

Focusing on the software of managing health workers: What can we learn from high commitment management practices?

This is the pre-peer reviewed version of the following article: MARCHAL, B. & KEGELS, G. (2008) Focusing on the software of managing health workers: What can we learn from high commitment management practices? *International Journal of Health Planning and Management*, 23, 299-311, which has been published in final form at www3.interscience.wiley.com/cgi-bin/fulltext/114276873/PDFSTART article].

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Acknowledgements

This work was funded through the framework agreement (*Raamakkoord*) between the Belgian Directorate-General for Development Cooperation and the Institute of Tropical Medicine, Antwerp. The sponsors had no role in the study nor in the writing of the paper.

Abstract

Knowledge of what constitutes best practice in public service human resource management is limited and the operational aspects of managing health workers at provision level have been poorly studied. In healthcare, the magnet hospital concept offers some insights in human resource management practices that are leading to high commitment. These have been shown to lead to superior performance of industrial business firms, but also in service industries and the public service. The mechanisms that drive these practices include positive psychological links between managers and staff, organisational commitment and trust.

Conditions for successful high commitment management include health service managers with a strong vision and able to transmit this vision to their staff, appropriate decision spaces for healthcare managers and a pool of reasonable well-trained health workers. Equally important is the issue of cultural fit: do these management approaches reinforce and/or validate the personal values and motivators of the staff? Making quality of working life better by adapting the HRM practice to the particular needs of health workers and the nature of their work may go a long way in attracting and keeping health workers where they are most needed.

Key words

Human resource management, high commitment management practices, magnet hospital, motivation, Ghana

1 Introduction

The health workforce has been put in the spotlights of the international development scene, the World Health Report 2006 (JLI, 2004; WHO, 2006) being the latest of a number of publications of international agencies calling attention to the HR crisis (JLI, 2004; Narabsimhan, Brown, Pablos-Mendez, Adams, Dussault, Elzinga et al., 2004; PHR, 2004; WHO, 2004). While countries like Malawi, Mozambique and Zimbabwe are indeed facing an acute crisis triggered by HIV/AIDS and the brain drain, most other sub-Saharan African countries and some other low income countries are confronted by diverse human resource problems that have been developing over time: problematic education and training capacity, unequal distribution of health workers and inadequate regulation of the health professionals both in the private and public sector.

Health workforce problems are not a very attractive field of work, neither for government officials, nor for the international partners (Homedes & Ugalde, 2005; Van Lerberghe, Adams, & Ferrinho, 2002) and this somehow explains why they are often neglected. Being diverse in nature, they all share one characteristic: they are messy, wicked problems, determined by many interrelated factors, often politicised and linked to macro-economic policies. While lack of reliable data on numbers, distribution, skill mix and performance are hampering analysis and planning, in many countries this latter capacity and human resource management capacities are underdeveloped. Furthermore, knowledge of what constitutes best practice in public service human resource management is limited (Nunberg, 1995), even more so for developing countries. Specifically the operational aspects of managing health workers at provision level have been poorly studied. Few studies describe the challenges faced by health service managers and how they deal with these (Agyepong, Anafi, Asiamah, Ansah, Ashon, & Narh-Domotey, 2004; Hagopian, Ofosu, Fatusi, Biritwum, Essel, Gary Hart et al., 2005; Kipp, Kamugisha, Jacobs, Burnham, & Rubaale, 2001; Mutizwa-Mangiza, 1998). Only recently have studies on motivation in developing countries been reported (Agyepong, Anafi, Asiamah et al., 2004; Blaauw, Gilson, Penn-Kekana, & Schneider, 2003; Dieleman, Toonen, Toure, & Martineau, 2006; Lindelow & Serneels, 2006; Manongi, Marchant, & Bygbjerg, 2006).

Despite the general acknowledgement of health workers as key players in health systems, little is known on how best to deal with the acute and chronic problems that are affecting the health services of developing countries. On the other hand, human resource management in industrialised countries has been written about *in extenso*, not only in the business management literature, but also in its academic counterpart.

One interesting section of the human resource management literature deals with high performance or high commitment management practices. In this paper, we aim to draw lessons and insights useful for the operational management of health workers in developing countries from it. Our starting point is the view that managing health workers requires a specific vision on how to deal with the specific needs and expectations of (professional) health workers, the tensions emerging from the nature of health care and

the constraints imposed by the environment. The first section of this paper will describe the concept of high commitment management (HiCoM) practices. Second, we'll describe whether they contribute to better performance and how. Third, the use of HiCoM for management of health workers will be discussed, with the magnet hospitals as an example. Finally, we'll explore the relevance for developing countries.

2 High commitment management practices

Management practices that are leading to high commitment or high involvement of employees are receiving quite some attention in the human resource management (HRM) literature. Such bundles of HRM practices have been shown to lead to superior performance of business firms in the automobile, apparel, semiconductor, steel and oil industries, but also in service industries and the public service (Pfeffer & Veiga, 1999; Whitener, 2001). Other studies found that employees working in such organisations report less stress and higher productivity (Davis & Landa, 1999). In the UK, 'people centred management' is the term more commonly used (Caulkin, 2001), while in the US literature, 'high performance work systems' or 'high performance management practices' is used as a synonym for high commitment management practices (Wright & Boswell, 2002). All these terms refer to the same principles we describe below and they are used interchangeably (Evans & Davis, 2005).

High commitment management (HiCoM) is built upon complementary bundles of HRM practices. Ichniowski et al (1993), cited by Gould-Williams (Gould-Williams, 2003) and Huselid (1995), are among the first authors to state that combinations of specific HRM practices have a higher impact on organisational performance than isolated HRM interventions. Subsequently, studies have been carried out across industries, identifying a number of specific HRM bundles. Pfeffer initially listed 16 practices (Pfeffer, 1994) and recombined these into 7 elements: putting in place selective hiring, providing employment security, ensuring comparatively high compensation contingent on organisational performance, instituting training and development, self-managed teams and decentralisation, reduction of status differences and information sharing (Pfeffer & Veiga, 1999). While not the first to discuss high commitment management practices, Pfeffer and Veiga's paper has elicited strong reactions and can be considered as a reference paper in the current debate. Other authors categorised HRM practices in employee skills, motivation and empowerment (Wright & Boswell, 2002) (Evans & Davis, 2005). A first message seems to be the need to have complementary practices that are congruent (i.e. not cancelling out each other) and fitting well with the tasks and work that the organisation is carrying out (Wright & Boswell, 2002), rather than the exact composition of the bundle.

In a sense, the HiCoM school is just putting old wine in new bags. Indeed, already in the 1930s the Hawthorne experiments showed that organisations are complex social systems, in which output is defined not only by the job design, but also by social norms, informal groupings, management-employee communication and the intensity of employee involvement in management (Jaffee, 2001). The human relations school, in

full swing in the 1950-60s, stressed that employees are capable, intelligent actors and that management should provide opportunities for communication and interaction with their employees in order to enhance their cooperation (Garvin & Klein, 1993; Jaffee, 2001). Management as a consequence needs to facilitate rather than direct. This evolved into the human resources approach that was built on the premise of self-actualisation as the major drive underlying human behaviour, described as Theory Y by McGregor in “The human side of the enterprise” in 1960 (McGregor, 1960). Managers could increase effectiveness of their organisation by aligning individual and organisational goals. Finally, these two strands came together, as for example in the contingency model developed by Morse and Lorsch (Morse & Lorsch, 1970), a framework based on the nature of the work, the people who carry it out and the organisation in which they work, and which stated that an optimal fit should be found between these three dimensions.

3 How does HiCoM contribute to better performance?

How HiCoM practices offer competitive advantages to business firms has been discussed elsewhere (e.g. reducing administrative costs (Pfeffer & Veiga, 1999), or investment in the human capital of the firm and tacit knowledge (Huselid, 1995)). If we want to explore whether HiCoM may work in healthcare settings in DC, we need to understand the underlying mechanisms: what does HiCoM mean for the individuals who work in the organisation, how does it affect the social interactions within the organisation and how can it contribute to a higher staff commitment and ultimately better health care work.

For Pfeffer and Veiga, “*People work harder*” if HiCoM is being practised, because decentralisation of decision making and access to information provides them with more control over their work, and this contributes in turn to higher commitment and involvement. “*People work smarter*”, because they are given opportunities to learn and develop their skills. “*People work more responsibly*”, because responsibilities are delegated down to self-managed teams at the operational levels of the organisation (Pfeffer & Veiga, 1999).

The literature offers several more profound explanations. HiCoM practices not only invest in competence, skills and knowledge of staff, but also change employee relationships. HiCoM indeed facilitates positive psychological links between organisational and employee goals (Evans & Davis, 2005; Gould-Williams, 2003) and stimulates the use of discretionary effort of individuals within the workforce towards the organisational goals (Pfeffer & Veiga, 1999). The end result is ‘*committed employees who can be trusted to use their discretion to carry out job tasks in ways that are consistent with organisational goals*’ (Arthur, 1994).

Organisational commitment, defined as a person’s “feelings of attachment to the goals and values of the organisation, one’s role in relation to this and attachment to the organisation for its own sake rather than for its strictly instrumental value” (Cook & Wall,

1980), is one of the mechanisms that link these practices to the output of better organisational performance. In practice, this is expressed by employees in terms of going out of their way for the organisation (e.g. willing to do extra hours or to change duty rosters at short notice) and attitudes like job satisfaction and commitment to the organisation's mission (Guest, 1997). Similarly, the interest of employees to remain with the organisation has been linked to HiCoM. In other words, through high commitment management practices, managers create conditions that allow employees to become highly involved in their organisation (Whitener, 2001).

Another main pathway is increased organisational trust and its link with commitment. Staff members assess decisions and actions of their managers (in this case their actual human resource management practices) and their trustworthiness in terms of the commitment of managers to their staff (Eisenberger, Fasolo, & Davis-laMastro, 1990). Eisenberger and colleagues developed the social exchange theory and specifically the notion of perceived organisational support, which are the beliefs and perceptions of employees regarding the support provided and commitment demonstrated by the organisation to their staff. Employees are likely to show higher commitment to the organisation in response to positive perceived organisational support (Whitener, 2001). Having clear formal power, access to information, feedback from superiors and opportunities to grow and learn were shown to lead to higher levels of perceived organisational support, which contributed itself to higher levels of role satisfaction and less frustration among middle level nurse managers (Patrick & Laschinger, 2006). High trust relationships between managers and staff have shown to contribute to better organisational performance and make the links between HiCoM, trust and performance even more complex (Davis & Landa, 1999).

Finally, Evans and Davis discern important processes within and caused by HiCoM at individual, interpersonal and team level that influence the internal social structure of the organisation (Evans & Davis, 2005). First, relationships between staff members change: weak ties are strengthened, norms and shared mental models reinforced. Second, behaviours such as role-making and organisational citizenship are facilitated by HiCoM. Through these processes, HiCoM practices are assumed to lead to higher organisational flexibility and efficiency.

4 Some criticism of the research on high commitment management practices

Before exploring whether HiCoM is relevant for healthcare, we discuss the limitations of the concept and of the studies on which it is based. Many of these have been summarised nicely by Marchington and Grugulis, who agree that HiCoM seems to lead to more agreeable working environments than the Taylorist approaches (Marchington & Grugulis, 2000). However, they are critical of the lessons that can be learned from Pfeffer's and others' papers. First, it is difficult to draw conclusions from the many studies because there is little uniformity of the HRM approaches that have been studied, nor of the proxies used to measure outcomes. For example, the proportion of production

workers in a team or the use of formal teams as proxies for team working does not *per se* reflect effectiveness of these teams. Furthermore, the respondents whose views are solicited in many studies are mainly human resource managers, who may not have much information on the link between the factors other than HRM practices and the performance of their companies. Finally, not only the indicators, but also the data collection methods vary between studies, making comparisons difficult.

Other commentators argue that the financial cost of HiCoM may efface the benefits of raised productivity (Cappelli & Newmark, 2001). Garvin and Klein mention the risk of raising unrealistic expectations, issues of inequity, unclear roles of coordinators and problems of regression and topping out as problems encountered in some organisations in which HiCoM has been introduced (Garvin & Klein, 1993).

Another point of criticism to Pfeffer's work is his best-practice approach. Indeed, Pfeffer claims that the current studies allow to identify a set of universally valid principles or elements (in his case making up the seven elements of the bundle presented above). This puts him squarely in the Universalistic school. Other authors, however, adhere to the Contingency perspective, saying that it is necessary to aim at a good fit between the HRM bundle elements and the other organisational attributes. The third school, the Configurational theorists, states that performance is the result of the specific composition of the bundle and that the organisational performance can be improved by an HR approach that is aligned to an 'ideal type' of bundle specifically fitting the organisation's competitive strategy (Richardson & Thompson, 1999). Most authors believe that the current state of research does not allow to identify universal elements of the ideal bundle. Especially when examining the possible contributions of HiCoM to management of health services in developing countries, a mixed contingency-configuration approach seems prudent. In line with Wright and Boswell (Wright & Boswell, 2002) and Richardson and Thompson (Richardson & Thompson, 1999), rather than to look for fixed practices, it may be more fruitful to empirically inventorise actual HRM practices and see in how far they contribute to good management, both from the managers' and the staff's point of view.

5 Fitting health care well?

As mentioned above, HiCoM models have been developed on the basis of studies in diverse industries in developed countries. For several reasons, HiCoM could be a promising approach to management of health workers. Since they give a central role to professional autonomy and peer control, they could be appropriate for any professional service where team work, trust and friendship may be important (Blaauw, Gilson, Penn-Kekana et al., 2003; Gould-Williams, 2003), and where the nature of the work often means working in uncertainty and in rapidly changing environments.

As we mentioned above, HiCoM practices can transmit strong messages of perceived organisational support from management to the staff, thereby strengthening shared mental models that allow mutual adjustment as a main coordinating principle. Such

models include the shared knowledge about tasks, staff's roles and attitudes that are used to coordinate and streamline work in multi-disciplinary teams, for example in accident and emergency rooms or operating theatres. Shared mental models of the organisation's goals and good practices feed into the organisational culture and constitute some form of alignment of goals or social control, similar to Ouchi's clan control mechanism of coordination (Ouchi, 1980). This may be an effective means of management in dynamic settings, where command and control type of coordination mechanisms are likely to be inadequate (Evans & Davis, 2005), and which occur in many healthcare provision settings.

Despite this seemingly good fit of HiCoM as a HRM approach with the nature of medicine, the professionals and the type of organisations, the literature yields virtually nothing on HiCoM in health care (Buchan, 2004), except for the Magnet hospital concept, on which quite some research has been done. We will argue this is in essence a form of HiCoM developed or emerging from the nursing care sector. We will describe the concept as it will allow us to see to which extent the HiCoM approach could be useful in health care in general.

5.1 Magnet hospitals: an example of the effectiveness of appropriate management approaches in the nursing care sector

The concept of magnet hospitals has its origin in the US nursing staff crisis of the 1980s, when major shortages of nurses occurred at hospital-level all over the US (Upenieks, 2003). Magnet hospitals were found to be able to attract and retain professional nurses even in times of global nurse shortage (Manville & Ober, 2003; Scott, Sochalski, & Aiken, 1999). Research to better understand the underlying mechanisms revealed that magnet hospitals are considered by nurses working within them as good places to practise nursing. The first studies in 1982-3 found that magnet hospitals share three categories of attributes: leadership attributes, professional attributes and organisational attributes. Table 1 describes the specific attributes.

Table 1 – Magnet hospital attributes

Underlying mechanisms of the magnet hospital approach

Major research was carried out by the team of Laschinger and colleagues (Havens & Aiken, 1999; Scott, Sochalski, & Aiken, 1999). From their work, the mechanism underlying the effect of the magnet hospital interventions can be described as facilitating professional autonomy for nurses, participation in decision-making and systematic communication. Through this, the professional nursing practice is explicitly or implicitly valued and respected, and nurses are being empowered.

One particular stream of research framed the magnet hospital concept in terms of Kanter's empowerment theory (Hatcher & Laschinger, 1996; Laschinger, 1996; Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger, Finegan, Shamian, & Casier, 2000; Laschinger, Sabiston, & Kutzcher, 1997; Sabiston & Laschinger, 1995). In this view, magnet hospital managers empower, in Kanter's terms (Kanter, 1979), nurses and

the nursing cadre in general: nurses were given the means, information and support to optimally carry out their professional duties. Further studies linked empowerment to increased trust in management and commitment to the organisation and its mission of care (Laschinger, Finegan, Shamian et al., 2000). Especially access to information and support was found to increase trust.

Linking the magnet hospital concept and HiCoM

Virtually nothing has been published on the link between HiCoM and magnet status of health facilities. Rondeau and Wagar discuss the link between HiCoM and magnet long-term care organisations and conclude that there is only a weak association between implementation of HiCoM and magnet status (Rondeau & Wagar, 2006). However, their definition of HiCoM is quite superficial - they describe it as a "*loose coterie of approaches to organising, deploying and managing human resources*". Furthermore, the authors themselves indicate that their definition of magnet institutions is somewhat different from the nursing care magnet literature. In short, this study leaves more questions than it provides answers or insights. Buchan writes that the Canadian researchers attribute the better staffing levels in magnet hospitals to implementing HRM bundles that fit both the organisational priorities and the staff they are aimed at (Buchan, 2004).

Magnet hospital managers empower nurses to do what they are supposed to do through a set of management interventions that reinforce each other (good internal fit or coherence). The interventions have also a good external fit, i. e. they are well adapted to the nature of the work and the norms of the nursing profession, which call for a certain degree of professional autonomy. Involving staff nurses on hospital-wide cross-cutting task forces and committees, delegation of responsibilities, and providing opportunities for further professional development are all strategies that create responsibility and challenge (Hatcher & Laschinger, 1996). These in turn increase feelings of respect and recognition among nurses (Upenieks, 2003), which contributes to their positive commitment towards the hospital and its mission.

6 Can HiCoM be used in health systems of developing countries?

Whereas it can be assumed that all over the world, nurses (and all health workers) want to be respected and recognised by the hospital administrators and managers, the importance of other elements of the underlying mechanism such as empowerment, professional autonomy and participatory decision making could well prove to be much more culture-sensitive. Two questions come to mind. First, do these approaches make sense in non-OECD countries, and second, if so, would they lead to better performance in such settings? In order to try to answer these questions, we first examine the conditions that seem essential for HiCoM to work.

Conditions

Conditions for HiCoM to work are rarely discussed in the current studies, but should be questioned when thinking about transferring models to other settings. These conditions

include, first, having health service managers with a strong vision and the competences to transmit this vision (Pfeffer & Veiga, 1999). Second, appropriate decision spaces for healthcare managers should at least cover human resource management, but preferably also governance, financial and logistic management. Managers need a margin of freedom to put in practice internally coherent bundles that fit their specific setting. Third, a pool of reasonable well-trained health workers in adequate numbers is required, if staff selection is to be possible. However, some say HiCoM works in situations where skilled labour is scarce and where employers may want to invest in training and job induction (MacDuffie, 1995). Finally, if basic needs in terms of a decent salary (that in absolute terms is attractive because of its purchasing power rather than its comparative position with other sector's scales), a supportive environment (working conditions, availability and quality of drugs, instruments and infrastructure) are not met, HRM practices alone won't presumably make much difference except for those staff who are intrinsically strongly motivated.

Does HiCoM appeal to staff and managers in developing countries?

Perhaps even more important than the question on conditions is the issue of cultural fit: do these management approaches reinforce and/or validate the personal values and motivators of the staff? What do health service managers think of the underlying values of HiCoM? Are these approaches fitting well with the expectations that health workers have regarding their managers? Involvement in decision-making is a central element in the magnet hospital concept, but could well be differently appreciated in countries where organisational cultures in the health sector are more hierarchy-based. These questions call for making explicit the assumptions on which the mechanisms of HiCoM strategies are built and to explore their fit with local contexts in order to constitute coherent bundles that are context-sensitive.

Will HiCoM lead to better performance?

HiCoM can contribute to improved organisational performance in sectors where highly skilled employees are knowledgeable in domains that management does not master and where the attainment of the organisation's goal is dependent on the discretionary effort of the workers (MacDuffie, 1995). In healthcare services, the patient outcomes, the end goal of the organisation, cannot be achieved without the commitment of the health professionals, who possess the specific skills and knowledge and whose practice cannot easily be codified into a series of specific activities that can be easily supervised by management. Another reason why it may work in healthcare is that in most settings, health professionals claim some autonomy and want to be involved in decisions that directly affect them. However, it can be assumed that the effect of HiCoM on organisational performance is moderated by a number of factors, including health workers availability and resource constraints. Furthermore, as we have discussed above, the package of HRM practices needs to be consistent and integrated, and applied during a sufficiently long period for results to merge (Marchington & Grugulis, 2000).

7 Conclusion

Activities that require mobilising knowledge and expertise for dynamic and rapidly changing problems are indications for HiCoM, a description that matches healthcare. However, given that it is at present too early to say that HiCoM effectively contributes to higher performance of health services in industrialised countries, it would be premature to clamour for its application in other settings. The main message from the current literature may be less about the exact composition of the bundles, rather than the internal coherence and the external fit of the bundles with both the nature of the work and the staff who carry out this work. It is all about making HRM more responsive to the needs and expectations of staff on one hand and the organisational mission of providing accessible and high quality care.

Research in health (wo)manpower management should direct more attention to the question of how to manage health workers within (public) health systems in developing countries and this by first adopting a holistic perspective on what motivates people and health workers in particular. While useful ideas can be found in the HiCoM literature, more should be known regarding the nature of the elements of HRM bundles that are really important for health service settings in developing countries. Making quality of working life better by adapting the HRM practice to the particular needs of health workers and the nature of their work may go a long way in attracting and keeping health workers where they are most needed. Magnet hospitals appear to demonstrate that it is possible to achieve this fit, but the challenge is now to focus our attention on how these mechanisms apply to the context of health systems in developing countries.

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Table to be inserted

Table 1 – Magnet hospital attributes

Magnet hospital nurse leaders (leadership attributes)
<ul style="list-style-type: none">○ visionary leaders, planning for the future○ able to create an organisational culture that enhances staff satisfaction and fosters professional growth○ maintaining a high visibility: open communication, responsive to staff concerns and interests○ supportive towards their own staff: (1) supporting staff involvement in decision making and control of patient care issues; (2) supporting staff development & Continued Medical Education
Clinical nursing practice (professional attributes)
<ul style="list-style-type: none">○ adequate autonomy within clinical practice: the ability to establish and maintain therapeutic nurse-patient relationships○ collaborative nurse-physician relationships at the level of the patient units.○ team autonomy: control over work, within clinical nursing practice and in decision-making at unit and hospital level
Organisational/management attributes
<ul style="list-style-type: none">○ a participative management style including nurse managers in hospital-wide decision making○ support of professional development for all cadres