorate is negatively related to the degree of implementation of control-related HRM tools. This result, which may appear counterintuitive and in contrast with those theories that assert that at higher levels of organizational differentiation there correspond higher levels of integration (LAWRENCE, LORSCH, 1967), might hide a relatively obvious explanation. In particular, managing highly complex directorates may be a difficult task which requires a fully developed managerial sensibility. It could hold true, therefore, that relatively "quiet" directorates may constitute a good test bed for managerial "experiments" while very complicated and vast scenarios might discourage managerial innovation, given the difficulty of implementing effectively the relative tools on a vast scale.

6. CONCLUSION

This study presents an innovative tool able to explore the concrete degree of managerial innovation within clinical directorates, with interesting implications in terms of detection of decoupling phenomena. The "resistance" clinical directors seem to pose on effectively managing administrative matters could constitute a starting point in asking oneself to what extent it makes sense to delegate administrative responsibility and not only clinical one.

Moreover, there seems to be interesting implications and food for thought in terms of the ideal dimension and complexity of clinical directorates.

Furthermore, it seems clear that research is needed in reference to what a clinical director's profile should look like. In particular, it would appear that he/she is in need of excellent leadership and relational skills in order to adopt and fully implement an evolved set of managerial tools. This, in turn, may have important implications in terms of what sort of training programs clinical directors

should attend, in consideration that, for example, these present heterogeneous characteristics across Italian regions.

Finally, it is worthwhile to mention some limits of this study: in the first place the small dimensions of the sample analysed may make it necessary to replicate the analyses on a larger scale in order to generalize the results obtained. Moreover, the study is tailored on the Italian context, and further considerations would be necessary before conducting a similar analysis across different countries. Specifically, in order to successfully adopt this tool in different contexts, it would probably be necessary to previously verify whether the set of HRM tools identified do indeed play the same role they play in Italian healthcare organizations. Further considerations are also likely to be needed in terms of possible organizational differences of Italian and foreign clinical directorates.

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