HR AND NEW APPROACHES TO PUBLIC SECTOR MANAGEMENT: IMPROVING HRM CAPACITY

Dr Stephen Bach

HR and new approaches to public sector management: improving HRM capacity

Dr Stephen Bach
Senior Lecturer, The Management Centre,
King's College, University of London

Dr Stephen Bach is Senior Lecturer, The Management Centre King's College, University of London (Franklin-Wilkins Building, 150 Stamford Street, London SE1 9NN Tel: +44 (0)20 7848 4090; e-mail: stephen.bach@kcl.ac.uk) His research interests include human resource management and the reform of employment practices in the public sector. His most recent books include *Personnel management: a comprehensive guide to theory and practice*, 3rd edition, Oxford: Blackwell, 2000 (jointly edited with K. Sisson) and *Public service employment relations in Europe: transformation, modernisation or inertia,* London: Routledge, 1999 (jointly edited with L. Bordogna, G. Della Rocca and D.Winchester). He has acted as a consultant to the International Labour Office, the World Health Organisation and the British government's Department for International Development.

Contents

Summary and Key Findings

This paper, commissioned by the World Health Organisation, examines why building HR capacity is important to effective health care reform, assesses the existing evidence on HR capability in the health sector, and draws out lessons from existing practice.

Building HR capacity for health reform

- It is important to recognise the distinctive features and historical legacy of HR management in the health sector if reform is to be effective.

- HR issues need to be considered at an early stage in health care reform and not be an 'add on'.

- Health care reformers have frequently been over-optimistic about what can be achieved without the necessary resources, human or financial, to make it happen. The commitment of senior policy makers to the HR agenda is vital otherwise it wont be taken seriously.

- The process of health sector reform – who is involved, the sequencing of developments, and the institutional mechanisms to support reform require as much consideration as the content of reform.

- Human resources for health work is frequently focused narrowly on workforce planning and training, effective HR is characterised by a much wider agenda.

- Developing an effective HR strategy requires ensuring that o*wnership, external fit* and *internal fit* issues are addressed.

- The focus on reforming pay systems, which has yielded limited results, has diverted attention from the important issue of non-pay rewards, work reorganisation and questions of performance management.

The HR function

- Developing HR capability requires investing in the training and development of both HR specialists and line managers/professionals with staff management responsibilities.

- It is vital that any investment in specialist HR capacity evaluates the different ways to deliver the HR function. Even if outsourcing is rejected the in-house HR function should be properly audited and monitored.

- To be effective the HR function must develop both an operational and a strategic HR capacity. The HR function should not try to run before it can walk – robust HR policies and practices should be developed before attempts at devolution or more radical changes in employment practices should be pursued.

Gaps in the knowledge base

- In comparison to the strong evidence base on health care reform, especially issues of health system finance and appropriate purchaser/provider incentive structures, there is very limited information on HR. The information that exists is frequently based on *espoused* policy at *national* level rather than *actual* practice. In many of the key functional HR areas - recruitment/selection, appraisal, staff involvement etc there is almost no systematic information on current practice. Many of the approaches to these issues are based on models of private sector 'best practice'. Are they appropriate for the health sector, if so, under what circumstances?

- The shift towards a more developed management function and increased devolution for employment practices, influenced by the *new public management,* highlights the need for workplace studies that explore the responses of employers and employees to restructuring initiatives and the emergent HRM agenda. What are the appropriate roles and division of responsibility between different organizational tiers? To what extent do existing regulatory frameworks support, or hinder, the process of reform? How could new regulatory frameworks be developed and who would need to be involved?

- There is currently very little information about the HR function within most countries or what makes for an effective HR function in the health sector – what are the key competencies required? How can these be developed? What are the most appropriate measures of effectiveness for the health sector HR function?

Links to other papers

This paper has a wide brief with links to other papers in this series. These include:

Training and education. **Building HR capacity requires greater co-ordination between training/education institutions, workforce planners and health care providers. Decentralization and devolution requires an increased focus on developing HR skills for *all* staff.**

Workforce planning. **Enhancing HR capability is often viewed as synonymous with workforce planning. A much wider agenda is required that moves beyond 'numbers driven' policy and that more explicitly recognises the *gendered* character of the health sector workforce.**

Employee relations. **Employees are insufficiently involved in the HR agenda which precipitates defensive reactions from staff. The extent to which forms of employee involvement and partnership working with trade unions facilitates more effective HR practice requires further examination.**

Introduction [1]

Across the world policy makers confront great uncertainty about the future for health care systems and the scope to reform them effectively. The 1990s were characterised by unprecedented interest in health system reform, but by the end of the decade it was clear that the high expectations of reformers had rarely been fulfilled. In the OECD countries the internal market reforms of Britain and Sweden were in retreat and the fragmented US health care system remained substantially unaltered. In Eastern Europe and Central Asia forms of privatisation and revamped health insurance systems have so far not been able to turn round deteriorating health systems *(1-2)*. In many developing countries measures to decentralise health systems have taken place in a context of structural adjustment programmes, exacerbated by the problems of HIV/AIDS.

The reform of health service employment conditions remains a sensitive issue. As the Director General of the WHO commented, 'dealing with issues such as pay and incentives in the public sector…constitute some of the most challenging items on the international health agenda' *(3)*. It has become increasingly recognised that poor human resource management practices remain a dominant constraint on the reform of health services *(4)*. The legacy of insufficient attention to HR is all too evident; the majority of countries have problems with shortages, misdistribution and poor staff utilisation that often co-exist with problems of chronic over-supply *(5-6)*. Even if countries possess sufficient numbers of staff they are often utilised ineffectively because they lack appropriate skills (e.g. in public health) or are concentrated in urban areas leaving rural areas poorly served. Honduras provides one such example *(7)*. These HR problems reduce service effectiveness resulting in health services being ranked as the least efficient public service, according to a World Bank survey of government services in developing countries, using industrialists as respondents *(8)*.

The almost universal reforms of health systems that were unleashed in the 1990s have raised many new HR challenges. In a labour intensive human service industry the quality of service is intimately linked to the skills, motivation and commitment of the staff providing that service. Although reforms of heath services have been badly needed, they have often been accompanied by reductions in staffing levels *(9-11)*. The uncertainty and more intensive working patterns associated with the reform process have frequently impacted on staff morale. At the same time, however, decentralisation and forms of marketisation require the development of new competencies and more sophisticated HR management. Moreover, the management of the workforce has become more complex arising from the growth of 'atypical' employment and greater competition for staff such as nurses, as alternative employment opportunities for women have expanded *(12)*.

This paper is divided into four main sections. The first section examines the broader context of public sector reform and draws out the implications of health reform for HR practice. The second section considers the contribution that HR can make to improved health sector effectiveness. The main section of the paper considers how a more strategic approach to HR can be developed in the health sector, drawing on the existing evidence base, and emphasising the importance of *ownership, external fit* and *internal fit*. The vital role of the specialist HR function, and the different ways in which HR services can be delivered and audited, comprises the final section, prior to a brief conclusion. This paper touches on many areas considered more fully in other papers. In these cases (for example, rewards, performance management) developments are noted but not discussed in any detail.

---

[1] I should like to thank James Buchan (WHO) and David Winchester (University of Warwick) for their comments on an earlier draft of this paper.

Health Care Reform, Human Resources and the New Public Management

In many countries health care reform has taken place against a background of substantial political and economic change. A WHO sponsored survey of 18 countries' HR strategies suggested that each country's particular political and economic circumstances had an important bearing on HR policy *(13)*. For example, in countries such as Angola and Cambodia continuing political and economic uncertainty has led governments to focus on minimum HR requirements that will enable more fully developed HR policies when political stability returns.

These differences highlight issues about whether management practice in the public sector has started to converge around a *new public management*, as some commentators have suggested *(14)*. Although not amenable to precise definition, it has been associated with a plea that the public sector should mimic 'best practice' in the private sector. *New public management* places great emphasis on accountability for results, with the development of a cadre of professional managers that are forced to compete for resources from government or donor organisations *(15)*. It has also been associated with measures to aid policy delivery. By separating the formulation of policy from its implementation, with the creation of separate business units measured against clear targets, greater clarity and expertise can be developed in both policy formulation and delivery. Nonetheless, *new public management* reforms require sophisticated capacity to develop targets and to enforce them through contractual means, expertise that is not well developed in many countries *(16)* and which may account for its modest impact in less developed nations *(17)*. In Europe, the experience with developing and implementing *new public management* reforms has been more uneven than is often suggested *(18)*.

Despite these uncertainties there remains substantial agreement on the main themes arising from the health care reforms of the last decade *(19-21)* Although often conflated in practice, for analytical purposes a distinction can be drawn between the *content* and *process* of health care reform. This allows the implications for HR to be drawn out more fully and the scope for policy interventions to be made more explicit. In almost all countries the *content* of health care reform has involved a mixture of: altering the role of the state, decentralisation, a greater emphasis on primary health care and, to a lesser degree, the empowerment of users (see appendix 1).

If the main strands of health care reform are well known, the consequences for human resource management are rarely considered in a systematic manner. Appendix 2 illustrates the *process* of health care reform with 'top-down', 'big-bang' *(22)* approaches the most prevalent. Although the process of reform can have an important bearing on the outcomes of the reform process it has been subject to much less attention and many of the issues examined in appendix 2 are *implicit* rather than explicit within the reform process.

An important lesson is that health reforms are frequently devised separately from human resource management policies and from broader processes of civil service reform. This divorce results in the implications of health reforms for HR policy not being considered until the end of the process or plans developed that can't be implemented because the Ministry of Health has neither the capacity nor the influence to make them happen. Insufficient attention has therefore been given to whether the management capacity and influence exists to implement reforms. An unfortunate side effect is that a gap emerges between espoused policy and actual practice (because of implementation problems) leading to cynicism and eroding support for change. In summary, policy analysis often focuses on the technical elements of reform without sufficient attention being given to *implementation* issues; especially the specific institutional and contextual factors that facilitate or constrain reform.

Human Resources: From Neglect to Valued Asset?

The lack of attention to human resource issues is not confined to the health sector. For many years commentators have bemoaned the traditionally low priority given to people management issues within most organizations *(23)*. In the health sector, in which the largest proportion of recurrent expenditure is invariably staff costs, it may seem curious that such neglect has persisted, but this reflects a historically narrow and low profile human resources agenda.

First, most governments which directly or indirectly fund the majority of health care expenditure have been primarily concerned with macro-economic issues, especially the size of the health sector workforce, rather than the micro-level focus of contemporary HR practice which concentrates on the motivation and performance of the workforce. In most OECD countries the state has had a long-standing concern to control the public sector paybill to ensure that fiscal objectives including the control of inflation are not jeopardised. By contrast in some African countries and parts of Southern Europe, the state has acted as an employer of last resort and dispensers of political patronage, allowing the continued growth of public employment even during periods of austerity *(8)*. Consequently, governments whilst pursuing different objectives for public employment have rarely been overly concerned with the detail of human resource management policy.

Second, the establishment of terms and conditions of employment in health systems has usually formed part of a broader system of public sector employment regulation, characterised by centralised personnel policies. In many developing countries, these issues are often handled by a separate Public Services Commission, with the Ministry of Finance taking a keen interest in wage determination. This has left the Ministry of Health bereft of personnel expertise or influence over HR issues, as noted in the case of Ghana *(24)*. In many industrialised countries, irrespective of whether wages and other conditions of employment are established unilaterally by government, by forms of pay review body or through collective bargaining, there has usually been little scope for managers to alter employment conditions *(25)*. Involvement in personnel management policy has therefore been confined to small groups of experts located at central level. In countries in which dedicated personnel managers have existed, their role has been circumscribed by these policies, leaving them with a limited, operational role, in implementing and interpreting national employment rules.

Third, health care systems and their development have been shaped strongly by the role of professionals, especially doctors, whose training emphasises autonomy and professional self-regulation. These values have led their professional organisations to focus on the regulation of their *own* profession rather than broader policy or operational matters. This agenda is distinct from the current focus of health reformers on issues of efficiency, effectiveness and equity. Moreover, the HR issues involved in managing professions has been given limited attention because in the past it has been assumed that health professionals are motivated by intrinsic rather than extrinsic factors discouraging the adoption of active HR policy.

The contribution of human resources

Within the specialist HR literature there has been increasing awareness of the contribution of innovative forms of human resource management (HRM) to organizational performance *(26)*. Traditionally, personnel management has been associated with management-trade union relations, maintaining control of the workforce and ensuring organizational adherence to policies on recruitment, appraisal, training and such like. These predominantly operational tasks, largely removed from the core preoccupations of senior managers, have tended to ensure a relatively low status and marginal position for personnel specialists.

By contrast in recent years it has become commonplace for organizations to suggest that human resources are their most important asset. Whether termed human resource management (HRM) or high performance management the novelty of these approaches is that they emphasize pursuing a *strategic* approach to the management of people. This involves developing a coherent human resources approach with the full backing of senior management and with a tight coupling between human resources and 'business' policy. HRM comprises a particular 'high commitment' route in which there will be organizational pay-offs if specific configurations of personnel policies are adopted. These policies aim to: secure the commitment of the workforce; ensuring highly flexible and innovative working practices; and establishing a high quality of work by developing a skilled workforce (*27-8)*. Many commentators suggest that a positive link exists between the establishment of sophisticated HR architecture and a firm's financial performance *(29)*.

This emphasis on adopting a more strategic approach to HR reflects a developing consensus that human resources are *the* key source of competitive advantage because it is the skills, behaviour and values of staff that are paramount in sustaining high performance
 (30). This insight has been associated with the resource-based view of the firm in which it is suggested that successful firms are those that systematically identify, use, develop and renew their core competencies (*31)*.

Models of HR practice

The resource-based view has influenced a number of models that try and demonstrate *how* a strategic approach to HR can be translated into a set of coherent HR policies. There are two broad approaches *(32)*. First, *universal* models imply that they there is one 'best way' for achieving high performance regardless of the context or specific circumstances of the firm. Second, *contingency* models link the human resource management policies adopted by the organisation to the particular aspects of the business environment. The universal models vary in their emphasis but they all put a premium on ensuring that HR policies are meshed together coherently and reflect the requirements of the external business environment (see appendix 3). The type of policies the HRM approach incorporates is shown in table 1.

By contrast the contingency models link HR policies to the particular circumstances of the organisation. Some models emphasise that it is the stage of the organisation's life cycle (start-up, growth, maturity) that should determine HR policy whilst others focus on the characteristics of the firm whether a single product firm or a highly diversified business. Finally, whether a firm is competing on the basis of cost, quality or innovation has also been associated with particular HR strategies.

Table 1: Seven dimensions of HR that produce profits through people

1. Employment security
2. Selective hiring of new personnel
3. Self-managed teams and decentralization of decision making as the basic principle of organizational design
4. Comparatively high compensation contingent on organisational performance
5. Extensive training
6. Reduced status distinctions and barriers, including dress, language, office arrangements, and wage differences across levels.
7. Extensive sharing of financial and performance information throughout the organisation

Source: Pfeffer, J. 1998: 64-65 *(30)*

This type of contingency approach has been applied to health care settings. Eaton examines the patterns of HR policy and patient outcomes associated with three different types of work organisation amongst nurse aides in the nursing-home sector in the USA *(33)*. Using the same type of approach as the contingency models, particular forms of 'business strategy' (models of care) were linked to specific HR policies, suggesting that managers could exercise a degree of 'strategic choice' in the approach adopted. Different HR approaches were associated with very different levels of performance in terms of the quality of patient outcomes (appendix 4).

Developing a Strategic Approach for the Health Sector

These models have value in highlighting some fundamental issues and demonstrating the importance of a strategic approach. With few exceptions, however, the models are focused on the development of HR strategy at the level of the individual firm with an implicit assumption that the organisation is relatively autonomous in developing its own strategy. In the health sector HR strategy needs to take account of a range of different stakeholder perspectives and to be focused at national as well as lower organisational tiers. This complexity reduces the scope for autonomous management actions and if these realities are ignored, unrealistic and naive HR strategies may be formulated. For example, in many countries such as China there is a tradition that the distribution and allocation of health professionals is decided centrally, with local managers having little discretion over staffing decisions *(34)*.

No pre-packaged model is therefore appropriate to the range of circumstances within health care systems. It is the ability to craft a strategy appropriate to local conditions and culture and to *implement* it effectively that is paramount. It is therefore important to move beyond generic models to distil the core *processes* and *values* that underpin successful HR. Three broad conclusions can be drawn on effective HR strategy from the research evidence:

- *Ownership:* people are regarded as a strategic resource to be nurtured and developed with top managers that support such an approach. There is clear leadership of the reform process with sufficient HR capacity to maintain the momentum of reform.

- *External fit:* organisations with an effective approach to HR are alert to the external environment, planning their HR requirements in a manner that incorporates the HR implications of a changing external environment and able to modify the strategy or resolve the problems arising from any environmental changes.

- *Internal fit:* refers to a coherent approach to HR policy which is not over-reliant on one element (e.g. training) but combines HR policies into an integrated bundle of policies and processes.

What is the evidence about the adoption of such approaches within the health sector and what improvements could be made to existing practice?

Ownership

The evidence suggests that ensuring the importance and ownership of HR within the health sector remains a major challenge. It is at national level that Ministries of Health are expected to lead health reforms, including HR activity. In many developing countries HR activity is located within a specific HR unit within the Ministry *(35)*. The difficulty is that many of these units are not staffed by HR specialists and they tend to concentrate on issues of personnel administration and training. This operational focus

can contribute to the sense, as in the case of Colombia, that the Ministry forms part of the problem rather than part of the solution and this weakness prevented it from building consensus for reform with other stakeholders (employer and union representatives) *(36)*. For this reason it is important to establish a specialist and independent HR capacity at central level to flesh out detailed plans because this is the best means to implement unpopular changes *(37)*.

Moreover, if at Ministry level there is a failure to invest in HR expertise, it undermines the message that HR issues are important. In the United Kingdom radical attempts to alter HR policy in the early 1990s, as part of the establishment of an internal market, floundered because the Ministry of Health provided little concrete support and guidance to local trust hospitals about how to implement HR strategies. This made local managers cautious about reforming employment practices because they believed that they were receiving mixed messages about the priority attached by the government to the reform of employment conditions *(38)*. These difficulties place a premium on investing in HR capacity at central level, including top level board representation for HR specialists, which has been shown to increase HR credibility and foster a tighter link between HR policy and business strategy *(28)*.

These problems of central capacity can be exacerbated by the undermining effects of constant change amongst senior staff. Accounts of transformational change in successful organisations are peppered with references to strong leaders and the emphasis placed on developing the next cadre of top managers *(39)*. The health sector, particularly at central level however, is subject to political fluctuations in which there may be frequent changes of personnel due to political upheaval *(40)* and the allocation of senior roles on the basis of patronage. This discourages a longer term perspective, erodes organisational memory and expertise, reducing the capacity to implement reforms.

So far the discussion has presupposed that the HR strategy is owned by the Ministry of Health. This assumption, however, ignores the extent to which ownership of HR issues is diffused amongst many different actors. Because HR policy invariably has paybill implications the Ministry of Finance takes a close interest in HR matters, as do other government departments. HR policies will only be effective if there is *agreement* and *co-ordination* at central level. In addition to the need to improve co-ordination with government departments, the role of the private sector and educational institutions needs careful consideration to ensure sector wide ownership of HR. This is not straightforward because the interests of educational institutions, for example, may clash with those of government. In Peru, private and loosely regulated educational institutions are creating an over-supply of physicians; an issue that has not been adequately addressed by the state even though it exacerbates existing problems of staff utilisation and deployment *(41)*.

Other key stakeholders also need to be involved. Although there is often a reluctance to include trade unions, their exclusion can store up problems for later. For example, in Costa Rica a relatively closed policy making process, at the behest of the World Bank and Inter-American Development Bank, marginalized union involvement and led to incoherent HR policy. Similar problems have been highlighted in Fiji and Guinea-Bissau. By contrast widespread consultation with stakeholders in Angola and Botswana facilitated a greater sense of ownership *(13)*.

Strengthening HR ownership. Several interventions can ameliorate the problems of HR ownership. The importance of a clear vision, which reflects the overarching view of where the organisation is heading, and a mission statement that puts in more concrete terms the key ideas that guide the organisation have been recognised as central to establishing a strategic approach to HR. In many countries there are forms of hospital charter that reflect the key mission of public hospitals, as for example in France (see appendix 5) *(42)*. This type of statement, however, is only of value if they it is developed in co-operation with staff

and taken seriously by managers. This is more likely to be the case when the mission statement is integrated with training and performance management systems.

Below Ministry level, at district or hospital level, many of the same issues of HR ownership and leadership arise. An important issue is the involvement of clinical staff which has become more pressing as decentralisation increases the role of professional staff in HR matters. It is crucial therefore that clinical staff receive training and support to build up their knowledge and understanding of management issues.

Ambivalence towards such developments and other forms of 'best practice' (e.g. teamworking) has led to suggestions that the management of culture and values is an integral part of the new HRM (see appendix 3). The argument is that improved organisational performance results from the development of explicit corporate values that guide behaviour *(43)*. The evidence suggests that within the health sector caution needs to be exercised. Health workers have highly developed professional values and there is a danger that attempts to manipulate the culture can easily back-fire and be treated with cynicism. As health workers appear especially hostile to managerial reforms that may undermine an existing public service ethos *(44)* it is more fruitful to gain ownership for HR policies by focusing on behaviours and competencies rather than trying to alter core values.

The evidence suggests that three main factors will influence employees' willingness to change their behaviour and consequently their capacity to 'own' the HR agenda. First, the further that new behaviours are distinct from the old one's the more threatening and uncertain are likely to be the reactions of staff. In the UK the pressure on doctors to take on budgetary and staff management roles led to considerable resistance because these responsibilities were radically different from those that clinicians had been expected to undertake in the past. In addition, without training and support, staff at hospital level may lack the confidence and experience to take on additional HR responsibilities as the experience of Hong Kong indicates *(45)*.

Second, the degree of transparency and the simplicity of HR changes is an important influence. Organisations that are able to communicate the key messages of their HR strategy and ensure that individuals understand how their role fits into wider organisation objectives have more success in managing change *(28)*. The complexity of the health sector with many stakeholders and multiple competing objectives that are not easily measured makes this a difficult task. In addition, the political character of health care organisations with informal alliances and trade offs between different objectives make policy makers understandably hesitant about revealing these political compromises. Inevitably clear priorities suggest that other objectives are less important, which may antagonise powerful groups and vested interests *(46)*. Nonetheless, innovative organisations have the maturity to debate their priorities, making decisions explicit and converting them into measurable targets. This type of approach has been adopted by the WHO in its *Health 21* programme in which HR forms an important component of the initiative *(47)*.

Third, in any change process there will be winners and losers. Not surprisingly the extent to which people will embrace change is influenced by their perception of whether they have gained from the change process. In the Czech republic, for example, physicians expected that privatisation would boost their incomes *(48)*. In general, however, a key lesson from health care reform is that in many countries too many influential stakeholders believe – rightly or wrongly – that reforms will have a detrimental effect on their status, working conditions and pay *(11)*. There is also considerable unease that the commercialisation of health services is placing financial considerations before patient care, fuelling industrial action, for example strikes amongst nurses in South Africa *(49)*. These concerns are reinforced by governments that are unable to provide sufficient resources to implement the reform agenda (e.g. Zambia) *(16)*. The experience of successful HR change, however, suggests that policy makers need carrots to offer staff in order to be able to pay for change.

External fit

The second key component of developing a strategic approach is a planning framework that enables alignment between HR and the external environment. This ensures that the organisation's policies support the behaviours and competencies required for it be effective. The focus of most attention is usually an HR audit and HR plan because without some knowledge of existing HR resources and future requirements, it is difficult to know whether HR capacity can fulfil the needs of the 'business plan' (health plan). In the health sector, the WHO has examined existing HR resources focusing on the medical and nursing workforce. The state of nursing and midwifery was investigated following the passage of World Health Assembly resolution 45.5 in 1992. This resolution addressed the problems of nursing and midwifery, especially staff shortages. A survey that examined the implementation of this resolution painted a mixed picture on responses to shortages, with the greatest attention being focused on improving educational programmes. Only half the countries responding had a written national action plan for nurses with a lower figure for midwives (39 per cent) *(50)*.

This situation reflects the generally very patchy picture of HR planning. Few countries have formulated a comprehensive national HR development plan (see the experience of the Caribbean countries). This problem is compounded by the lack of a database on existing skills in the health sector *(51)*. This picture is perhaps unsurprising because there is a limited tradition of effective planning and strategy development *(52)*. Even if a HR strategy exists too often it has been discredited by being a top down, formulaic planning ritual using inaccurate and dated information with HR considerations isolated from health policy issues (see appendix 6 *(53)*. Nonetheless the near universal attempts to reform the health sector provide an opportunity for policy makers to use the objectives of reform (table 1) to develop a more strategic view of health services, including *at the same time* the implications for HR, formulated in clear and measurable HR plans.

This has been the approach of the British Government which has recently published its revised strategy for the NHS which sets out its core principles (appendix 7). Importantly this strategic plan does not simply *quantify* the goals of the organisation and the number of staff that it believes will be necessary to achieve these aims, important as this is, but it also outlines in *qualitative* terms the expectations of staff *(54)*. The HR components of the plan are integral to it not a separate add on component. To ensure that local employers take their HR responsibilities seriously the government has included the way that employers treat their staff as a core component of the performance framework; linked to the financial resources that hospital trusts receive. For example, each employer is to be assessed against a 'Improving Working Lives' standard that will assess the organisation's training record, sickness and safety performance, approach to discrimination and the like.

The UK approach takes a broad perspective that emphasises the impact of HR strategy on customer service, investors and employees; mirroring a 'balanced scorecard' type approach *(55)*. This is in contrast to most of the evidence in the health care sector in which HR strategy is defined narrowly in terms of workforce supply and demand issues (e.g. Eritrea) or attempts in Greece to establish a register of all nursing personnel and to predict future workforce requirements *(56-7)*. These efforts are a *necessary* but not a *sufficient* condition for developing HR capacity.

First, the focus of analysis tends to be the *occupation*, especially doctors and nurses. This not only ignores many other healthcare occupations, but planning on this basis assumes relatively fixed roles for staff. As discussed below, competency based approaches which focus on the behaviours required of staff rather than existing professional roles, may increase the flexibility and thus the capacity of the workforce. Second, numbers orientated workforce planning methods leave key questions about the distribution,

qualifications, motivation, development and performance of staff unexplored. Finally, the issue of whether adequate measures exist to forecast the numbers of staff needed given that staff roles in health services are changing and that the process of globalisation is expected to increase health sector mobility remains an unresolved issue *(58)*. It is for these reasons that many organisations whilst maintaining a systematic approach to human resource planning are moving away from an emphasis on quantitative techniques *(59)*.

A final issue in terms of integrating HR policies to health policy requires more detailed and explicit consideration of key health trends that are not included sufficiently in the planning process, even though scanning the environment is a central component of ensuring external fit. A number of sensitive issues may not be factored into HR plans. For example, the growth of HIV/AIDS has considerable implications for the availability of health personnel in many countries and the type of services that will need to be provided. It may be politically too sensitive to incorporate accurate forecasts of HIV/AIDS despite its consequences for HR. Private practice raises different issues. In many African and other countries professional staff carry out private practice to boost their salaries, even though it has an ambiguous status *(60)* and may compromise their public sector work, as noted in the Caribbean *(51)*. Nonetheless, the failure to incorporate private practice and the activities of NGOs into an analysis of HR requirements will reduce the credibility of HR planning.

In summary, the key lessons are simple. Health policy goals have to be translated into operational plans if there is to be a strategic approach to managing HR; people undertaking this task need to have sufficient influence to ensure plans are taken seriously and implemented to prevent the 'Strategic Plans on Top Shelf' (SPOT) trap *(53)*. Indeed if senior policy makers and managers really believe that HR is fundamental to organisational effectiveness they will be involved in developing HR plans and capacity at the same time as they develop health policy rather than the former being 'downstream' of the latter *(32)*. It is for these reasons that issues of *fit* are central to building HR capacity.

Internal fit

As well as the need to align health policy and HR policy (*external fit)* there is also the need to ensure that personnel policies are internally consistent *(internal fit)*. The widespread use of competency frameworks are one means to ensure that the requirements of the HR strategy can be linked to the specified attitudes and behaviour of staff. These standards are then incorporated into all aspects personnel practice (recruitment, appraisal, training etc). The appeal of the competencies approach is that it provides a currency to describe and link personnel practices that have often been characterised as a set of disparate activities with little cohesion. There are a number of different types of competency framework that have been developed [appendix 8 *(61)*].

Within the health sector the competencies based approach is most prevalent in the industrialised countries and has been applied particularly to *leadership* positions. In Sweden, for example, case study evidence from a number of clinics emphasised the central role that competency based management development played in improving leadership skills and enhancing employee attitudes to change *(62)*. Other studies have asked nurse managers to rank the behaviours of health executives that they found most helpful in supporting organizational change with 'frequent communication about transition plans' and 'commitment to quality of care' ranked highest *(63)*.

Competency based approaches, despite their potential to provide the 'glue' in complex organisations, are not without their critics. First, competency frameworks are often viewed with suspicion by professional staff that wish to retain a monopoly of expertise and are reluctant to accept new categories of health

worker. Competency approaches by emphasising behaviours rather than qualifications can break down the barriers between occupational groups and encourage cross-functional working. Professional resistance, however, can be exaggerated as over time attitudes appear to change and medical staff are more willing to delegate work to nurses, as appears to be the case amongst general practitioners in Britain *(64)*. A lot depends on the structure of incentives that can facilitate or hinder changes in behaviour.

Second, competency approaches have been criticised because they focus on what people can do rather than what they know. Based on Australian experience, it has been suggested that competency frameworks reduce the importance of the learning process and do not equip staff to be 'problem solvers' *(65)*. In practice, considering that in many parts of the world training and development activity has been inadequate and focused on narrow technical skills, for example, in Central and Eastern Europe *(66)*, competency based approaches can make a valuable contribution to reducing the gap that frequently exists between the output of educational and training institutions and the needs of the health sector as, for example, in the Philippines *(67)*.

Recruitment and selection. Cohesive HR policies are heavily dependent on effective recruitment and selection practice. A number of difficulties have been highlighted in the literature. First, decisions about recruitment and selection are often handled by a central government body using standard staffing ratios that are often poorly linked to local service requirements. Policies that decentralise service provision whilst retaining central control of staffing add to these problems. Poor distribution of staff can result, for example in Tanzania, because recruitment and allocation decisions are based on political influence rather than linked to workload *(40)*. These difficulties can be exacerbated by the poor links between recruitment requirements and training outputs; graduates in Nepal and Indonesia have to wait months or years before they can take up posts *(35)*.

Second, selection procedures very often part of a formalised recruitment process for the whole civil service in which formal exams are set that have little relevance to the particular jobs undertaken. In Honduras, selection is based principally on medical qualifications. Candidates are rarely interviewed and management skills are not considered *(7)*. Similarly in Spain, selection examinations are heavily weighted towards legal matters of questionable relevance *(68)*. This type of cumbersome recruitment process has encouraged forms of 'backdoor' recruitment to allow more flexibility and autonomy in recruitment matters; encouraging the growth of temporary employment *(69)*. The difficulty is that it encourages a haphazard increase in staff levels, with staff on different terms and conditions of employment, often with little legal protection. The recruitment of temporary staff may be a logical component of an HR strategy but it should not be used to circumvent cumbersome recruitment and selection regulations.

Instead, especially in countries that are decentralising management practice in line with the precepts of the *new public management,* employers have been granted increased discretion over recruitment and selection. This encourages staffing patterns linked to local requirements, increases the authority and accountability of local managers and streamlines the process. This does not mean that local managers should have a completely free hand to recruit; the process must remain within a clear HR framework, but it does allow discretion to move beyond the internal labour market and recruit externally which can boost the quality of applicants [e.g. Kenya *(70)*].

A related issue is the *criteria* used to select staff. Innovative organisations use targeted selection methods driven by their competency framework. In the health sector this approach has been translated into a more critical approach to standardised tests that cannot detect competencies such as organisational commitment or communication skills. Coupled with problems of recruitment and retention it makes sense to use

more flexible recruitment and selection methods. For example, in the United States, many states including Connecticut, Indianapolis and Virginia have largely dispensed with written tests for recruiting many welfare staff and use experience, references, work samples and interviews as the main selection techniques *(71)*.

Performance management and rewards. The management of these issues and the outcomes in terms of working conditions present some of the greatest challenges to policy makers in the health sector. The criticisms of employment conditions in the Caribbean are illustrative of these difficulties (appendix 9). The problems can be stated bluntly: salaries have in general been eroded in recent years, performance expectations are under-developed, and pay determination arrangements are often inappropriate focusing almost exclusively on seniority with no link made between rewards and performance *(11)*. These points can be briefly developed here.

Although it is very difficult to generalise, salaries are relatively poor, especially in developing countries. This has encouraged staff to supplement their meagre incomes by private practice, with detrimental consequences for public health services; a practice that many governments have condoned because it takes some pressure off them to raise public sector salaries *(72)*. Low salaries arise not only because of the universal constraints on the public sector paybill, but also because health sector pay determination arrangements are frequently incorporated within wider civil service pay systems. One possible solution has been to break the link between health sector and civil service wage setting (for example, in Ghana) increasing wage dispersion. Staff may be reluctant, however, to transfer onto different employment contracts because of the benefits of civil service employment (for example, pensions) as noted in countries such as Zambia *(73)*.

Different approaches to reform are influenced heavily by the characteristics of existing pay determination arrangements, not least the degree of centralisation and decentralisation, as the case of Europe demonstrates *(74)*. Although it has become very fashionable to advocate more decentralized systems of pay determination there are considerable risks involved in such an approach. There is the requirement to invest in considerable HR capacity and the danger that far-reaching reforms of pay systems may have the opposite effect to that intended by *demotivating* staff as experience from both industrial countries (for example local pay in Britain) and developing countries (e.g. The Phillipines) suggests *(37-38, 75)*. The important lesson is that systems of health service pay determination are highly resilient to change because of managerial conservatism, trade union opposition and the cost implications of pay reforms. It is striking, however, that significant changes in employment practices can be introduced (performance management systems, working time changes, alterations in work organization) within a national pay determination framework as long as managers have some local flexibility *(76)*.

Too much emphasis has been placed on the need to reform pay systems and pay levels of health service staff and insufficient attention has been given to the equally important issues of improving non-pay benefits and working conditions. Appendix 9 provides illustrations of these problems, suggesting that addressing issues of career structures, working conditions and working hours could have a crucial bearing on improving the performance and morale of health care staff. Rewarding good performers through promotion, more responsibility and incentives such as attending conferences and making space for research has been one such approach *(70)*. In industrialised countries the promotion of 'family-friendly' working practices has also been a prominent recruitment and retention strategy. Performance appraisal systems also have an important role to play in ensuring that staff are aware of the expectations of them and that transparent promotion criteria are developed. Performance appraisal also forms an important component of the overall HR strategy because it provides important information for HR planning and training purposes and can also help communicate key messages *(77)*.

The Specialist HR Function

The discussion so far has examined key aspects of HR practice and approaches that can be taken to build HR capacity, however, a key question remains who should undertake these roles? It is often assumed that a specialist HR function will exist in health care organisations, but this is not necessarily the case and a key issue is the balance between the role of HR specialists, other staff that perform HR roles and other means to deliver HR service (e.g. outsourcing). There is very limited information on the role of HR specialists within the health sector and it is predominantly prescriptive focusing on what HR *should* do rather than evaluating *what* it actually does. There is an important gap in our knowledge of health sector reform both in terms of the facilitating or constraining role played by HR expertise within Ministries of Health and how HR reforms are actually implemented at workplace level.

The contribution of the HR function

The HR function like any 'support' function needs to prove its worth to justify its existence. In the health sector it is often hard for HR staff to be viewed as legitimate, and resources to be invested in HR capacity, when their role does not obviously contribute to improved patient care. The uncertain contribution of HR specialists is a continuous theme of the wider HR literature *(53)*. This ambiguity reflects the very wide range of tasks that they are expected to perform and their uncertain influence in which they often have to work through line managers. It has also been suggested that the prevalence of women in HR roles may reinforce their marginal role within many organisations.

The tradition of centralised wage determination and employment conditions has confined HR to an administrative role in implementing and policing national agreements. The professional character of the workforce, with the dominance of the medical profession, has ensured that personnel can only exert influence in a subtle manner. If not, professional staff can feel that their autonomy is threatened and will seek to marginalize any personnel role, for example, in the selection of junior medical staff *(78)*. Recognition, however, of professional power can be a positive force for change when HR professionals gain professional support and encourage them to lead on HR issues, for example training and development initiatives *(79)*. It is important therefore to question much of the historical baggage or 'myths' that the HR function has inherited (appendix 10) to enable it to make a more positive organisational contribution. How can this type of role be developed?

This paper has emphasised the importance of developing a strategic approach to HR. A very important lesson, however, is that HR specialists need to develop both effective *operational* and *strategic* roles. The reason for this is that the HR function cannot establish its credibility with senior managers and be invited to make a strategic contribution *unless* it can deliver effective operational services. For example, on issues like recruitment and selection and giving employment advice HR needs to be able to offer a timely and accurate service if it is to establish its credibility. It is for these reasons that HR needs to fulfil a variety of roles which requires the development of a number of key competencies (appendix 11).

Role of line managers

A crucial issue is the division of responsibility between HR specialists and line managers. The trend is towards the devolution of responsibility to line managers especially in areas like recruitment and selection, appraisal, communication, and to some extent over training and disciplinary matters. Pay determination is the area that is least likely to be devolved *(80)*. The rationale for devolving responsibilities for people management to line managers is clear and the same logic applies to devolution from a central HR

unit to local HR specialists. Because HR responsibilities form part of every manager's job, devolution allows greater ownership of those decisions and enables them to be tailored to local circumstances *(32)*. It also reinforces the trend towards health service decentralisation, noted earlier.

Nonetheless dangers exist. First, it is inadvisable to devolve HR activities until formal personnel practices and procedures have been developed, which employees understand and accept. If personnel policies are not in place there is a danger that line managers will flounder and inconsistent HR practice will result or local HR managers will continue to rely on the central HR unit *(45)*. Considerable investment is therefore needed in training line managers and local HR managers so that they understand their responsibilities and feel confident in carrying them out. Second, experience in the UK suggests that HR managers may be reluctant to abandon the familiarity of their traditional roles. Devolution can also foster tensions with line managers and with the central personnel department *(81)*. Finally line managers although supportive of devolution in principle may be reluctant to take on additional people management responsibilities because of their existing workload and because they may be uncertain whether they will get sufficient training and support *(82)*. The pros and cons of devolution are summarised in appendix 12.

Many of these issues revolve around local HR activity, but are the same considerations appropriate at central level within the Ministry of Health? The emerging consensus is that it is crucial to have a specialist central HR capacity at Ministry level and that the central HR unit should have: an *information and monitoring* role in terms of developing an HR information system that includes collecting and analysing information about the reform process; a *policy* role in terms of developing an appropriate regulatory framework for health staff in liaison with other public bodies; and an *advisory and guidance* role in terms of providing technical assistance on HR issues and providing support for cultural change *(36, 83)*.

Delivering specialist services

Outsourcing HR. It has been assumed that there will be a specialist in-house service to deliver HR activity, but the increased use of outsourcing is a well-documented development *(84)* and in the health sector it has been reported in industrial countries and to some degree in India, Mexico, Papua New Guinea, South Africa, Thailand and Zimbabwe *(85)*. The question arises at to whether HR activity should also be outsourced. The arguments in favour are that it allows the organisation to buy in particular specialist expertise, removes time-consuming activities from managers allowing them to focus on key core activities and may provide a better service at lower cost *(86)*. To be set alongside these advantages are considerable disadvantages. First, the health sector is distinct from many other industries in terms of the complexity and interdependence of delivering effective health care. Best practice therefore indicates the importance of integration rather than fragmentation *(87)*. The danger of outsourcing is therefore that a substantial proportion of HR activity is crucial to the organisation's strategy and culture and therefore it should be provided internally *(88)*. Moreover, outsourcing often provokes strong resistance from staff, for example in the Philippines *(89)*, and it may not be worth antagonising staff over this issue when more important changes are in the pipeline.

Second, outsourcing assumes that suitable suppliers of such services exist. In many industrialised countries this is not the case with the market fragmented between providers that specialise in particular areas like training, job evaluation etc and which may have no particular expertise in the health sector. The unavailability of suitable providers is likely to be a major limitation in many developing countries. Although multi-national companies are extending their reach, contracting out can also be prone to problems of poor service specification and corruption *(90)*.

A number of alternatives are available which can bring market discipline and expertise into the organisa-

tion without making use of full outsourcing. With the growth in contracting mechanisms within health care via purchaser/provider splits, the same type of mechanism can be applied to the personnel service. HR can act as business unit or trading division within the Ministry of health or at lower tiers (for example, an individual hospital) and can sell agreed services at an agreed specification level (for example, job adverts will be placed within 48 hours) to their customers. The advantages of such an arrangement are that it clarifies objectives and outcomes, but it also incorporates some of the disadvantages of contract mechanisms; especially the difficulties and costs of specifying contract levels.

Measuring HR effectiveness. Irrespective of which approach is adopted it is crucial that the *effectiveness* of the HR department is measured and audited. There are three broad approaches:

1. Quantitative or hard measures, i.e. numerical measures of inputs, outputs and outcomes [see appendix 13 and 14 *(91)*].

2. Qualitative or soft measures which provide information on staff attitudes and line managers' views of HR via surveys and focus groups.

3. Process analysis which can trace a process through its various stages (e.g. recruitment and selection) to gauge its effectiveness.

HR can also ensure that its performance is effective by benchmarking its practice against other organisations and using the balanced score card approach discussed earlier.

A WHO sponsored initiative has developed key HR indicators for the health sector (for details see *92)*. The key message of the WHO research is that if HR indicators are to be accepted and used effectively they must form part of a broader process of cultural change and management development. Unless these pre-conditions are satisfied, the scope to highlight 'outlier' values and make comparisons between organisational units will be undermined.

Conclusion

In the last decade there has been much more attention paid to health care reform and the relative merits of different health systems *(93)*. The argument of this paper is that diverse attempts at health care reform have been hampered by the insufficient attention that has been given to human resource management (HRM) issues. Policy makers have been overly optimistic in their expectation that once plans for reform have been devised, the process of implementation will be relatively straightforward. This has led to insufficient attention being given to building support for reforms amongst the workforce and other key stakeholders, developing the leadership skills and competencies needed to implement complex reforms, and establishing realistic timetables for implementation.

There is clearly a long way to go in developing effective HR capability in the health sector.
More positively, however, there is an increasing commitment to take such steps and because the health sector starts from a relatively low base line in HR terms, a variety of measures in areas such as recruitment and selection could make a substantial difference to the working lives of staff and the effectiveness of health systems. Nonetheless, even simple measures will be more effective if they are based on a sound evidence base that critically appraises both the successes and failures of recent attempts to strengthen HR capacity in the health sector.

References

1. **Fawcett-Henesy A.** The impact of health care reforms on nursing – a European perspective, in: Henesy D, Spurgeon P, eds. *Health policy and nursing: influence, development and impact* London, Macmillan, 2000.

2. **International Labour Office/Public Services International.** *Employment and working conditions in the health Sector of Central Asian countries: Report.* Geneva, International Labour Office, 2000.

3. **Brundtland G-H**. Message from the director-general, in: *The world health report 1999: making a difference.* Geneva, World Health Organization, 1999.

4. **Johnson T, Stout S, eds.** *Investing in health development. Effectiveness in the health, nutrition, and population sector.* Washington, The World Bank, 1999.

5. **International Council of Nurses.** *Position statement: nurse retention, transfer and migration.* Geneva, International Council of Nurses, 2000.

6. **Ianus V**. The status of the medical profession in Romania, *Eurohealth,* **4**: 27-28, 1999.

7. **World Bank.** *Honduras: toward better health care for all.* Washington, World Bank, 1998.

8. **World Bank**. *The state in a changing world, world development report 1997.* Oxford, Oxford University Press, 1997.

9. **Corkery J.** Country study: Uganda, in: Ullrich G. (Co-ordinator) *Public service reforms and their impact on health sector personnel.* Berlin, German Foundation for International Development (DSE), 2000.

10. **Domagala A et al.** Country study: Poland, in: Ullrich G. (Co-ordinator) *Public service reforms and their impact on health sector personnel.* Berlin, German Foundation for International Development (DSE), 2000.

11. **International Labour Office.** *Terms of employment and working conditions in health sector reforms*, Geneva, ILO, 1998.

12. **Organisation for Economic Co-operation and Development.** *The future of female dominated professions,* Paris: OECD, 1998.

13. **Egger D, Lipson D, Adams O.** *Human resources for health. Issues in health services delivery, discussion paper 2.* Geneva, World Health Organisation, 2000.

14. **Osborne D, Gaebler, T.** *Reinventing government.* Reading, MA, Addison-Wesley, 1992.

15. **Ferlie E et al.** *The new public management in action.* Oxford, Oxford University Press, 1996.

16. **McPake B, Mills A.** What can we learn from international comparisons of health systems and health systems reform? *Bulletin of the World Health Organization,* **78**(6): 811-819, 2000.

17. **Minogue M, Polidano C, Hulme D. eds.** *Beyond the new public management.* Cheltenham, Edward Elgar, 1998.

18. **Bach S, Della Rocca G**. The management strategies of public service employers in Europe. *Industrial Relations Journal,* **31**(2): 82-96, 2000.

19. **Saltman R, Figueras J.** *European health care reform,* Geneva, WHO, 1997.

20. **Altenstetter C, Björkman JW. eds.** *Health policy reform, national variations and globalization.* London, Macmillan, 1997.

21. **Powell F, Wessen A. eds.** *Health care systems in transition, an international perspective.* London, Sage, 1999.

22. Alain Enthoven in his evaluation of the UK internal market is critical of the 'big bang' approach to reform. See **Enthoven AC.** In pursuit of an improving national health service. *Health Affairs,* **19**(3): 102-119, 2000.

23. For an overview see **Bach S, Sisson K**. Personnel management in perspective, in: Bach S, Sisson K, eds. *Personnel management: a comprehensive guide to theory and practice, 3rd edition.* Oxford, Blackwell, 2000.

24. **Dovlo D.** Ghana: HRD policy reform issues, in: Martinez J, Martineau T, eds. *Workshop on human resources and health sector reforms.* Liverpool, Liverpool School of Tropical Medicine, 1996.

25. **Bach S.** Changing public service employment relations, in: Bach S, Bordogna L, Della Rocca G, Winchester D, eds. *Public service employment relations in Europe, transformation, modernization and inertia.* London, Routledge, 1999.

26. **Guest D.** Human resource management and performance: a review and research agenda. *International Journal of Human Resource Management,* **8**(3): 264-76, 1997.

27. **Schuler R, Jackson S.** *Strategic human resource management.* Oxford, Blackwell, 1999.

28. **Gratton L et al.** *Strategic human resource management: corporate rhetoric and human reality.* Oxford, Oxford University Press, 1999.

29. **Becker BF, Huselid MA.** High performance work systems and firm performance: A synthesis of research and managerial implications. *Research in Personnel and Human Resource Management,* **16**: 53-101.

30. **Pfeffer J.** *The human equation: building profits by putting people first,* Boston, Mass: Harvard University Press, 1998.

31. **Barney J** Looking inside for competitive advantage, *Academy of Management Executive*, **9**(4): 49-61, 1995.

32. **Sisson K, Storey J.** *The realities of human resource management.* Buckingham, Open University Press, 2000.

33. **Eaton S.** Beyond 'unloving care': linking human resource management and patient care quality in nursing homes. *International Journal of Human Resource Management,* **11**(3): 591-616, 2000.

34. **Youlong G et al.** Health human resource development in rural China. *Health Policy and Planning,* **12**(4): 320-328, 1997.

35. **Martínez J, Martineau T**. Rethinking human resources: an agenda for the millennium, *Health Policy and Planning*, 1998, **13**(4): 345-358.

36. **Bossert et al.** Transformation of ministries of health in the health reform: the case of Colombia. *Health Policy and Planning*, **13**(1): 59-77, 1998.

37. **Perez J.** The Philippines: employee relations to facilitate sectoral reforms in health in: Martinez J, Martineau T, eds. *Workshop on human resources and health sector reforms.* Liverpool, Liverpool School of Tropical Medicine, 1996.

38. **Bach S, Winchester D.** Opting out of pay devolution prospects for local pay bargaining in UK public services. *British Journal of Industrial Relations*, **32**(2): 263-282, 1994.

39. **Becker B, Huselid M.** Overview: strategic human resource management in five leading firms. *Human Resource Management,* **38**(4): 287-301.

40. **Kolehmainen-Aitken RL.** Decentralization and human resources: implications and impact. *Human Resources for Health Development Journal,* **2**(1): 1-16, 1998.

41. **World Bank.** *Peru: improving health care for the poor.* Washington, World Bank, 1999.

42. **Geschwind H.** Health care in France: recent developments. *Health Care Analysis,* **7**(4): 355-362, 1999.

43. **Begley T, Boyd D.** Articulating corporate values through human resource policies. *Business Horizons.* **43**(4): 8-12, 2000.

44. **Pratchett L, Wingfield M.** The demise of the public service ethos in: Pratchett L, Wilson D. eds. *Local democracy and local government,* London, Macmillan, 1996.

45. **Thompson D, Snape E, Stokes C.** Health services reform and human resource management in Hong Kong Public Hospitals. *International Journal of Health Planning and Management,* **14**(1): 19-39, 1999.

46. For case studies of how the process of political exchange and organizational culture effects health service reform see **Pettigrew A, Ferlie E, McKee L.** *Shaping strategic change, making change in large organizations: The case of the national health service.* London, Sage, 1992.

47. **World Health Organisation.** *Health 21 – the introduction to the Health for All policy for the WHO European Region,* Copenhagen, WHO, 1998.

48. **Scheffler R, Duitch, F.** Health care privatisation in the Czech republic: ten years of reform, *Eurohealth.* **6**(2): 5-7, 2000.

49. **Ehlers V, Litt, et Phil, D.** Nursing and politics: a South African perspective. *International Nursing Review,* **47**(2): 74-82, 2000.

50. **O'Brien-Pallas L et al.** An evaluation of WHA resolution 45.5: health human resource implications. *Canadian Journal of Nursing Research,* **31**(5): 51 –67, 1999.

51. **Nunes F, Reid U.** Health infrastructure: human resources. In Pan American Health Organization. *Health Conditions in the Caribbean,* Washington, PAHO, 1997.

52. **Green A.** *Introduction to health planning in developing countries, 2nd edition.* Oxford, Oxford University Press, 1999.

53. **Ulrich D.** *Human resource champions: the next agenda for adding value and delivering results,* Boston, Mass: Harvard University Press, 1997.

54. **Department of Health.** *The NHS plan: a plan for investment, a plan for reform,* Cm 4818, London, The Stationery Office, 2000.

55. The balanced scorecard framework is a performance index that focuses on multiple stakeholders and defines three categories to judge performance in any large organisation: Economic Value Added (EVA), Customer Value Added (CVA), and People Value Added (PVA).See **Kaplan R, Norton, D.** *The balanced scorecard.* Boston, Mass, Harvard Business School Press, 1996.

56. **Omar M, Tekeste A.** Shaping the health of the nation: development of human resources in Eritrea. *Health Manpower Management,* **23**(6): 212-215, 1997.

57. **Plati, C.** Nursing manpower development and strategic planning in Greece. *Image: Journal of Nursing Scholarship*, **30**(4): 329-332, 1998.

58. **Buchan J, O'May F**. Globalisation and healthcare labour markets: A case study from the United Kingdom', *Human Resources for Health Development Journal*, **3**(3), 1999.

59. **Liff S.** Manpower or human resource planning – what's in a name? in: Bach S, Sisson K, eds. *Personnel management: a comprehensive guide to theory and practice, 3rd edition,* Oxford, Blackwell, 2000.

60. **Ferrinho et al.** How and why public sector doctors engage in private practice in Portugese-speaking African countries. *Health Policy and Planning,* **13**(2): 332-338, 1998.

61. **Briscoe J, Hall D.** Grooming and picking leaders using competency frameworks: do they work? *Organizational Dynamics*, **28**(2): 37- 51, 1999.

62. **Modell S**. Integrating management control and human resource management in public health care: Swedish case study evidence. *Financial Accountability and Management,* **16**(1): 33-53, 2000.

63. **Knox S, Irving J.** Nurse manager perceptions of healthcare executive behaviors during organizational change. *Journal of Nursing Administration,* **27**(11): 33-39, 1997.

64. **Richards A. et al.** Skill mix between nurses and doctors working in primary care-delegation or allocation: a review of the literature. *International Journal of Nursing Studies,* **37**(3): 185-197, 2000.

65. **Winskill R.** Is competency based training/education useful for workplace training? *Contemporary Nurse,* **9**(2): 115-119, 2000.

66. **Healy J, McKee M.** Health sector reform in Central and Eastern Europe: the professional dimension. *Health Policy and Planning* **12**(4): 286-295, 1997.

67. **World Health Organization.** *The world health report 1998: life in the 21st century a vision for all,* Geneva, WHO, 1998.

68. **Jódar P, Alós R, Jordana J.** Spain: the modernization of public service employment relations since the transition to democracy, in: Bach S, Bordogna L, Della Rocca G, Winchester D. (eds.) *Public service employment relations in Europe: transformation, modernization or inertia?* London, Routledge, 1999.

69. **Mossé P, Tchobanian R.** France: the restructuring of employment relations in the public services, in: Bach S, Bordogna L, Della Rocca G, Winchester D. (eds.) *Public service employment relations in Europe: transformation, modernization or inertia?* London, Routledge, 1999.

70. **Collins D et al.** Hospital autonomy: the experience of Kenyatta national hospital. *International Journal of Health Planning and Management*, **14**(2): 129-153, 1999.

71. **Kraus A.** Personnel practices to support health and human service reform. *Policy and Practice: Journal of the American Public Human Services' Association* **58**(2): 19-28, 2000.

72. **Segall M.** From cooperation to competition in national health systems – and back? Impact on professional ethics and quality of care. *International Journal of Health Planning and Management,* **15**(1): 61-79, 2000.

73. **Cassels, A.** Health sector reform: key issues in developing countries. *Journal of International Development,* **7**(3): 329-347, 1995.

74. **Bach S.** Health sector reform and human resource management: Britain in comparative perspective. *International Journal of Human Resource Management*, **11**(5): 925-942, 2000.

75. **Buchan J.** Health sector reform and human resources: lessons from the United Kingdom. *Health Policy and Planning,* **15**(3): 319-325, 2000.

76. **Arrowsmith J, Sisson K.** Pay and working time: towards organization-based systems? *British Journal of Industrial Relations,* **37**(1*)*: 51-77, 1999.

77. For an overview of the literature on performance appraisal see **Bach S.** From performance appraisal to performance management. In S. Bach and K.Sisson (eds) *Personnel management: a comprehensive guide to theory and practice, 3ʳᵈ edition,* Oxford, Blackwell, 2000.

78. **Lupton, B.** Pouring the coffee at interviews? Personnel's role in the selection of doctors. *Personnel Review*, **29**(1): 48-64.

79. **Bach S**. NHS pay determination and work re-organisation: employee relations reform in NHS trusts. *Employee Relations* **20**(6): 565-576, 1998.

80. **Hall L, Torrington D.** *The human resource function: the dynamics of change and development,* London, Financial Times/Pitman, 1998.

81. **Bach S.** Restructuring the personnel function the case of NHS trusts. *Human Resource Management Journal,* **5**(2): 99-115, 1995.

82. **Bach S.** Personnel managers: managing to change? In Corby S, White G eds. *Employee relations in the public services,* London, Routledge, 1999.

83. **Collins C.** *Management and organization of developing health systems.* Oxford, Oxford University Press, 1994.

84. **Siegel G.** Outsourcing personnel functions. *Public Personnel Management,* **29**(2): 225-237, 2000.

85. **Mills A.** Contractual relationships between government and the commercial privatesector in developing countries, in: Bennett S, McPake B, Mills A (eds) *Private health providers in developing countries. Serving the public interest?* London, Zed Books.

86. **Industrial Relations Services.** The evolving HR function. *IRS Management Review,* **10,** London, Eclipse Group, 1998.

87. **Shortell S et al.** *Remaking health care in America.* San Francisco, Jossey-Bass, 1996.

88. **Fowler A.** How to outsource personnel. *People Management,* **3**(4): 40-42, 1997.

89. **Sia I.** Country study: Phillipines in G. Ullrich (Co-ordinator) *Public service reforms and their impact on health sector personnel* Berlin, German Foundation for International Development (DSE), 2000.

90. **Hall D**. Privatisation, multinationals and corruption, *Development in Practice,* **9**(5): 539-556, 1999.

91. **Collins M.** *Human resource management audit.* Birmingham, North Western and West Midlands Regional Health Authorities, 1991.

92. **Hornby P, Forte P.** Human resource indicators and health service performance. *Human Resources for Health Development Journal,* **1**(2): 1997.

93. **World Health Organisation** *The world health report 2000 – health systems: improving performance.* Geneva, World Health Organization, 2000.

Appendix 1: The content of health care reform: implications for HR

Content of health care reform	*Implications for HR*
Altered role of the state: increased use of market-style incentives and private sector involvement in provision and funding	- more diverse terms and conditions of employment arising from different employers or self-employment - forms of incentive pay and performance systems introduced - job losses and role changes occur from privatisation (contracting out etc) - more complex to forecast workforce requirements due to greater diversity of finance and provision
Decentralisation: delegation of decision making to lower organizational tiers and greater community involvement	- requires increased administrative and managerial expertise at local level with associated increases in staff costs - information may be under-developed
Renewed role for primary health care and a strengthening of public health infrastructure	- staff may have more autonomy - more interdisciplinary team work than in traditional acute hospital environments shifts in staff roles skill mix? - requires increased public health expertise
Increased user involvement and empowerment	- development of a customer/client orientation amongst staff - approaches to performance management that include client feedback (360 degree) - altered working patterns – longer/more convenient opening hours - staff to follow protocols???
Focus on cost containment: a central objective is to contain expenditure and develop more transparent budgeting mechanisms??	- human resources are viewed as a cost rather than as an investment - personnel costs are a prime target for expenditure reductions via incomes policies, recruitment freezes etc - reduced educational opportunities???

Source: Author's compilation

Appendix 2: The process of health care reform: implications for HR

Process of health care reform: key tendencies	Implications for HR
Top-down: reforms are centrally led by ministries and other political elites, supported by management consultants and international agencies (for example Colombia*)*	- little attention to involvement and ownership of reforms by the workforce - encourages uncertainty, fear and resistance from stakeholders
Big bang approach to reform: the main infrastructure of health care reform is implemented in one rapid phase, for example the internal market in the UK	- limited time for development activity to - managers concentrate on establishing the organi-sational structures and information requirements for the reforms and limited attention is given over to HR issues?? - limited time to develop capabilities - few opportunities to learn from experience and 'reform the reforms' as knowledge of the reforms unfolds
Finance and managerial values dominate the reform process	- HR issues are secondary to 'business needs' - changes in personnel policy are limited - a professional HR role is slow to develop

Source: Author's compilation

Appendix 3: Linking HR and business strategy: the HRM model

Policy area	Policy choice/practice
Beliefs and assumptions	Business and customer (internal and external) needs are main referent Search for excellence, quality and continuous improvement are dominant values Aim to go 'beyond contract'; high levels of trust and commitment **HRM is central to business strategy**
Managerial role	Top managers are highly visible leaders that set the mission and values of the organisation Line managers encourage and facilitate change by harnessing co-operation of employees and developing them accordingly **Managers own and are committed to the HR strategy**
Organisation design	'Federal' highly decentralised, flat organisational structures 'Cross functional' project teams and informal groups responsible for particular services to customers Teams enjoy high level of autonomy and work organisation is flexible **Organisational design and work organisation is focused on satisfying customer requirements**
HR Policies	Numerical flexibility, i.e. core and periphery workforce Time flexibility e.g. annual hours Selection – emphasis on attitudes as well as skills Appraisal – open and participative – two-way feedback Training- learning and development of employees are key Participation – extensive use of two way communication Rewards – individual and group performance rewarded **Integrated HR policies ensure external and internal fit**

Source: adapted from Storey and Sisson, 2000: 40 *(32)*

Appendix 4: A typology of nursing-home work and care organisation for nurse aides

	Traditional low service quality	**Semi-skilled high service quality**	**Semi-autonomous *'regenerative'***
Work patterns	Rigid, traditional	Teams; flexible, adaptive	Neighbourhood units; resident assistance
Worker input	Discouraged	Welcomed	Built into work
Information shared	Little to none	Most	Virtually all
Supervision and control	For tasks only; compliance with formal procedures	For outcomes; help to do the job	Co-ordination; resident choice
Assumptions about workers	Theory X	Theory Y	Community members
Staffing ratio: day	Ten + residents	Seven to nine	Five to seven
Wages	$5.50 +	$7.00 +	$6.50 +
Turnover, annual	More than 80 %	30-80 %	20-40 %
Career paths	Little or none	Senior NA; scholarships	Cross training evolving
Ownership/reimbursement	For profit chain	Non profit; special chain high-end for profit	Non profit, religious or high-end private for profit
Labour relations	Mostly non-union	The most unionised	Mixed
Cost structure	Low to average	Average to high	Average to high
Philosophy of care	Medical-custodial	Medical-rehabilitative	'Regenerative'

Source: Eaton, 2000: 598 *(33)*

Appendix 5: Hospital mission in France: A charter for hospital patients

1. Public hospitals should be available for everyone, especially for unprotected patients, and they must be suited to the needs of the disabled.

2. Hospitals guarantee high quality health care, focusing especially on pain relief.

3. Patients should be fully and faithfully informed about the disease and planned diagnostic and therapeutic procedures. The patient is deeply involved in decision making.

4. Medical procedures can be carried out only after the patient's informed consent.

5. Special informed consent is required for patients involved in biomedical research, organ donation and any use of human body products.

6. The patient is entitled to be discharged from the hospital on his /her own responsibility.

7. The patient should be handled with respect, including respect for privacy.

8. Confidentiality of any personal information is guaranteed.

9. Free access to any information from the patient's record will be provided, but should be made available through the general practitioner.

10. The hospitalised patient is allowed to make any comment on the health care and the reception by the hospital.

Source: Geschwind, H. 1999: 360 *(42)*

Appendix 6: Approaches to merging strategic and HR planning

Afterthought/'add on'	*Integration*	*Isolated*
The focus is on business planning, with HR practices considered as an afterthought	The focus is on a synthesis of business and HR planning	The focus is on HR practices and how the HR function can add value to the business
Line managers own the HR discussions, with tangential involvement of HR professionals	Line managers and HR professionals work as partners to ensure that an integrated HR planning process occurs	HR professionals work on the plan and present it to line managers
The outcome is a summary of HR practices required to accomplish business plans	The outcome is a plan that highlights HR practices that are priorities for accomplishing business results	The outcome is an agenda for the HR function, including priority HR practices

Source: Ulrich, D 1997: 59 *(53)*

Appendix 7: The UK NHS plan – core principles

---

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.

2. The NHS will provide a comprehensive range of services.

3. The NHS will shape its services around the needs and preferences of individual patients, families and their carers.

4. The NHS will respond to the different needs of different populations.

5. The NHS will work continuously to improve quality services and to minimise errors.

6. The NHS will support and value its staff *

   The strength of the NHS lies in its staff, whose skills, expertise and education underpin all that it does. They have the right to be treated with respect and dignity. The NHS will continue to support, recognise, reward and invest in individuals and organisations, providing opportunities for individual staff to progress in their careers and encouraging education, training and personal development. Professionals and organisations will have opportunities and responsibilities to exercise their judgement within the context of nationally agreed policies and standards.

7. Public funds for healthcare will be devoted solely to NHS patients.

8. The NHS will work together with others to ensure a seamless service for patients.

9. The NHS will keep people healthy and work to reduce health inequalities.

10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

---

* Reproduced in full
Source: Department of Health 2000: 3-4 *(54)*

Appendix 8: Approaches to developing competencies: advantages and disadvantages

Approach	Research-based	Strategy-based	Values-based
Description	Competencies based upon behavioural research on high performance executives	Competencies forecast to be strategically important based upon anticipated future	Competencies based formally or informally upon organizational norms/cultural values
Processes used	Competencies validated by capturing behaviour of high performance managers or via interviews/focus groups	Interviewing top managers as to anticipated changes and/or use of consultants' competency databases	Approaches range from 'pronouncements of chief executives/owners or lists generated by HR departments
Advantages	Grounded in actual behaviour Air of legitimacy Managerial sense of ownership	Competencies based upon future not past Focuses managers on learning new skills Can support organisational change measures	Competencies can have strong motivating power Values can provide stability and direction over time The 'wrong' values may lead to misguided competencies
Disadvantages	Based upon past not future competencies May omit intangible and unmeasurable competencies Requires considerable financial and HR investment	Anticipated future may prove inaccurate/misguided Competencies based upon speculation instead of actual behaviour	Can be difficult to translate into actual behaviour Competency development process can lack rigour

Source: Adapted from Briscoe and Hall, 1999 *(61).*

Appendix 9: Disenchantment with health sector rewards and employment conditions in the Caribbean

- Salary, career structure and mobility, grievance review and disciplinary actions are covered under the Public Service Regulations, even though these rules may not be strictly relevant to health sector personnel.

- Salaries, which are developed within public service procedures and negotiated with trade unions not exclusively representing.

- Promotion is slow and usually tied to age or years of service rather than education and training.

- Top-heavy management in certain categories, such as nurses, creates a bottleneck in the organization/ management structure.

- Career structures and mobility within and between the different professional groups are weak or absent.

- Actions on staff grievances and discipline, being centralized, are very slow, creating managerial problems since remedial action cannot be taken at the workplace.

- The majority of health personnel also experience unsatisfactory conditions of service and work, including inadequate supervision.

- Frequent lack of supplies and malfunctioning equipment add to frustration by creating a large amount of downtime for these professionals.

- Professionals are often obliged to waste a certain amount of their time on non-professional duties.

Source: Nunes and Reid, 1997: 79 *(51)*

Appendix 10: Myths that keep HR from being a profession

Old myths	*New realities*
People go into HR because they like people.	HR departments are not designed to provide corporate therapy. HR professionals must create the practices that make employees more competitive, not more comfortable.
Anyone can do HR.	HR activities are based on theory and research. HR professionals must master both theory and practice.
HR deals with the soft side of the organization and is therefore not accountable.	The impact of HR practices on business results can and must be measured. HR professionals must learn how to translate their work into financial performance.
HR focuses on cost, which must be controlled.	HR practices must create value by increasing the intellectual capital within the organization. HR professionals must add value, not reduce costs.
HR's job is to be the policy police and the health-and–happiness patrol.	The HR function does not own compliance – managers do. HR practices do not exist to make employees happy but to help them become committed. HR professionals must help managers commit employees and administer policies.
HR is full of fads.	HR has evolved over time. HR professionals must see their work as part of an evolutionary chain and explain their work with less jargon and more authority.
HR is staffed by nice people.	At times, HR practices should force vigorous debates. HR professionals should be challenging as well as supportive.
HR is HR's job.	HR work is as important to line managers as are finance, strategy and other organisational domains. HR professionals should join with managers in championing HR issues.

Source: Adapted from Ulrich, D. 1997: 18 *(53)*

Appendix 11: Definition of HR roles and key competences to fulfil these roles

Role	*Outcome*	*Metaphor*	*Activity*
Management of strategic HR	Executing strategy	Strategic partner	Aligning HR and business strategy 'organizational diagnosis'
Management of firm infrastructure	Building an efficient infrastructure	Administrative expert	Re-engineering organization processes; shared services
Management of employee contribution	Increasing employee commitment and capability	Employee champion	Listening and responding to employees
Management of transformation and change	Creating a renewed organisation	Change agent	Managing transformational change ensuring capacity for action

Key competences required to fulfil these roles:

1. Understanding of the business
2. Knowledge of HR practices
3. Ability to manage culture
4. Ability to manage change
5. Personal credibility.

Source: Ulrich, 1997: 25 and chapter **8** *(53)*

Appendix 12: Pros and cons of devolving HR to line managers

Pros	*Cons*
Local management accountability	Lack of time to perform HR duties
Line management responsibility for People issues	Increase in line manager's workload
Potential cost savings	Additional costs of training managers
Increase speed of decision-making	Increase in grievances/tribunal cases
Policies/practices to suit local conditions	Lack of consistency in decision making
Strategic role for central HR/IR	Potential for HR/IR to be marginalized
Short lines of communication	Less consistent communications
Increased awareness of people management issues throughout the organisation	People management not considered to be part of line manager's job

Source: Industrial Relations Services, 1998 *(86)*

Appendix 13: Hard and soft measures of HR effectiveness

Hard

Recruitment and selection

- Number of long term vacancies
- Average time to fill vacancies
- Proportion filled through promotion, demotion or lateral movement
- Average time spent in a job or function per employee

Training and development

- Number of trainee days/number of employees
- Total training budget/total employment expenditure

Compensation and benefits

- Total compensation cost/total revenues
- Basic salary/total remuneration
- Number of salary grades/employees

Employee Relations

- Number of resignations/total headcount per year
- Average length of service per employee
- Rate of absenteeism
- Average length of absence per employee
- Number of supervisors and managers per employee

Overall HR management

- Total revenue per employee
- Total headcount this year compared with last year
- Proportion of part-time employees to total number of staff
- Employment cost/total expenditure
- Number of HR professionals per employee
- Age distribution of employees

Soft

Internal customer satisfaction

- Total revenue per employee
- Employee focus groups
- Line management survey of HR's performance
- Senior management views of HR performance

Source: Industrial Relations Services, 1998 *(86)*

Appendix 14 Strategic HR Audit: Questionnaire

Is there a clearly understood HR strategy?

- Is this strategy known and understood by the organisation?
- Does the strategy support and fit in with the business plan?
- Is the HR strategy regularly reviewed?
- Is the HR strategy consistent with the organisation's mission?
- Is the HR strategy consistent with other functional strategies?

Are people seen as a strategic resource by senior management?

- Does the business plan demonstrate a belief that human resources are a valuable source of long-term competitive advantage?
- Do managers at all levels manage their staff in a way that recognises their role in strategy implementation?
- Do management training and development programmes take account of the need for managers to think and behave strategically?

Are there clearly understood strategies for each element of HRM?

- Are these strategies integrated and mutually supportive?
- Do these strategies focus on improving individual and organizational performance?
- Have strategies been formulated for all the main elements of HRM? Are they consistent with other functional strategies?
- Are the values of these strategies consistent with the values of the overall HRM strategy?
- Are these strategies tested by developing feasible implementation plans?

Does Human Resource Planning (HRP) take account of internal and external environmental factors?

- During the planning process is a SWOT analysis carried out on human resources?
- Does HRP incorporate long-term environmental trends?
- Are short and medium term HR plans consistent with long-term forecasts and environmental trends?

Does the personnel function have a strategic role in HRM?

- Does the most senior HR manager help formulate business strategy?
- Does the personnel department have a strategy for delivery of its services?
- Is the strategic role of the HR department understood by both personnel staff and the line managers?
- Does the personnel department's strategy focus on successful implementation of the HR strategy?

Source: Adapted from Collins, 1991 *(91).*