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HRM support for leadership, management and improvement: The key role of health contexts and professionalism

Introduction

This chapter discusses the way Human Resource Management (HRM) might support, leadership, management and improvement in healthcare, introduces three following related chapters, and finally discusses their common themes and implications. Before doing so, however, it is useful to discuss what management, leadership, improvement and HRM mean, as they are often referred to and enacted in ambiguous or contradictory ways. Drawing on common themes in the following chapters, the chapter concludes that supportive health care contexts and professionals, particularly 'hybrid' managers-professionals, are necessary to support HRM to, in turn, support the development of leadership and improvement in health care.

Management in public organizations

Early ideas about public administration (Weber, 1978), 'scientific management' (Taylor, 1911) and Fordism were conceptualised in rational, top-down terms, focused on planning, organizing, command, coordination, control (Fayol, 1949), with a clear separation between management and the work being managed. While this approach aimed to maximise efficiency and order, it often produced disenchantment, demotivation and resistance among workers. Consequently, management thinking developed to enhance motivation by considering the

human needs of people working in organizations, albeit alongside ongoing rational managerialism (Grey, 2016), and to show management as a practice involving both planning and implementation (Minzberg, 2009).

We see a similar tension and trajectory in the development of public health care management. 'New public management' (NPM) introduced private sector style management, measurement and competition into public services in the 1980s, with the aim of improving their efficiency and quality. NPM also challenge and attempted to control health professionals working in public health care organizations systems who previously dominated them, resulting in professionals' resistance to NPM's encroachment on their professional autonomy and values. NPM consequently therefore developed in a 'softer' way, oriented around quality improvement and professional leadership, which was designed to appeal to and motivate health professionals, although 'harder' aspects of NPM also remained alongside (Ferlie et al., 1996). Indeed, some public management scholars (O'Reilly and Reed, 2010, Martin and Learmonth, 2012, Wallace et al., 2023) suggest that leadership in public services is simply a more professionally acceptable discourse disguising ongoing 'hard' NPM.

Delivery of health care has become increasingly complex, including addressing increasingly 'wicked problems' (e.g., preventing rising levels of diabetes), requiring the involvement of multiple professions and organizations with different perspectives and interests. Government's role therefore shifted from delivering public healthcare to 'steering' its provision by a range of public, voluntary and private sector organizations. Reflecting a wider shift-towards 'post-Fordist' and network modes of organisation (for example as first seen in Silicon Valley), there was a transition from hierarchical top-down NPM towards lateral modes of management and 'network governance'. Collaboration between health care

organisations also required ‘softer’, lateral forms of leadership, in which health professionals play a key role (Ferlie et al., 2013, 2011, 2012).

‘Hybrid’ manager-professionals, such as medical or clinical directors and nurse managers are health professionals enacting managerial roles. Their health professional backgrounds enable them to understand and influence other health professionals in ways general managers cannot (Croft et al., 2015, McGivern et al., 2015, Fitzgerald and Ferlie, 2000). Accordingly, hybrid manager-professionals have been found to play key roles in the management, network governance and leadership of health services in Europe (Croft et al., 2015, McGivern et al., 2015, Fitzgerald and Ferlie, 2000, Kurunmaki, 2004, Fitzgerald et al., 2013, McDermott and Keating, 2011), North America (Hoff, 1999) and East Africa (Nzinga et al., 2019, McGivern et al., 2017).

Leadership

Leadership is seen as a panacea for a wide range of ills affecting organization (Pfeffer, 2015). However, while leadership can be broadly understood as relating to ‘influence’ (Yukl, 2006), it is discussed in loose, ambiguous and sometimes contradictory ways (Yukl, 2006, Croft et al., 2022). Some management scholars, like Kotter (2001), differentiate leadership, which he conceives of as about envisioning and motivation, from management, which he associates with control and maintaining order. However, in practice, managers often do leadership and leaders do management, so the two concepts may be difficult to distinguish (Minzberg, 2009) and, as noted above, the benign ‘leadership’ label may disguise less benign managerial work (O'Reilly and Reed, 2010, Martin and Learmonth, 2012). Moreover, there is little objective evidence of leadership’s impact on organizational performance (Van Knippenberg and Sitkin, 2013) with Pfeffer (2015) describing claims made about leadership’s importance as ‘BS’!

Historically, studies of leadership have focused on individual 'heroic', charismatic or transformational leaders (Yukl, 2006). Yet in 'pluralistic' health care contexts, where a diverse range of professionals and organizations affect patient care (Denis et al., 2001, 2012, Ferlie et al., 2013), leadership cannot be provided by a single 'heroic' individual (Kings-Fund, 2011, Hartley, 2018). Instead, 'distributed' (Fitzgerald et al., 2013, Ferlie et al., 2013) and 'collective' modes of leadership (Denis et al., 2001, West et al., 2014, Croft et al., 2022), involving a constellation of leaders across organizations and professions are required to bring about change and improvement. Thus, distributed or collective leadership provides a better approach to leadership practice and 'unit of analysis' (Gronn, 2002) or 'lens' (Nzinga et al., 2018) for studying it,

Distributed and collective leadership, and their impact on health systems, depend on the context in which they are enacted (Bolden, 2011, Denis et al., 2012). For example, Fitzgerald et al. (2013) found distributed change leadership associated with delivery of improvements in health service outcomes. However, this depended on leadership being enacted in a context where there were effective hybrid manager-professionals and good pre-existing relationships between managers and professionals more generally. Croft and colleagues (2022: 460) explain collective leadership as aligning organizations' external policy context and internal context, 'resulting in agreed collective aims, alignment and coordination of activities, commitment to collective success, and the maintenance of divergent perspectives'. They term is a mode of collective leadership they term 'unified divergence'.

Other studies have shown distributed and collective leadership teams drawing upon wider health and evidence-based policy to develop a collective 'governmentality' (Foucault, 1979)

influencing health service improvement. For example, Ferlie and colleagues (2013, 2012, Ferlie and McGivern, 2014) describe leadership teams in health care networks using evidence-based guidelines, policy mandates, and clinical audits making local health care practices and outcomes transparent, to 'persuade' health professionals to change and improve how they provide care. Similarly, Waring and Martin (2016) describe leaders in healthcare networks shaping how health professionals perceived themselves in relation to wider clinical guidelines, evidence and audit mechanism in ways leading to health care improvement. Likewise, McGivern et al. (2017) describe a constellation of leaders using evidence-based policy documents and clinical audits of local practices and outcomes to improve health care and hence raise the standing, status and identities of professionals in a Kenyan clinical network.

In sum, distributed or collective leadership have an important role in public health services, particularly those involving lateral collaborations or network organizations. However, differing definitions of what distributed or collective leadership are, and the influence of context on them, undermine our ability to objectively assess their impact on health care improvement (Croft et al., 2022, Denis et al., 2012, Ospina, 2017). Nonetheless, HRM could play a key role in training (future) leaders and creating receptive organizational contexts in in which distributed or collective leadership might thrive.

HRM

HRM is a sub-branch of management, broadly encapsulating the management of people ('human resources'), individually and collectively, and the work they do. HRM is associated with specific practices and functions (e.g., training and development, performance appraisal, job (re)design, pay and reward management) and human resource professionals. HRM has the

potential to improve employee engagement, hospital performance, patient outcomes, quality, safety and mortality (McDermott and Keating, 2011, West et al., 2006, WHO, 2016, Buchan, 2004, Shantz et al., 2016, Dieleman et al., 2009). However, HRM has been found to be underdeveloped, lacking credibility and capacity in health care (Hyde et al., 2009, Fitzgerald et al., 2006, WHO, 2016, Dieleman et al., 2009, Mathauer and Imhoff, 2006) and the HR function has limited capacity to manage core professional groups in professionally dominated health care organizations (McDermott and Keating, 2011).

McDermott and Keating (2011) note that HRM functions in health care are often enacted by general and line managers or 'hybrid' managers rather than HR managers. For example, while HR professions may be involved in orchestrating the process, the performance appraisal of doctors is conducted by 'hybrid' clinical or medical directors (McGivern and Ferlie, 2007, McGivern and Fischer, 2012). The implementation of job redesign is heavily influenced by professionals in health and social services (Chen et al., 2022).

HRM practices have been found to improve engagement among nurses to a greater extent than for administrative staff by enhancing nurses sense of professionalism (Shantz et al., 2016). However, if nurses are unable to enact new skills and HRM practice following training, training may increase frustration with health care organisations, and hasten nurses departure from health professional roles (Croft et al., 2015). HRM's potential seems to depend on it augmenting health professionalism and the context in which HRM practices are enacted.

In sum, HRM has the potential to help improve health services but this depends on people's ability (skills), motivation and opportunity (AMO) (Boxall and Purcell, 2022) to both enact

HRM practices and perform their roles more generally (McDermott et al., 2013). Thus, HRM finds itself in a Janus-faced position; HRM is potentially being able to shape conditions to increase people's ability, motivation and opportunity to improve health care, whilst also being constrained in its opportunity to so by these same conditions, particularly wider professional cultures.

Chapters in this section

The tensions and issues discussed above play out in the chapters in this section of the book. Tracey Rosell and Martin Kitchener's chapter, *'Virtualising HR in Health during COVID: Early insights from a study of surgical teams'*, discusses how the introduction of new digital technologies and virtual consultations, accelerated by the COVID19 pandemic, changed HR practices in the English and Welsh NHS. The chapter describes the role of virtual technologies (such as WhatsApp groups) as part of a wider shift from a traditional hierarchical 'firm' model in surgical teams, in which consultant surgeons were the 'bosses' but which was associated with poor-quality care delivery, towards more collaborative HR practices and distributed leadership in health systems.

The chapter describes some benefits of collaborative HR practices facilitated by virtual technology. These include connecting people who had not previously met through WhatsApp groups, bypassing long established barriers to multidisciplinary collaboration. However, virtual technologies also had downsides. Virtual HR practices 'disrupted' collaboration by 'distancing' surgical teams, undermining a sense of 'family' and excluding team members from conversations in WhatsApp groups. By enabling registrars' to contact and rely on senior consultants to make decisions in ways that were not previously possible, virtual technologies also undermined registrar's clinical and leadership development. Moreover, managers were

also less able to pick up on cues relating to clinicians' disengagement (e.g., clinicians talking among themselves in the background) in online meetings. Thus, virtual technologies may both support and undermine sustainable change implementation in health care.

Finally, Rossell & Kitchener describe how, in response to the COVID19 pandemic, the NHS England Emergency Preparedness Resilience and Response Unit (EPRR) promoted a military style command and control approach in which HR emerged from a central point. This clashed the collaborative practices and clinical structures that had been previously developed. Overall, the chapter highlights the potential benefits and downsides of virtual communication mediated via new technology and how context and professionals affect the implementation of new collaborative HR practices.

Nina Meier's chapter, *'Key Issues in Management of Interorganizational Coordination'*, discusses multi-level interorganisational coordination. She draws on empirically research examining a Danish quality improvement (QI) initiative in urological health care, involving collaboration between three medical specialities (acute care, oncology and internal medicine). Meier connects interorganizational coordination to distributed leadership and relational coordination, involving the development of structures designed to support rather than replace role relationships (Gittell, 2002). Inspired by Drath and colleagues' (2008) DAC (direction, alignment, commitment) framework, she conceptualises leadership as a social process through which actors produce direction, alignment and commitment, resulting in individuals willingly subsuming their own efforts and benefits within the collective effort and interest.

Meier notes that the management of interorganisational coordination is a distributed and relation practice, aiming to develop and implement structures across organisations and build

and maintain relationship. This process, she argues, it shaped by and shapes the context in which it is practised at two levels: the clinical level, to provide 'clinical direction', and the organisational level, to provide 'organisational direction' among the organisations involved in providing care. Meier notes the challenge of simultaneously directing and aligning day-to-day clinical work while maintaining a shared commitment to developing the structures and relationships needed as demands and conditions change. She also argues that separation of clinical work from managerial and leadership is not conducive to delivering high quality care, and therefore highlights the importance of hybrid professionals within the distributed leadership of interorganisational coordination.

Finally, in his chapter, *'A Call for Strategic HRM in the NHS to Support Service Innovation'*, Graeme Currie examines the role of 'strategic' HRM in supporting innovation in health systems. He suggests that strategic HRM holds significant potential to support service innovations, care pathway and redesign, performance management, training and development in health care. However, because strategic HRM emerged from corporate settings, very different to health care contexts, its impact on change and innovation in health care may be limited.

Currie notes that health care is a pluralistic context and containing archetypical professional bureaucracies, where professionals, particularly doctors, wield significant power to resist changes that they do not support. Alongside managers and professionals, policymakers also play a significant role in 'steering' change and innovation, although he notes rarely this occurs in line with top-down mandates and usually requires professionals to be co-opted into its implementation. Thus, Currie argues, HR managers are often stymied by being caught between policymakers' top-down mandates and professional power, with HR rarely

represented at Board level in health care. Thus, HRM often depends on 'hybrid' manager-professionals enacting strategic HRM functions.

Currie illustrates his argument drawing on three studies he has been involved in. The first, a study of workforce innovation designed to 'mainstream' genetics into the English NHS, involving the development of new specialist roles, such as genetics counsellors and genetics nurses. Here, however, powerful doctors resisted the implementation of new roles to maintain the status quo and, despite this being a workforce related issues, HRM played little role in the case.

Second, Currie discusses a regional translational health initiative designed to drive evidence-based health care improvement and move care delivery 'out of hospitals'. He notes that the change here relied upon distributed leadership involving multiple clinicians, managers and organisations. Again, he notes that senior doctors resisted these changes and that, despite potentially playing a role creating a climate for change, HR managers played little role in the initiative, while general managers picked up the cross organisational strategic HRM remit.

Finally, Currie's chapter discusses a case of an initiative to increase use of evidence-based guidelines by doctors in trauma and orthopaedic surgery. Here, while HRM and HR managers might have played a role in tackling non-compliance with guidelines for 'bad' reasons, they were largely absent, again illustrating their relative weakness vis-à-vis the medical profession

The chapter concludes that strategic HRM does have a key role to play in supporting innovation in health care and enhancing performance. However, in practice, the HRM function is usually enacted by generalist managers according to their ability, motivation and

opportunities (AMO), rather than HR managers. HRM also requires professional involvement for to it be implemented. In sum, Currie chapter highlights the limited power of strategic HRM practices and managers to influence change in health care due to contextual constraints and professional power.

Common themes, implications and conclusions

Overall, the chapters contain key common themes. They first show the *potential* role of HRM in supporting the shift from hierarchical top-down organization towards lateral network governance in health care, along with distributed or collective leadership. This trend that may be magnified with a further recent lateral shift towards co-production of public services (Ferlie, 2021).

These changes are associated with new digital technologies, illustrated in Rossell & Kitchener's chapter, collaborative governance, illustrated in Meier's chapter, and new roles and community-based modes of service delivery, discussed in Currie's chapter. Given current austerity and professional burnout experienced in global health systems following the COVID19 pandemic, there is a significant need to learn from positive examples of how to support professionalism, innovation and improvement in conditions of significant resource constraint (Wiedner et al., 2020).

The chapters also all show that the implementation and impact of management, leadership and HRM are highly contextually determined and difficult to separate from wider health care systems. As Currie's chapter particularly notes, research examining HRM in health care are difficult to distinguish from wider studies of management, leadership and improvement in

health services and are therefore likely to be illustrated in wider studies of the management and organization of health care.

Significantly, the chapters also show the relative weakness of HRM as a practice and occupation vis-a-vis medical professionals, who have the power to undermine implementation of changes they do not agree with. Indeed, anyone new to management, organization and HRM in health care, should read up on the sociology of professions and occupational jurisdiction (Freidson, 2001, Abbott, 1988), as health professionals and related politics affect much of what happens in health care.

Likewise, implementing HR processes and practices that might support collaboration and distributed leadership is dependent on health professionals' support too. The chapters therefore highlight that 'hybrid' manager-professionals are key to the implementation of HRM. As argued in relation to management generally (McGivern et al., 2015), professionals are likely to support 'hybrids' implementing HRM and related improvement where they can integrate HRM with wider professionalism in a way enhancing professional status without increasing manager's control over professions.

To conclude, HRM provides no 'silver bullet' for the problems facing health systems around the world, occupying a double-edged position in relation to management, leadership and improvement. Where health workers lack motivation, because they do not have the resources to fulfil their professional vocation or HRM tools are inappropriately deployed, HRM is likely to have little impact on health care improvement (Hyde et al., 2009, Fitzgerald et al., 2006, WHO, 2016, Dieleman et al., 2009, Mathauer and Imhoff, 2006). Conversely, where HRM can enhance health professionalism and distributed leadership, and is supported by

professionals and particularly hybrid manager-professionals it may play a useful role in supporting health service improvement (McDermott and Keating, 2011, Fitzgerald et al., 2013). Key questions for HRM, then, are two-fold. First, how HRM can support health systems improvement, for example, by developing leadership and training leaders, particularly health professional leaders, in change management; second, how HRM can help improve health care in a way aligning with health professionalism so.

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