# Care and Cure in the Dutch healthcare sector: Exploring differences between intended and realized HRM

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## ABSTRACT
This study seeks to explore the differnces between intended and realized HRM in the dutch healthcare sector. During the research phase the differnces between intended and realized HRM turned out to be more nuanced and five dimensions to the gap were identified along which the gap can be viewed. Decentralized responsibilities for HR, responsibilities of HRM professionals, governance of HR processes, external environment and control. The research is done in three healthcare organizations in the eastern part of the Netherlands. Semi-structured interviews were held with a director, three HR professionals and one coach.
In the interviews questions were asked to deepen the knowledge about intended and realized HRM in the organization and what the roles of different actors are in the HRM implementation process. Transcripts were analyzed for differences between intended and realized HRM and the findings divided over the five dimensions. The organizations were divided into cure and care organizations which seemed to be a clear distinction after analyzing the findings. The use of self-managed teams and different organizational structure was a major influencer in the findings. The research suggests that the clear distinction of intended and realized HRM being HR professional's vs managers is not valid in all situations and neither is it that simple. The five dimensions as presented give a more nuanced view on the gap.

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Human resource management, implementation, realized HRM, intended HRM, Healthcare

# 1. INTRODUCTION

The Dutch healthcare sector is under constant pressure due to developments and changes in this sector. Firstly is the cost of care per persona increases every year due to the aging of the population. The CBS (central bureau for statistics) reports that the percentage of GDP in the Netherlands spent on healthcare will increase by 6-18% in the next two years. Secondly, the healthcare expenses are the second biggest by the Dutch government: 74,6 billion Euro in 2015 according to the 'Miljoennennota 2015' and has been the target of budget cuts throughout the last few years. Since 56% and growing of the healthcare organization's spending comes from labour expenses according to Kocher and Sahni (2011) it is of great importance to manage labour in the organization. Because of the pressure that exists within healthcare organizations to cut costs, the need for effective and efficient management of the workforce for better care quality, makes Human Resource Management of critical importance in this sector (Cooke and Batram, 2015). This conclusion was made after examining the changing landscape of the health care from state-sponsored care systems toward market-driven and client satisfaction–oriented regimes within aging care systems by Cooke and Bartram (2015). We think that a new more careful and nuanced approach to HRM within this sector might bring an extra inspiration to fit the management of the workforce with particular needs of the sector and its customers, and ultimately meet the budget requirements. Furthermore, the healthcare sector is different from other sectors in how much it impacts people's life. And not to forget, healthcare is one of the few sectors of an economy in which workforce management is often quite literally a matter of life (Propper & Van Reenen, 2010; West et al., 2002; West, Gutherie, Dawson, Borrill, & Carter, 2006). Mortality is the most extreme of potential negative outcomes, but it is certainly the case that the management of workers in the healthcare sector has consequences related to the quality and longevity of life of patients.

Having said all above, it is not difficult to assume that the management of the workforce needs to be well implemented. This thesis departs from this idea and will focus on the implementation of HRM in the healthcare sector. There has been a lot of research devoted to the process of HRM, and how it can be successfully implemented. (Wright and Nishii, 2006) For the implementation of HRM to be successful, it is argued that HRM needs to send unambiguous messages to the various organizational social groups, resulting in a collective sense of what is expected (Bowen and Ostroff, 2004; Gilbert et al., 2011; Wright and Nishii, 2013). Some scholars argue stronger, - even if the intended HRM is well designed, they will be ineffective if they are not properly implemented (Khilji & Wang, 2006). The concept of a collective sense has been reflected in the research on shared frames, which has been used to explore HRM implementation . For example, Guest and Bos-Nehles (2013) in their conceptual study, postulate that the quality of HRM depends on the combination and integration of a range of perceptions concerning HRM during its implementation process. In a more recent study, Bondarouk, Bos-Nehles and Hesselink (2016) found that the differences between the HRM perceptions of line managers and HR professionals played a crucial role in HRM implementation in a home care organization. It is widely accepted that there is a gap between the perceptions of HRM for line managers and HR professionals. The fact that actual implementation implies that not all intended HRM is implemented, reinforces this (Wright and Nishii, 2013). In this thesis we view implementation as a process of closing the gap between intended- and realised (actual) HRM. The main research question, therefore is what the differences between intended and realised HRM in the Dutch healthcare sector are. In order to answer the researchquestion we start with building a theoretical framework that comprises concepts as the HRM implementation process, Intended and realized HRM and the gap between the latter.

# 2. THEORETICAL FRAMEWORK

Buchan (2004) states that the irony is that the 'health' business is probably one of the most research based sectors with the use of sophisticated methods, yet HRM as "the set of distinct but interrelated activities, functions, and processes that are directed at attracting, developing, and maintaining (or disposing of) a firm's human resources" (Lado & Wilson, 1994, p. 701), in health is under-researched. HRM in the healthcare has to deal with some unique factors that make it special for the sector. In the healthcare sector HRM can have a fast and direct effect on patients because employees stay in direct contact with those patients (Buchan, 2000). This characteristic causes according to Buchan (2000) that HRM has an important role in the business process. Another characteristic of the healthcare sector that influences the role of HRM, is that there is a multitude of stakeholders such as tax payers, the government, health professionals, management, researchers, health insurance companies, patients, and they all require and demand different performance information and have various opinions as to what constitutes success (Harris, Cortvriend & Hyde, 2007: 453).

A quick literature review about HRM implementation shows that there is no shortage of theories about the concept of HRM implementation. The consensus has been reached that HRM implementation involves a process, but there is still debate about what exactly this process comprises ((Boselie, Dietz, & Boon, 2005; Guest & Bos-Nehles, 2013; Runhaar & Sanders, 2013; Woodrow & Guest, 2014; Wright & Nishii, 2007). Some studies see HRM implementation as the translation of intended into actual practices (Khilji & Wang, 2006; Wright & Nishii, 2007). Other scholars view the implementation process more broadly and include the design of HR practices and policies as an essential part (Guest & Bos-Nehles, 2013; Woodrow & Guest, 2014). Also the understanding of when the HRM implementation process is completed is not generally the same. Some scholars include the experience of HR practices by employees (Bowen & Ostroff, 2004)

in the process, others regard the implementation by line managers as the end of the process (Khilji & Wang; Wright & Nishii, 2007). The complete process can be seen as a much more dynamic process, as described by Bondarouk & van Mierlo (2015) "HRM implementation is the transposition process in which HR practices are incorporated into daily organizational life by HR professionals, targeted managers and employees, through the design, introduction, application, enforcement, experience and perception, but also the subsequent evaluation, redesign and reintroduction of the HR practices".

We view the success of the HRM implementation by, the extent, to which the gap between intended- and realised (actual) HRM is closed. By 'intended HRM' we mean the practices as designed by policy-makers of the organization (e.g., HRM professionals and senior management) supporting the business strategy (Boxall & Purcell, 2003). By realised HRM we mean the practices that are used on a daily basis in the different departments by line managers (Khilji & Wang, 2006). Figure 1 shows the conceptual map of HRM implementation as intended and realised HRM.

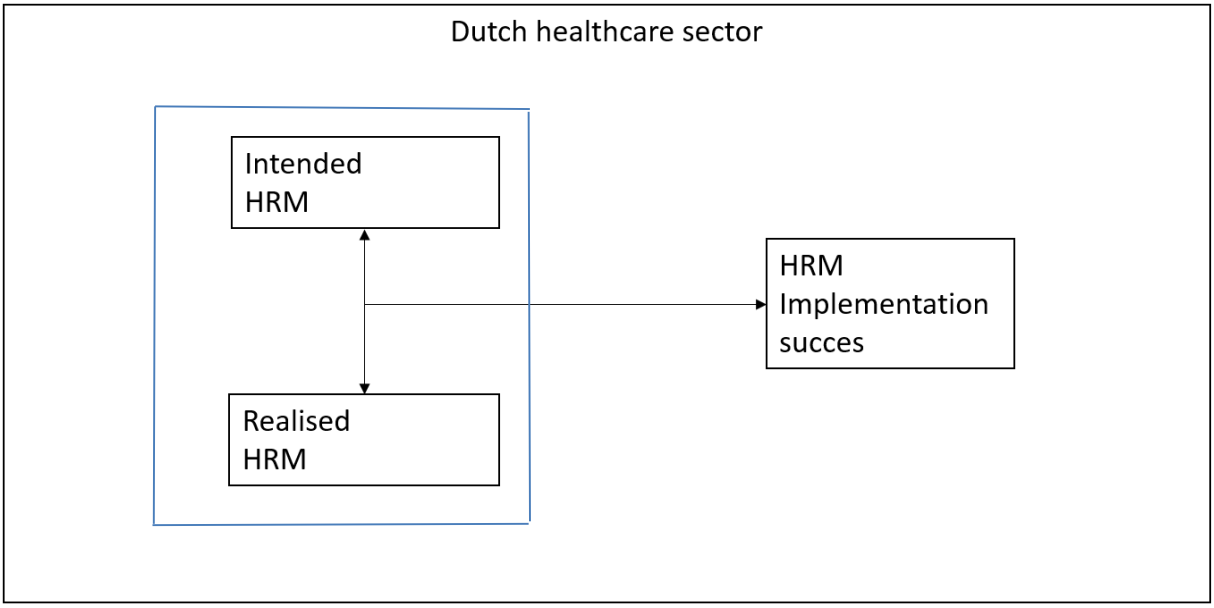


**Figure 1 Concept map**

Evidence shows that there is a gap between intended and realised HRM in organisations (Hope-Hailey et al, 2005; Khilji & Wang, 2006). Qualitative and quantitative analysis of Khilji and Wang (2006) explained that there are varying HR satisfaction levels in the research population which depends on the implementation of HRM. The gap between intended and actual HRM is also stated by Purcell and Hutchinson (2007), as literature often identified the gap between "what is formally required in HR policy and what is actually delivered by line managers".

It is essential to include both intended and realized HRM in research because, previous analyses of the HRM – performance relation resulted in varied findings due to only exploring HRM at the top management levels or within HR departments, which at best captures only the intended HRM and ignores implemented HRM (Khilji & Wang, 2006). Gratton and Truss (2003) argue: 'A key message is that the bridging from business goals to employee performance requires not only policies but also a determination to act, as seen through actual practice'. Khilji and Wang (2006) also take the importance for closing the gap because "organizations with the minimum disparities between intended and implemented HRM will achieve higher HR satisfaction". Their empirical results demonstrate that it is employee satisfaction with HRM, not the mimicry of HR practices, that translates into improved organizational performance (Khilji & Wang, 2006). Woodrow and Guest (2014) also found reinforcing evidence highlighting the implementation. In their study on workplace bullying they found that good HR practices and policies can still get bad results, highlighting that more attention needs to be paid to the implementation of HRM.

To gain insight into these concepts the following topics were explored in the interview. The role of HR in the organization. The structure of the organization relative to HR. What currently HRM implies in the organization. Intensions of HRM and who formulates this. To what extend intensions lead to realization.

## 3. METHODOLOGY

### 3.1 Data collection

A qualitative research method was used, to get insight in the gap between intended and actual HRM, because we were seeking to explore phenomena of HRM implementation (Denzin, 2000). The use of this method allowed to describe variation and individual experiences in HRM practices in the healthcare sector through semi-structured interviews. We applied semi-structured interviews as we were open to new ideas brought up during the interview. Before the interviews only a framework of themes was predetermined: the role of HR in the organization and

how it is implemented and what HRM intensions are relative to the realization of HRM. Interviews were chosen because interviews offer first-hand information about a subject (Swanborn, 2010) and provided a high degree of assurance for obtaining the appropriate information. Interviews also offered the possibility to remain questioning until the appropriate information was gathered (Plochg, Juttmann, & Klazinga, 2007).

The data for this study is gathered between the April 2016 and the June 2016. Background information was given to the managers and HR professionals that participate in interviews to prepare for the study.

The interviews are structured by concepts that are studied in the theoretical framework of this study. For every concept a few questions were prepared as a base for the interview. Topics included the role of the respondent in HRM and HRM implementation, their perception of HRM implementation, constraining factors for HRM, the strategic business goals relation with HRM, the different HR practices and how conflicts in the implementation process are resolved (Appendix 5). There were five interviewees devided over three different organizations which resulted in a total of seven hours of interviewing.

## 3.2 Sample

To get insight into the gap between intended and actual HRM this study is performed at multiple organizations with several line managers, and one who does not have any managers, which offers an appropriate setting for this study. We divide the organizations in care and cure organisations. A hospital in the Eastern part of the Netherlands is the selected organization along with a home care organization and a general practice center. This hospital has two locations who are combined as one organization. It is a general hospital with about 200 medical doctors and 3500 employees who provide care to 250.000 patients a year. In 2012, a reorganization has taken place. This reorganization resulted in a more specified group of line managers and was accompanied with the devolution of several HR tasks to the line managers. Because of changes due to the reorganization, it was assumed that a gap between the intended HRM, as established by the top management, and the actual HRM, as implemented by the line managers exists. It is not feasible to use the total population of line-managers and HR professionals in the timeframe of this study. Within this company, two HR professionals were chosen to be interviewed to examine the intended HRM. On the other hand, two line managers were chosen to be interviewed to determine the realised (actual) HRM. In this organization the line managers are the heads of the different departments of the hospital. The HR professionals design the HRM (policies and practices) but have no direct authority over the managers.

The home care organization is an organization that specifies in all kinds of care for example, elderly care and terminal care. It has a lot of locations in the easter part of the netherlands but care for people in the whole area of Twente. It is especially interesting for this study to investigate the part of the organization that delivers care to people's homes and does not cure diseases because this is entirely different from the hospital. The reason I choose for this is to have a contrast between the different organizations which might have implications for the HRM implementation as well. This part of the organization has about 250 employees, whom are in self-managed teams and have the support of three coaches. This structure is also entirely different because it is very flat and there is not much hierarchy in opposite to the hospital.

The general practice center is a center for health issues off business hours, normally you would go to your GP but in the middle of the night this is not possible therefore these centers are founded. There work about 80 supporting employees in the organization. The doctors are not included neither are they on the payroll. This organization is relatively small and has no HR professionals but hires one externally for one day each week when situations need it.

## 3.3 Data analysis

The interviews with the respondents were taped with their permission and transcribed. Those transcripts were sent to the respondents to ensure the right understanding of their responses during the interview. The respondents were given the opportunity to comment on the transcripts. All of the respondents checked the transcripts but they made no changes.

We conducted five steps in our analysis. First, to analyze the outcomes of the interviews the findings were categorized with the help of the senior researcher. As mentioned above the transcribpts of interviews in care and cure organizations were separately analysed to identify differences or similarities between these types of organizations. The second step of analyzing the data included categorizing all chunks of text into large categories. We identified five categories at this stage of the analysis: *Decentralized HR responsibilities, Responsibilities of HR professionals, control, Governance of HR processes and external environmentl.* The third step was to devide the results for care and cure organizations. The fourth step included open coding together with the senior researcher in which all chunks of tekst, piece by piece were assigned to the designated topics. In the fith step the differences and similarities along the categories were explored and checked for extra subcategories but we did not find any. The whole analysis and overview can be found in appendix 1.

# 4. RESULTS

## 4.1 Decentralized responsibilities for HR

Both care and cure organization assign responsibilities to the employees to keep them motivated and involved.

*We try to involve employees in policy making and such to keep them motivated. We try to get people involved in making the changes that are desired. We*

*listen to employees and follow up on it, that is very important.* (CURE1)

*Giving the workforce responsibility over their own health is an example of a recent introduction. They want to have control over their own health. It was the case that if a worker gets sick he will lean back and wait till the organization does something for him, now he is responsible for making appointments and calls to ask what the organization can do for him. The employee has more responsibility over his own reintegration process. (CURE1)*

It is believed that the sense of being able to co-decide and also have responsibilities makes employees more satisfied.

*This results in an overall happiness score of the workforce of a 7,5 which is not bad. People feel important in the hospital and they are glad that they have a job. In these times not everyone has a job in this sector and the employees know this. (CURE1)*

In the cure organization HR professionals involve people in policy making and HRM activities to stimulate their motivation and sense of shared responsibility. In the care organization the employees already bear the responsibility over a lot of HRM activities and execute these. In the care organization is worked with self-managed teams. Working in self-managed teams is amongst others about direct participation e.g. empowerment, job design e.g. job enrichment, autonomy and decentralized decision making, and recruitment and selection.

*We have had self-managed teams for some time now (5 years) and adapted to a far extend to it. It is part of the culture of the organization.* (CARE1)

This organization has 50 teams who have three coaches. The director of this organization steers all these people which makes it a very flat organization in hierarchy. These teams have next to the responsibilities mentioned above also other tasks that would normally be centralized decided on.

*The teams select their own office buildings within certain boundaries as budgets and such and schedule their own hours, we have provided them with a calculation tool to make this easier. Also conflict resolving is done within the group but sometimes things can't be resolved within the group and they can contact the service center. The next step is than that they have a conversation with the 'P&O adviseur' (HR advisor) to resolve their internal struggles. In this sense the HRM role has changed a bit to a situation where I am only engaged with the teams if they ask for it.* (CARE1)

In the cure organizations a manager is responsible for his/her employees while in the care organization the HR responsibilities are decentralized and the teams of employees are responsible for HRM. In the care organization an HR professional only gets involved if the teams call for it (pull) while in the cure organization HR professionals constantly try to improve internal processes (push).

The self-managed teams do have a framework that is set out and given to them in order to make sure they chase the goals of the company.

*Employees have to make the most of it within those boundaries. If they have trouble working within these boundaries and do not follow what HRM intends, they can be asked to have an conversation with the director and explain why they cannot do what is expected. A consensus might be reached between employee and director if the rules should be bent a little bit for the employee to do his job properly. A coach can help this employee to prepare for the conversation with the director. The director can then be persuaded to devise from the boundaries in some situations.* (CARE1)

Within these boundaries employees are supposed to fill in their jobs themselves. It is generally perceived easier to make employees behave and work in a certain why by implementing policy and practices.

*What you are trying to do is make the employees behave in a certain way. They will not change their behavior if you try to make them follow all kinds of rules. The self-managed teams are based on the idea that the behavior should be changed and giving the employee responsibilities and understanding will make them see why this is necessary.* (CARE2)

But the line between setting boundaries and implementing rules is very fine according to the HR advisor. It is very likely that one slips into old methods of managing very easily.

*Self-managed teams can only be successful if it is done with vision from the director. He really has to believe in it and people will feel this, like in our organization. Otherwise the director will soon enough implement guidelines and frameworks and rules which are not meant to be in place for self-managed teams.* (CARE2)

The cure organizations are not at the level of self-managed teams yet, but the HR advisor of the care organizations believes that self-managed teams can be implemented in any organization. According to (CURE1) HR advisor:

*Managers are resistant to change sometimes if it costs them extra work. But this is inherent in change itself. People don't like it or are sceptic. In practice these people have to work with the new things that we come up with so it takes a certain behavior from them to accept change and work with it. New things have to be repeated until they are part of the daily job and the behavior is changed. New practices do not seem successful until the behavior is changed to fit with the new practices.*

In the large cure organization, the internal politics and relationship management also play a much bigger role in HRM.

*Implementation stands or falls with management involvement. We involve managers too late sometimes and they have their own agenda. If the interest of managers has to be created afterwards the managers don't want it. In business organizations implementation goes way faster, there you just do what you have to do for the bottom line, not care about what everybody wants.* (CURE2)

*Relationship management with management is very important in order to implement practices. If the manager has no interest in trying new HR practices he can block the implementation process and I can do nothing about it. For instance, if the practice is accepted by the board and the manager has to implement it, he/she can say that he/she tried and that it did not work. In that case the practice gets cut again.* (CURE2)

It seems inefficient how dependent HR in the implementation process on business managers and their interest.

*Perfect plans for HRM can be useless if the manager does not see the necessity for it. There is no way around the managers of implementing these HR practices. Sometimes I have put plans in the freezer because the manager was not ready. Then I tried it in 6 months and then it works because I saw a trend that the manager did not see. So than I wait my turn till the events happen and then propose my plan again. Of course they then want the new practices. But if I try to force a manager to do something he will not do it. He will only be more resistant, and won't share information with me anymore which makes it even harder to do my job and see trends in the department. So the key for me is not pressuring the relationship too much with the manager.*

## 4.2 Responsibility of HR professionals

How far the HR professionals' responsibilities stretch and how long the ties are from HR to work-floor seems to be playing parts in the implementation process.

*I am in direct contact with the HR manager who is responsible for all HRM and he reports to the board of directors. Basically he is responsible for the intentions of HRM. Our strategic goal of HRM is to have high quality personnel. To help people who come to us in the best way possible. Therefore, we have an own academy inside the organization to train our nurses and doctors.*

*The intention of HRM is to have a vital workforce, happy and employable. But, there is not enough money and personnel to lower the work pressure in order to do so. This should have the focus of the organization.* (CURE1)

There is a difference in the structure and the links between different people for the care and cure organization. At the care organization the HR advisor has very close relationship with the director and together they set out the strategy or decide on new practices.

*I talk to the director weekly or two weekly and we share ideas. He trusts my expertise and if I propose something to him he almost always implements it. I really like this way of working.* (CARE1)

This way of HRM implementation looks faster because there are no people or stops in between the communication. At the cure organization the HR advisor has to convince the HR manager who proposes it to the board of directors. Then they can pass the message on to the business managers who then have to implement it. There are much more factors and people involved to achieve the same and the road from idea to implementation is way longer.

The HR advisor of the cure organization has found a way to overcome some of the struggles in the implementation process.

*I like to try new things and try it in one department in consultation with the manager. If this works and is successful he can see it and I created his support, also do I now have evidence that I can show the HR manager and the board of directors. Now I have more chance that they will like this new practices. If they do, it can be made a policy or practice for the whole organization. (CURE1)*

The other HR advisor handles things a bit different but also the role that she plays is different.

*My role is more conflict resolving while my colleagues' is more facilitating. I keep myself busy with the OK and IC departments and due to the switch from one hospital to two hospitals I have to resolve a lot of problems. It affected the workers greatly.* (CURE2)

*The people that work here used to work with the same group of people for years and now have to travel to work and work with different people due to the merge of the hospital. This leads to many struggles within the departments between the employees and the managers.* (CURE2)

In both care and cure organizations the size of the organization influences the relations internally as described above. It is not hard to imagine that if the company gets smaller HRM gets less formalized. As can be seen from the small cure organization where there is not even a full time HR professional hired. They hire an HR advisor for one day per week externally.

## 4.3 Governance of HR processes

The cure organization has dual management as a structure of managing.

*Doctors and managers make policy together. Doctors are however, not busy with the management of people and there are no doctors in the board of directors. So it is a bit complicated what their role exactly is.* (CURE1)

There are steps taken in order to get doctors and managers together responsible to focus on quality and productivity. The HR advisor it will help to have both parties look at this matter because in the end doctors are involved in the primary process.

In the care organization however, the self-managed teams do almost everything but they do have some support.

*There is a service center in place which the teams should contact if something gets out of their control or if they can't solve something. After that the question will come to the HR advisor sometimes. In reality do the employees now know how to find and*

*contact me so sometimes they skip the service center if they have questions or need support.* (CARE1)

Since the HR processes also are executed sometimes by employees the director does not simply tell the employees new things to do.

*The director asks the employees for agreement to implement a new plan or HR practice. The employees either agree or get a conversation with the director in which they can explain why they would not want this new thing. At the end, people do not have to like new practices, but as long as they are workable they will get implemented.* (CARE1)

The governance of processes is different since there are no managers. The director is in direct contact with the employee's and the coaches are supportive but are more on the sideline as explained by a coach.

*The director provides the teams with a framework in which they have to operate. The coach can support the teams in working within this framework. This is entirely different from the role of a manager. (Which the coach used to be) There is no longer a person in between director and employee.* (CARE1)

Self-managed teams seem to only have a framework but of course they also work within the legal requirements of their professions.

*Guidelines set by the law are always followed. We have a person who looks after legal issues so policies can be made within these lines. The director then simply implements these by telling the employees.* (CARE1)

For the cure organization governing HR processes is very different. The governing process is way more difficult due to the various persons involved.

*There is misalignment between the focus of managers and what the board of directors wants and what HRM needs them to do. Managers tend to focus on their own department and try to reach the goals of their department, there is little attention for the hospital's goals. The thing is that managers are scared that their department's budget will get cut. If they save money by working efficiently, the year after that the budget will be cut because they did not need all the money. But the managers should not care about this because they should look out for the hospital's best interest and not just their department. Another example is that they should lend their employees to other departments more to help those but the managers are hesitant to do so.* (CURE1)

The complicated relationships also lead to a lot of internal politics.

*There is competition between departments and doctors. They fight over budget and other internal matters. I think a flatter organization will help without managers and with self-managed teams. But this is very hard in an organization like a hospital because we have so many different departments. I think it only works for organizations with low diversity in service, here it's too specialized for management to coordinate this.*

The small cure organization has due to its size simpler ways of governing HR processes and less formalization is used.

*We are a very flat organization with an HR advisor hired externally for only one day per week. Due to this most of the HRM activities are initiated only if they are requested by the employees. We simply have no budget or time to constantly look for new HR practices and if I do come up with something I will just implement it.* (CURED)

*There is also no 'Ondernemersraad' (OR) in this organization which makes implementing strategy for HRM much easier/faster. Because fewer people have to agree with the decisions.* (CURED)

*There are only 5 managers with whom I work very closely and as a team we have the same thoughts and ideas about situations, you could say that it is our culture.* (CURED)

## 4.4 External environment

As mentioned above, there are a lot of external pressures on the sector and on the healthcare organizations. The respondents noticed that this is not very different in the organizations they work for.

*I experience budget cuts on a daily basis. The first step is that we stop hiring people and with that the workforce goes down and also the costs. We also let people go and cannot replace them, it is than essential to increase our efficiency with the people that we have left.* (CURE1)

*On the other hand, we keep training doctors and nurses but just have to work with less support people. We do not cut on the training. We have to have enough doctors, because no doctors mean no production means no money.* (CURE1)

Certain problems are related and fuel others which can also be seen for the budget cuts, which is related to the sickness rate as mentioned earlier.

*When the department is reorganized or there are many budget cuts, people get insecure. And insecure people have even more stress than normal and get sick more than normally, this leads to a higher sick rate. This higher sick rate only causes more trouble money wise, and not getting the job done right.* (CURE1)

The financial pressure on the healthcare organization that led to the merge of the two hospitals and the latest developments in the sector lead to struggles.

*There has been a shift in how the care is provided. Many people have worked here for 30 years. Since then, there have been a lot of changes. Nowadays the pressure is on higher quality and there is less time to talk to patients and visitors. It is all about production now. Some people that have worked here for a long time at the hospital don't like their work anymore because it has changed so much. Due to this we are losing qualified workers. It costs us money to train new people and have them work at the same standards.*

*An issue that I notice myself since the merger that it is harder for managers to manage business units over*

*different locations. Due to this they are more likely to miss things then when there were managers at both locations. Managers are less on top of things I would say.* (CURE2)

## 4.5 Control

The different organizations have control mechanisms and are controlled from the outside.

*We get audited a lot because the care we provide is essential for somebody's quality of life, or if the person survives. Certain quality standards should be met of course. This is why we never cut back on education and training for our doctors and nurses.* (CURE1)

Control from within the company also changed with the latest developments of the merging two hospitals.

*A layer of management was cut. This leads to a higher span of control, the managers have responsibility over more people. This is challenging, for instance with the sick employees it is harder to stay on top of everybody's reintegration situation of the sick workers.* (CURE1)

*The sickness rate was low for a long time because all the managers had to focus on it. After that the control and focus shifted because the rate was low and didn't need as much attention anymore in the eyes of top management. Then the sickness rate rose again because of the lack of focus by management.* (CURE1)

The HR advisor expresses frustration about how the lack of control leads to the internal politics.

*Doctors and other people in this organizations have all different reference frameworks and their own agenda's and interests. There is a lot of conflict of interest within this hospital. People from the medical world are very good at politics and defending their own interest. Within this organization there is no focus on the bottom line of saving and making money and the internal processes are way too social. I come from a business background where if something is not profitable it simply gets cut out. There is a lot of internal politics here due to conflict of interest that hinder efficiency.* (CURE2)

*This conflict of interest led to a recent misalignment of policy. A sick worker was replaced by a younger person to fill in the gap. Policy stated that the sick worker had to reintegrate once he was no longer sick but the manager of that unit lost trust in that worker. And also the young worker did the job a bit better and still could learn a lot of things. Due to that the younger worker could stay while this was in conflict with the normal policy.* (CURE2)

# 5. DISCUSSION

This paper contributes to the existing knowledge in theory and practice in several ways. Firstly, it confirms the existence of the gap between intended and realized HR practices. This has been shown by several examples in the results of this study, and corresponds with many studies conducted by HRM scholars (Khilji & Wang, 2006; Damhuis, 2014)

Furthermore, this study has nuanced the becoming conventional rhytoric about the gap between intended and realized HRM. It showed that the difference between intended- and realized HRM, can be manifested by several factors. First, we discovered that the decentralized responsibilities of HR certainly played a role. The implementation process is different when HR responsibilities are decentralized in, for example a situation where there are self-managed teams. Different actors are now involved in the implementation process than would 'normally' be the case in the devolution concept where managers have a lot of responsibilities for implementation of HRM.

The responsibilities of HRM professionals as reviewed in the previous section, play a role in the intended- vs realized HRM gap too. In the literature HRM professionals are mostly seen as the intentions side of the gap. (Wright & Nishii, 2007) This is in contrast with our results where we explained how the role of the HRM professionals has changed in some situations. Especially in the care organization where an HR advisor described her role as more supportive and only engaged with the primary process when the self-managed teams called for it. Whether this is a new trend cannot be said with confidence but it does provide evidence for changing the role of HRM professionals.

To identify the differences between intended- and realized HRM would be very beneficial for organizations because knowing these differences could enable those to improve their HRM implementation process. With this research we see our main contribution as uncovering reasons for the mentioned gap. More factors seemed to play a role and it were not always clear gaps or differences that could be identified. More important was the size of the organization or structure of management that influenced the gap. Due to these factors there was no 'one size fits all' measure for intended vs realized HRM. Gaps and differences had different meanings for different situations. For an organization with self-managed teams for instance the gap is different in meaning and actors than for a formalized organization with business managers for every department.

If we compare our results with Khiilji & Wang (2006), which has been a great theoretical source, this study goes more into the nuances of the gap between intended and realized HRM. They state that implemented HRM may be substantially different than intended HRM but are more interested in proving how consistent implementation than can lead to organizations performance through higher HR satisfaction.

## 5.1 Limitations and Future research

The aim of this study was to identify differences between intended and realized HRM. The main limitation of this research is that we did not study deeper into the intended vs realized HRM gap. The first emipirical scan reaped such rich data about the five dimensions and the differentiation between care and cure organizations that the research took a different direction. We acknowledge that not much can be said about the gap within the found five

dimensions but this opens the door for future research. It would be interesting to focus in the future studies on exploring the five dimensions as described above.

## 6. CONCLUSION

To conclude this research, aimed at answering the research question: '*what the the differences between intended and realized HRM in the Dutch healthcare sector are?*', results confirm that there indeed is a difference between intended and realized HRM but that the form of this gap differs for different healthcare organizations. Several clear differences between intended and realized HRM have been identified and add to the already known research about this topic.

## 7. ACKNOWLEDGEMENTS

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## 8. REFERENCES


Paauwe J, Guest DE, Wright P: HRM and Performance: Achievements and Challenges. UK: Wiley Press; 2013.

Becker, B. E., & Huselid, M. A. (2006). Strategic Human Resources Management: Where Do We Go From Here? *Journal of Management, 32*(6), 898-925.

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

Paauwe, J. & Boselie, P. (2007). HRM and societal embeddedness. In Boxall, P.,

Purcell, J., & Wright, P. Human Resource Management. Oxford: Oxford University Press.

Van Mierlo, J. & Bondarouk, T. (2015). Revisiting HRM systems strength: Conceptualising the dynamic nature of HRM implementations. Conference Paper.

Boselie, P., Dietz, G., & Boon, C. (2005). Commonalities and contradictions in HRM and performance research. Human Resource Management Journal, 15(3), 67–94

Guest, D. E., & Bos-Nehles, A. C. (2013). Human resource management and performance: the role of effective implementation. In HRM and performance: Achievements and challenges. Chichester: Wiley-Blackwell.

Runhaar, P., & Sanders, K. (2013). Implementing Human Resources Management (HRM) within Dutch VET institutions: examining the fostering and hindering factors. Journal of Vocational Education & Training, 65(2), 236–255.

Woodrow, C., & Guest, D. E. (2014). When good HR gets bad results: exploring the challenge of HR implementation in the case of workplace bullying. Human Resource Management Journal, 24(1), 38–56.

Wright, P. M., & Nishii, L. H. (2007). Strategic HRM and organizational behavior: Integrating multiple levels of analysis. CAHRS Working Paper Series, 468.

Chang, E. (2005). Employees' overall perception of

HRM effectiveness. Human Relations, 58, 523–544.

Huselid, M. A., Jackson, S. E., & Schuler, R. S. (1997).

Technical and strategic human resource management effectiveness as determinants of firm performance. Academy of Management Journal, 40, 171–188.

Kane, B., Crawford, J., & Grant, D. (1999). Barriers to

effective HRM. International Journal of Manpower,

20, 494–515.

Wright, P. M., McMahan, G. C., Snell, S. A., & Gerhart, B.

(2001). Comparing line and HR executives' perceptions of HR effectiveness: Services, roles, and contributions. Human Resource Management, 40, 111–123.

Gratton, L., & Truss, C. (2003). The three-dimensional

people strategy: Putting human resources policies

into action. Academy of Management Executive,

17(3), 74–86.

Han, J., Chou, P., Chao, M., & Wright, P. M. (2006). The

HR competencies-HR effectiveness link: A study in Taiwanese high-tech companies. Human Resource Management, 45, 391–406.

Wright, P. M., & Nishii, L. (2006). Strategic HRM and

organizational behavior: Integrating multiple levels of analysis. Working paper 06-05. Ithaca, NY: CAHRS Cornell University.

Khilji, S. E., & Wang, X. (2006). 'Intended' and 'implemented' HRM: The missing linchpin in strategic human resource management research. International Journal of Human Resource Management, 17, 1171–1189.

Guest, D. (1987). Human resource management and industrial relations. Journal of Management Studies, 24(5), 503-521.

Lowe, J. (1992). Locating the line: the front-line supervisor and human resource management. In: P. Blyton, & P. Turnbull (Eds.). Reassessing human resource management. London: Sage.

Marchington, M. (2001). Employee involvement at work. In: J. Storey (Ed.). Human resource management: a critical text (2nd ed.). Padstow, U.K.: Thompson Learning.

Storey, J. (1992). Developments in the management of human resources (1st Ed.). Oxford: Blackwell Publishers.

Gratton, L., & Truss, C. (2003). The three-dimensional people strategy: putting human resource policies into action. Academy of Management Executive, 17 (3), 74-86.

Bowen, D.E. and Ostroff, C. (2004), "Understanding HRM-firm performance linkages: the role of the 'strength' of the HRM system", Academy of Management Review, Vol. 29 No. 2, pp. 204-221.

Gilbert, C., De Winne, S. and Sels, L. (2011), "The influence of line managers and HR department on employees' affective commitment", The International Journal of Human Resource Management, Vol. 22 No. 8, pp. 1618-1637.

Wright, P.M. and Nishii, L.H. (2013), "Strategic HRM and organizational behavior: integrating multiple levels of analysis", in Paauwe, J., Guest, D. and Wright, P. (Eds), HRM and Performance: Achievements and Challenges, Wiley-Blackwell, Chichester, pp. 97-110.

Goodhew, G.W., Cammock, P.A. and Hamilton, R.T. (2005), "Managers' cognitive maps and intra-organisational performance differences", Journal of Managerial Psychology, Vol. 20 No. 2, pp. 124-136.

Brewster, C., & Larsen, H. H. (1992). Human resource management in Europe: evidence from ten countries. The International Journal of Human Resource Management, 3 (3), 409434.

Sims, R. R., Veres III, J. G., Jackson, K. A. & Facteau, C. L. (2001). The challenge of frontline management – flattened organizations in the new economy. Westport: Quorum Books.

Hales, C. (2005). Rooted in supervision, branching into management: continuity and change in the role of first-line manager. Journal of Management Studies, 42 (3), 471-506.

Lowe, J. (1992). Locating the line: the front-line supervisor and human resource management. In: P. Blyton, & P. Turnbull (Eds.). Reassessing human resource management. London: Sage.

Luthans, F., Hodgetts, R. M. & Rosenkrantz, S. A. (1988). Real managers. Cambridge, Massachussetts: Ballinger Publishing Company.

Hope Hailey, V., Farndale, E., & Truss, C. (2005). The HR department's role in organizational performance. Human Resource Management Journal, 15 (3), 49-66.

Cunningham, I., & Hyman, J. (1999). Devolving human resource responsibilities to the line. Personnel Review, 28 (1/2), 9-27.

Harris, L., Doughty, D., & Kirk, S. (2002). The devolution of HR responsibilities – perspectives from the UK's public sector. Journal of European Industrial Training, 26 (5), 218-229.

Kulik, C. T., & Bainbridge, H. T. (2006). HR and the line: the distribution of HR activities in Australian organizations. Asia Pacific Journal of Human Resources, 44 (4), 240-256.

Brewster, C., & Larsen, H. H. (2000). Responsibility in human resource management: the role of the line. In C. Brewster, & H. H. Larsen (Eds.). Human resource management in Northern Europe, Oxford: Blackwells.

Hall, L., & Torrington, D. (1998). Letting go or holding on – the devolution of operational personnel activities. Human Resource Management Journal, 8 (1), 41-55.

Bond, S., & Wise, S. (2003). Family leave policies and devolution to the line. Personnel Review, 32 (1), 58-72.

Wright, P. M. & Nishii, L. H. (2007). *Strategic HRM and organizational behavior: Integrating multiple levels of analysis* (CAHRS Working Paper #07-03). Ithaca, NY: Cornell University, School of Industrial and Labor Relations, Center for Advanced Human Resource Studies.

Cunningham, I, & Hyman, J. (1999). Devolving human resources responsibilities to the line. Personnel Review, 28 (1/2), 9-27.

Renwick, D. (2000). HR – line work relations: a review, pilot case and research agenda. Employee Relations, 22 (2), 179-205.

Storey, J. (1992). Developments in the management of human resources. Oxford: Blackwell Publishing.

Drever, E. (1995). Using Semi-Structured Interviews in Small-Scale Research. A Teacher's Guide.

Harris, C., Cortvriend, P., & Hyde, P. (2007). Human resource management and performance in healthcare organizations. Journal of Health Organization and Management, 21, 448-459.

Boxall, P., & Purcell, J. (2003). Strategy and Human Resource Management (Vol. 57, p. 299). New York: Palgrave Macmillan.

Plochg, T., Juttmann, R. E., & Klazinga, N. S. (2007). Handboek gezondheidszorgonderzoek. Houten: Bohn Stafleu van Loghum.

Swanborn, P. (2010). What is a Case Study? In Case Study Research: What, why and how (pp. 1–23). Sage Publications ltd.

Gioia, D.A. and Chittipeddi, K. (1991), "Sensemaking and sensegiving in strategic change initiation", Strategic Management Journal, Vol. 12 No. 6, pp. 433-448.

Balogun, J. and Johnson, G. (2004), "Organizational restructuring and middle manager sensemaking", The Academy of Management Journal, Vol. 47 No. 4, pp. 523-549.

APPENDIX 1 – ANALYSIS OF DATA

| Category | Care | Cure | Cure2 |
|---|---|---|---|
| Decentralized responsibilities for HR | This organization has self-managed teams for some time now and adapted to a far extend to it. It is part of the culture of the organization. This greatly influences the HRM implementation process. | **There is dual management, doctors and managers make policy together. No doctors in the board of directors.** | **HR advisor states that steps are taken to counter this in the dual management. Doctors and managers together responsible so the focus is both on quality and productivity. This lead to a more overall view.** |
| Responsibility of HRM prof | HRM persons are only engaged if there is a pull from the work floor. | **HR manager is responsible for all HR policies and he reports to the board of directors. He makes the intentions of HRM.** | **There is competition between departments and doctors. As mentioned above about budgets and there are internal politics. HR advisor thinks that a very flat organisation will help (as seen in other interview) with self-supporting teams and no managers. But he thinks that this only works in organizations that don't have much diversity. For the hospital it is too difficult, there are too many different departments and very specialized thinks and there is management needed to coordinate this.** |
| governance of HR processes | The HR advisor has a very close link with the director of all workers, who trusts in her expertise, and together they decide over the HRM activities. This leads to fast implementation of HRM because there are no stops in between. | **The operational managers are the implementers of HRM.** | **HR advisor likes to try new things in departments so that he can try if it is successful. If it is, it can be made a policy for the whole organisations. He states that he then has evidence he can show the board of the success and they are more likely to listen and implement this new policy.** |
| External environment | There are about 50 teams and 3 coaches and 1 director. Very flat organisation. | **Doctors do make policies but not manage any personnel.** | The other HR advisor has a more conflict resolve role in the OK and IC. Which often occurs due to the switch of 2 separate hospitals to one organisation. This has many implications for the workers of the hospitals. |
| control | There is a service center in place which the teams should contact first if something is going on, after that the question will come to the HR advisor sometimes. In reality now the workers know the number of the HR advisor and directly ask her in case of need. Like conflict resolving. | **The strategic goal of HRM is to have high quality personnel. There is an own academy to train nurses and doctors.** | Also for managers it is hard to manage the business units of 2 different locations. Due to this they are more likely to miss things than when there were managers for both locations. |
| | The director asks the employees for agreement to implement a new plan or HR practices. The employees either agree or get a conversation with the director in which they can explain why they do not agree with the new practices. It is explained that people do not have to like practices but only have to be able to work with them. | **Heavily audited organisation, it is important that it can be shown that the required quality is met. This is why education is so important.** | If the HR advisor sees a new trend or wants something she first tests the manager if he also sees or wants the same thing. When things are unit specific she talks to the manager of the unit otherwise to the business manager. If I want something I can try to convice the HR manager but if the board does not see it the same way, it stops there. |

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| | Teams have a lot of responsibility next to their normal job responsibility. They for instance pick their own office buildings, decide on who's hired or fired, and do conflict resolving. It is very hard to help these teams. The HRM role also changed in this setting. A bit from push to pull kind of work setting. | **Budget cuts lead to the fact that people are let go and they cannot be replaced. So working more efficiently is than necessary to keep things running.** | If new things need to be implemented managers are resistant sometimes if it cost them extra work. But this is inherent in change. People don't like it or are sceptic. In practice the people have to work with the new things so it takes a certain behaviour from the to accept change and work with it. New things have to be repeated until they are part of the daily job. It does not give off the fruits until the behaviour is changed. |
| | **The director provides the teams with a framework in which they have to operate. The coach is supportive for the teams. This is entirely different from the role of a manager. There is no person in between the director and the employee's.** | **The intentions of HRM is to have a vital workforce, happy and employable. But, there is not enough money and personnel to lower the work pressure. This should have the focus of the organisation according to the HR advisor.** | Implementation stands or falls with management involvement. We involve managers too late sometimes and they have their own agenda. If the interest for managers has to be created afterwards the managers don't want it. In business organizations implementation goes way faster. |
| | **For HRM activities the framework is set out and given to the employee's, they have to make the most of it within those boundaries. If employees cannot work within these boundaries and do not what HRM intends, they have to go to the director and reach a consensus with him. The coaches can help the employees to persuade the director to devise from the boundaries if needed.** | **They try to keep the workers involved with policy making and such to keep them motivated. They try to listen to the employees and their wishes and follow up on it. We try to get people involved in making the changes that are desired by them. This results in a overall happiness score of the workforce of a 7,5 which is not bad according to the HR advisor but could be better. He states that people feel important in the hospital and that people are glad to at least have a job, not everyone has one in the sector and employees know this.** | Relationship management with managers is very important in order to test and try new HR practices. If the manager has no interest in trying new HR practices he can block the implementation process. For instance, not doing something, or if the board wants him to, he can just say that it does not work. |
| | **A calculation tool was developed so the teams can schedule their own hours to give the care to the people.** | **There are challenges when investigating if the intensions are the same as the realisation. Setting goals and following up on them is hard. It is hard to measure certain things like is the quality high? Easier is if the sickness has gone up or down, but then still the challenge is to isolate the drivers.** | There is no focus on the bottom line of making and saving money, the internal processes are way too social. In business if something is not profitable it gets cut, that is not the case here. There is a lot of internal politics that hinder efficiency. Also the fact that there are almost no people who come from the business world but all from the medical world makes it very hard. They have another reference framework and their own interest. Their interest conflicts with that of the hospital. |
| | **All the clients that ask for care have to be accepted. (if they have the right indication that they need care), whilst the budget that the organisation receives from the insurance companies is limited.** | **Giving responsibility to the workforce for their own health was introduced. Which is appreciated by the employees, they want to have control over their own health. (Now people ask what can you do for me and what can I do for myself.)** | Perfect plans for HRM can be useless if the manager does not see the necessity for it. There is no way around the manager of implementing these HR practices. |
| | **Guidelines set by the law are always followed. They have a person who looks after legal issues and the HR advisor can make policy to keep within these lines. The director simply implements these by telling the employees.** | **Managing sick workers is getting better according to the HR advisor. One step at a time, because a manager has 80 employees. The first 6 weeks it's a problem, but for 6 months there is a replacement and the employee can get out of the picture. The challenge here is to stay on top of it which sometimes lacks. The responsibility giving works to counter this.** | The HR advisor role is completely dependent on managers which is not efficient. |

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| | **Making policy and implementing practices for employees is perceived easier, but what you are trying to do is make the employees behave in a certain way. They will not change their behaviour of you try to make them follow all these rules. The self-management teams are based on the idea that you should try to change the behaviour and give the employee understanding and responsibility.** | **The cut of a layer of managers led to a larger span of control. This leeds to the fact that managers have more people to look after. For the example of the sick employees this makes it more challenging to stay on top of the situation while sick.** | There was a sick worker and a younger person was hired to stand in. Policy said that the permanent worker had to reintegrate into the work floor and the temporary stand in has to go. But the manager lost trust in that worker and liked the younger one more on certain levels so he was kept. The interest of the manager completely made a gap between intended- and realised HRM. |
| | **Tasks beyond the normal job that teams have are switched with a year. Like make a schedule for the team. This is so that everybody can do every task.** | **The sickness rate was low for a long time due to well implemented policy and all managers had a focus on it. The focus shifted because the rate was low and did not need as much attention any more in the eyes of top management and quality was the new focus. Then the sickness rate rose again because of the lack of focus.** | Giving managers and HR people the same targets would enhance teamwork and efficiency. At the moment different people have different interest which leads to conflict. Internal politics with doctors only add to the trouble. HR advisor suggest doctors on the payroll in a manager and employee relationship to be much more efficient. |
| | Self-managed teams can only be successful if it is done with vision from the director. He has to believe in it and the people will feel this. Otherwise the director will soon enough implement guidelines and frameworks which aren't meant to be in place for self-managed teams. | **When the department is reorganized or there are many budget cuts people get insecure, insecure people get more sick which lead to a higher sickness rate.** | The huisartsenpost is a very flat orginisation with a hr advisor externally hired for 1 day per week. Due to this most of HRM activities are initiated only if it is asked/required by employees. The director will than look to see how she can come up with fitting solutions. |
| | The director and coaches are trying to alter the mind-set of employees | **There is even special training in place to learn people how to combine work and private life in order to reduce their stress.** | There is also no Onderdernemersraad in this organisation which makes implementing strategy and HRM for the director very easy in the decision making. Because fewer people have to agree with the decision. |
| When about decentral in care we talk about self managed teams, for cure: managem ent tries to involve people. | | **There has been a shift in how the care is provided. Many people work for 30 years in this hospital and since then there were many changes. The pressure is on higher quality and there is less time to talk to patients and visitors. Some people who work for a long time at the hospital don't like their work anymore because it has changed so much.** | There are only 5 managers with whom the director works very closely, together they are a team who has "de neuzen dezelfde kant op" which means they have the same thoughts on subjects. Therefore they almost always agree on what HRM activities to use. |

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| | | **There is misaligned between the focus of managers and what the board of directors want and what HRM needs them to do. Managers tend to focus on their own department and only reach department specific goals, there is little attention for the hospital's goals. Also the lending of employees to other departments, which should be done, is not accepted by managers that often.** | In order to compensate for the problems that might arise if somebody gets sick, they train the staff to function in each other's jobs, otherwise a part of the process would be missing. |
| | | **There is no incentive for working efficient for managers, if they work efficient and not spend the complete departments budget. The board will think that they did not need all the money and cut the budget. Actually the managers shouldn't mind the budget cut in their department because it's the whole hospital's budget of course. They should care about the total result. But in practice they do complain about department cuts.** | That everybody has the same vision leads to easy implementation on the manager's part, but to check if the employees also can work with new practices there is a plan do check act step system in place to make sure the new practices are workable. If not, they get adapted. |
| | | | Steps are only taken on HRM activities if the work floor asks for it, the director says she has not enough time and it is not worth the effort and money otherwise. Being the small organisation that it is HRM is just not that formalised as it would be in a large organisation as we have seen as mentioned aboven. |

## Appendix 2 – Categorization of data

| Decentralized responsibilities for HR | Responsibility of HRM professionals | Governance of HR processes | External environment | Control |
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| This organization has self-managed teams for some time now and adapted to a far extend to it. It is part of the culture of the organization. This greatly influences the HRM implementation process. | HR manager is responsible for all HR policies and he reports to the board of directors. He makes the intentions of HRM. | There is dual management, doctors and managers make policy together. No doctors in the board of directors. | Budget cuts lead to the fact that people are let go and they cannot be replaced. So working more efficiently is than necessary to keep things running. | Heavily audited organisation, it is important that it can be shown that the required quality is met. This is why education is so important. |
| HRM persons are only engaged if there is a pull from the work floor. | The HR advisor has a very close link with the director of all workers, who trusts in her expertise, and together they decide over the HRM activities. This leads to fast | There is a service center in place which the teams should contact first if something is going on, after that the question will come to the | All the clients that ask for care have to be accepted. (if they have the right indication that they need care), whilst the budget that the organisation | The cut of a layer of managers led to a larger span of control. This leeds to the fact that managers have more people to |

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| | implementation of HRM because there are no stops in between. | HR advisor sometimes. In reality now the workers know the number of the HR advisor and directly ask her in case of need. Like conflict resolving. | receives from the insurance companies is limited. | look after. For the example of the sick employees this makes it more challenging to stay on top of the situation while sick. |
| The operational managers are the implementers of HRM. | The strategic goal of HRM is to have high quality personnel. There is an own academy to train nurses and doctors. | The director asks the employees for agreement to implement a new plan or HR practices. The employees either agree or get a conversation with the director in which they can explain why they do not agree with the new practices. It is explained that people do not have to like practices but only have to be able to work with them. | When the department is reorganized or there are many budget cuts people get insecure, insecure people get more sick which lead to a higher sickness rate. | |
| There are about 50 teams and 3 coaches and 1 director. Very flat organisation. | The intentions of HRM is to have a vital workforce, happy and employable. But, there is not enough money and personnel to lower the work pressure. This should have the focus of the organisation according to the HR advisor. | The director provides the teams with a framework in which they have to operate. The coach is supportive for the teams. This is entirely different from the role of a manager. There is no person in between the director and the employee's. | There has been a shift in how the care is provided. Many people work for 30 years in this hospital and since then there were many changes. The pressure is on higher quality and there is less time to talk to patients and visitors. Some people who work for a long time at the hospital don't like their work anymore because it has changed so much. | |
| Doctors do make policies but not manage any personnel. | HR advisor likes to try new things in departments so that he can try if it is successful. If it is, it can be made a policy for the whole organisations. He states that he then has evidence he can show the board of the success and they are more likely to listen and implement this new policy. | Guidelines set by the law are always followed. They have a person who looks after legal issues and the HR advisor can make policy to keep within these lines. The director simply implements these by telling the employees. | There is no incentive for working efficient for managers, if they work efficient and not spend the complete departments budget. The board will think that they did not need all the money and cut the budget. Actually the managers shouldn't mind the budget cut in their department because it's the whole hospital's budget of course. They should care about the total result. But in practice they do complain about department cuts. | |

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| Teams have a lot of responsibility next to their normal job responsibility. They for instance pick their own office buildings, decide on who's hired or fired, and do conflict resolving. It is very hard to help these teams. The HRM role also changed in this setting. A bit from push to pull kind of work setting. | The other HR advisor has a more conflict resolve role in the OK and IC. Which often occurs due to the switch of 2 separate hospitals to one organisation. This has many implications for the workers of the hospitals. | The director and coaches are trying to alter the mind-set of employees | Also for managers it is hard to manage the business units of 2 different locations. Due to this they are more likely to miss things than when there were managers for both locations. | |
| For HRM activities the framework is set out and given to the employee's, they have to make the most of it within those boundaries. If employees cannot work within these boundaries and do not what HRM intends, they have to go to the director and reach a consensus with him. The coaches can help the employees to persuade the director to devise from the boundaries if needed. | If the HR advisor sees a new trend or wants something she first tests the manager if he also sees or wants the same thing. When things are unit specific she talks to the manager of the unit otherwise to the business manager. If I want something I can try to convice the HR manager but if the board does not see it the same way, it stops there. | There is misaligned between the focus of managers and what the board of directors want and what HRM needs them to do. Managers tend to focus on their own department and only reach department specific goals, there is little attention for the hospital's goals. Also the lending of employees to other departments, which should be done, is not accepted by managers that often. | There is no focus on the bottom line of making and saving money, the internal processes are way too social. In business if something is not profitable it gets cut, that is not the case here. There is a lot of internal politics that hinder efficiency. Also the fact that there are almost no people who come from the business world but all from the medical world makes it very hard. They have another reference framework and their own interest. Their interest conflicts with that of the hospital. | |
| They try to keep the workers involved with policy making and such to keep them motivated. They try to listen to the employees and their wishes and follow up on it. We try to get people involved in making the changes that are desired by them. This results in a overall happiness score of the workforce of a 7,5 which is not bad according to the HR advisor but could be better. He states that people feel important in the hospital and that people are glad to at least have a job, not everyone has one in the sector and employees know this. | The HR advisor role is completely dependent on managers which is not efficient. | HR advisor states that steps are taken to counter this in the dual management. Doctors and managers together responsible so the focus is both on quality and productivity. This lead to a more overall view. | At the moment different people have different interest which leads to conflict. Internal politics with doctors only add to the trouble. HR advisor suggest doctors on the payroll in a manager and employee relationship to be much more efficient. | |
| A calculation tool was developed so the teams can schedule their own hours to give the care to the people. | | There is competition between departments and doctors. As mentioned above about budgets and there are internal politics. HR advisor thinks that a very flat organisation will help (as seen in other interview) with self- | | |

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| | | supporting teams and no managers. But he thinks that this only works in organizations that don't have much diversity. For the hospital it is too difficult, there are too many different departments and very specialized thinks and there is management needed to coordinate this. | | |
| Giving responsibility to the workforce for their own health was introduced. Which is appreciated by the employees, they want to have control over their own health. (Now people ask what can you do for me and what can I do for myself.) | | Giving managers and HR people the same targets would enhance teamwork and efficiency | | |
| Making policy and implementing practices for employees is perceived easier, but what you are trying to do is make the employees behave in a certain way. They will not change their behaviour of you try to make them follow all these rules. The self-management teams are based on the idea that you should try to change the behaviour and give the employee understanding and responsibility. | | The huisartsenpost is a very flat orginisation with a hr advisor externally hired for 1 day per week. Due to this most of HRM activities are initiated only if it is asked/required by employees. The director will than look to see how she can come up with fitting solutions. | | |
| Tasks beyond the normal job that teams have are switched with a year. Like make a schedule for the team. This is so that everybody can do every task. | | There is also no Onderdernemersraad in this organisation which makes implementing strategy and HRM for the director very easy in the decision making. Because fewer people have to agree with the decision. | | |
| Self-managed teams can only be successful if it is done with vision from the director. He has to believe in it and the people will feel this. Otherwise the director will soon enough implement guidelines and frameworks which aren't meant to be in place for self-managed teams. | | There are only 5 managers with whom the director works very closely, together they are a team who has "de neuzen dezelfde kant op" which means they have the same thoughts on subjects. Therefore they almost always | | |

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| | | agree on what HRM activities to use. | | |
| There is even special training in place to learn people how to combine work and private life in order to reduce their stress. | | Steps are only taken on HRM activities if the work floor asks for it, the director says she has not enough time and it is not worth the effort and money otherwise. Being the small organisation that it is HRM is just not that formalised as it would be in a large organisation as we have seen as mentioned aboven. | | |
| If new things need to be implemented managers are resistant sometimes if it cost them extra work. But this is inherent in change. People don't like it or are sceptic. In practice the people have to work with the new things so it takes a certain behaviour from the to accept change and work with it. New things have to be repeated until they are part of the daily job. It does not give off the fruits until the behaviour is changed. | | | | |
| Implementation stands or falls with management involvement. We involve managers too late sometimes and they have their own agenda. If the interest for managers has to be created afterwards the managers don't want it. In business organizations implementation goes way faster. | | | | |
| Relationship management with managers is very important in order to test and try new HR practices. If the manager has no interest in trying new HR practices he can block the implementation process. For instance, not doing something, or if the board wants him to, he can just say that it does not work. | | | | |
| Perfect plans for HRM can be useless if the manager does not see the necessity for it. There is no way around the manager of implementing these HR practices. | | | | |

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| In order to compensate for the problems that might arise if somebody gets sick, they train the staff to function in each other's jobs, otherwise a part of the process would be missing. | | | | |
| That everybody has the same vision leads to easy implementation on the manager's part, but to check if the employees also can work with new practices there is a plan do check act step system in place to make sure the new practices are workable. If not, they get adapted. | | | | |

## Appendix 3- Analysis

| | Care | cure |
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| Decentralized responsibilities for HR | This organization has self-managed teams for some time now and adapted to a far extend to it. It is part of the culture of the organization. This greatly influences the HRM implementation process. | The operational managers are the implementers of HRM. |
| | HRM persons are only engaged if there is a pull from the work floor. | Doctors do make policies but not manage any personnel. |
| | There are about 50 teams and 3 coaches and 1 director. Very flat organisation. | They try to keep the workers involved with policy making and such to keep them motivated. They try to listen to the employees and their wishes and follow up on it. We try to get people involved in making the changes that are desired by them. This results in a overall happiness score of the workforce of a 7,5 which is not bad according to the HR advisor but could be better. He states that people feel important in the hospital and that people are glad to at least have a job, not everyone has one in the sector and employees know this. |
| | Teams have a lot of responsibility next to their normal job responsibility. They for instance pick their own office buildings, decide on who's hired or fired, and do conflict resolving. It is very hard to help these teams. The HRM role also changed in this setting. A bit from push to pull kind of work setting. | Giving responsibility to the workforce for their own health was introduced. Which is appreciated by the employees, they want to have control over their own health. (Now people ask what can you do for me and what can I do for myself.) |
| | For HRM activities the framework is set out and given to the employee's, they have to make the most of it within those boundaries. If employees cannot work within these boundaries and do not what HRM intends, they have to go to the director and reach | There is even special training in place to learn people how to combine work and private life in order to reduce their stress. |

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| | a consensus with him. The coaches can help the employees to persuade the director to devise from the boundaries if needed. | |
| | A calculation tool was developed so the teams can schedule their own hours to give the care to the people. | If new things need to be implemented managers are resistant sometimes if it cost them extra work. But this is inherent in change. People don't like it or are sceptic. In practice the people have to work with the new things so it takes a certain behaviour from the to accept change and work with it. New things have to be repeated until they are part of the daily job. It does not give off the fruits until the behaviour is changed. |
| | Making policy and implementing practices for employees is perceived easier, but what you are trying to do is make the employees behave in a certain way. They will not change their behaviour of you try to make them follow all these rules. The self-management teams are based on the idea that you should try to change the behaviour and give the employee understanding and responsibility. | Implementation stands or falls with management involvement. We involve managers too late sometimes and they have their own agenda. If the interest for managers has to be created afterwards the managers don't want it. In business organizations implementation goes way faster. |
| | Tasks beyond the normal job that teams have are switched with a year. Like make a schedule for the team. This is so that everybody can do every task. | Relationship management with managers is very important in order to test and try new HR practices. If the manager has no interest in trying new HR practices he can block the implementation process. For instance, not doing something, or if the board wants him to, he can just say that it does not work. |
| | Self-managed teams can only be successful if it is done with vision from the director. He has to believe in it and the people will feel this. Otherwise the director will soon enough implement guidelines and frameworks which aren't meant to be in place for self-managed teams. | Perfect plans for HRM can be useless if the manager does not see the necessity for it. There is no way around the manager of implementing these HR practices. |
| | | In order to compensate for the problems that might arise if somebody gets sick, they train the staff to function in each other's jobs, otherwise a part of the process would be missing. |
| | | That everybody has the same vision leads to easy implementation on the manager's part, but to check if the employees also can work with new practices there is a plan do check act step system in place to make sure the new practices are workable. If not, they get adapted. |
| Observations | - Self-managed teams are implemented for 5 years now in a care organization which provides homecare. This changed the implementation process of HRM because it | - In the structure of dual management, the organization tries to decentralized HRM responsibilities somewhat but does not go as far as self-managed teams. |

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| | is implemented from director to employee in a direct relationship and employees bear responsibilities for HRM.<br>- The role of the HR professional in this organization is changed due to the structure with self-managed teams. Since this the way of working, HR professionals are only involved with the employees if the employees call for this, instead of that they are constantly trying to improve the processes. Their involvement is more switched to a pull situation instead of a push in which they actively disrupt processes or change certain things.<br>- Frameworks are guidelines are set in order for the teams to have boundaries. If employees do not agree to these boundaries, they can discuss this with the director. The lines of communication are not long and there is not much hierarchy which seems to improve speed of implementation.<br>- | - Employees are involved in policy making and are given more responsibilities of HR, for example over their sickness reintegration. According to HR professionals this giving responsibility to employees and involving them in policy making motivates the employees. The employees feel more engaged with the company and its goals and gain a sense of responsibility.<br>- The implementation process is disturbed by internal politics and differences in interests. Managers can have a different interest than HR professionals, for them it is critical to involve managers at an early stage in the development otherwise managers might ignore or block implementation.<br>- For smaller companies the implementation process is easier since there are less actors involved in the process, also come implementation more from the business side (director) than from HR professionals who are not always hired in small organizations. |
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| Responsibilities of HR professionals | The HR advisor has a very close link with the director of all workers, who trusts in her expertise, and together they decide over the HRM activities. This leads to fast implementation of HRM because there are no stops in between. | HR manager is responsible for all HR policies and he reports to the board of directors. He makes the intentions of HRM. |
| | | The strategic goal of HRM is to have high quality personnel. There is an own academy to train nurses and doctors. |
| | | The intentions of HRM is to have a vital workforce, happy and employable. But, there is not enough money and personnel to lower the work pressure. This should have the focus of the organisation according to the HR advisor. |
| | | HR advisor likes to try new things in departments so that he can try if it is successful. If it is, it can be made a policy for the whole organisations. He states that he then has evidence he can show the board of the success and they are more likely to listen and implement this new policy. |
| | | The other HR advisor has a more conflict resolve role in the OK and IC. Which often occurs due to the switch of 2 separate hospitals to one organisation. This has many implications for the workers of the hospitals. |

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| | | If the HR advisor sees a new trend or wants something she first tests the manager if he also sees or wants the same thing. When things are unit specific she talks to the manager of the unit otherwise to the business manager. If I want something I can try to convice the HR manager but if the board does not see it the same way, it stops there. |
| Observations | - HR professionals are in this organization in a more conflict resolving role. They also engage in policy and framework development but the idea of the self-managed teams is that they are responsible for HRM and implementing a lot of policies will only hinder these teams.<br>- HR professionals do solve conflicts within teams which teams cannot solve themselves. Also can the teams contact HR professionals for other problems that they feel they cannot handle themselves.<br>- The coaches are to support the teams when trends arise or formalities must be handled, coaches can also help employees in their communication with the director. But the role of the coaches are always supportive and not in between director and employee. | - The intensity of HRM activities is fueled by strategic focus. For instance, quality is very important therefore an in house academy to train nurses and doctors is within the hospital. While other practices which should need more attention or budget do not get this according to HR professionals.<br>- HR professionals main goal is to keep the workforce of high quality, happy and employable. Which of course is with one eye to financials because happy and employable employees are not sick and do not lose the hospital money.<br>- HR professionals are constantly trying to improve processes, make them more efficient and effective because budget cuts demand this. There is a constant trend of doing more with less resources.<br>- In the small organization the director has most HR responsibilities since there are no HR professionals in that organization, for some situations or idea's an extern HR advisor is hired. |
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| Governance of HR processes | There is a service center in place which the teams should contact first if something is going on, after that the question will come to the HR advisor sometimes. In reality now the workers know the number of the HR advisor and directly ask her in case of need. Like conflict resolving. | There is dual management, doctors and managers make policy together. No doctors in the board of directors. |
| | The director asks the employees for agreement to implement a new plan or HR practices. The employees either agree or get a conversation with the director in which they can explain why they do not agree with the new practices. It is explained that people do not have to like practices but only have to be able to work with them. | There is misaligned between the focus of managers and what the board of directors want and what HRM needs them to do. Managers tend to focus on their own department and only reach department specific goals, there is little attention for the hospital's goals. Also the lending of employees to other departments, which should be done, is not accepted by managers that often. |
| | The director provides the teams with a framework in which they have to operate. The coach is supportive for the teams. This is | HR advisor states that steps are taken to counter this in the dual management. Doctors and managers together responsible so the focus is both on quality and productivity. This lead to a more overall view. |

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| | entirely different from the role of a manager. There is no person in between the director and the employee's. | |
| | Guidelines set by the law are always followed. They have a person who looks after legal issues and the HR advisor can make policy to keep within these lines. The director simply implements these by telling the employees. | There is competition between departments and doctors. As mentioned above about budgets and there are internal politics. HR advisor thinks that a very flat organisation will help (as seen in other interview) with self-supporting teams and no managers. But he thinks that this only works in organizations that don't have much diversity. For the hospital it is too difficult, there are too many different departments and very specialized thinks and there is management needed to coordinate this. |
| | The director and coaches are trying to alter the mind-set of employees | Giving managers and HR people the same targets would enhance teamwork and efficiency |
| | | The huisartsenpost is a very flat orginisation with a hr advisor externally hired for 1 day per week. Due to this most of HRM activities are initiated only if it is asked/required by employees. The director will than look to see how she can come up with fitting solutions. |
| | | There is also no Onderdernemersraad in this organisation which makes implementing strategy and HRM for the director very easy in the decision making. Because fewer people have to agree with the decision. |
| | | There are only 5 managers with whom the director works very closely, together they are a team who has "de neuzen dezelfde kant op" which means they have the same thoughts on subjects. Therefore they almost always agree on what HRM activities to use. |
| | | Steps are only taken on HRM activities if the work floor asks for it, the director says she has not enough time and it is not worth the effort and money otherwise. Being the small organisation that it is HRM is just not that formalised as it would be in a large organisation as we have seen as mentioned above. |
| Observations | - The director governs the HR processes by having conversations with employees if they disagree with something. In most situations the HRM is top down implemented based on authority if it is workable according to employees.<br>- Certain guidelines are set in order for the employees to have a reference framework but it is generally the case that they fill in their own job. | - There is dual management officially, but doctors do not manage people they are only involved in making policy.<br>- The board of directors approves or disapproves propositions for HRM that come from HR professionals.<br>- In order to get more efficiency out of the processes the objectives for managers and HR professionals should be more aligned. Now different interest and goals lead to conflicts or misalignment.<br>- The small cure organization has no OR which makes governance faster since less people have to agree over the governance issues. |

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| | - The mindset of employees is changed to one where they are more involved with the company and are much more eager. | The director may simply implement whatever is necessary in her eyes. Also the small amount of manager makes the communications of rules and steps easier towards the business process. Interference is only done when the employees ask for it, there is no time or budget to continuously try to improve processes. |
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| External environment | All the clients that ask for care have to be accepted. (if they have the right indication that they need care), whilst the budget that the organisation receives from the insurance companies is limited. | Budget cuts lead to the fact that people are let go and they cannot be replaced. So working more efficiently is than necessary to keep things running. |
| | | When the department is reorganized or there are many budget cuts people get insecure, insecure people get more sick which lead to a higher sickness rate. |
| | | There has been a shift in how the care is provided. Many people work for 30 years in this hospital and since then there were many changes. The pressure is on higher quality and there is less time to talk to patients and visitors. Some people who work for a long time at the hospital don't like their work anymore because it has changed so much. |
| | | There is no incentive for working efficient for managers, if they work efficient and not spend the complete departments budget. The board will think that they did not need all the money and cut the budget. Actually the managers shouldn't mind the budget cut in their department because it's the whole hospital's budget of course. They should care about the total result. But in practice they do complain about department cuts. |
| | | Also for managers it is hard to manage the business units of 2 different locations. Due to this they are more likely to miss things than when there were managers for both locations. |
| | | There is no focus on the bottom line of making and saving money, the internal processes are way too social. In business if something is not profitable it gets cut, that is not the case here. There is a lot of internal politics that hinder efficiency. Also the fact that there are almost no people who come from the business world but all from the medical world makes it very hard. They have another reference framework and their own interest. Their interest conflicts with that of the hospital. |
| | | At the moment different people have different interest which leads to conflict. Internal politics with doctors only add to the trouble. HR advisor |

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| | | suggest doctors on the payroll in a manager and employee relationship to be much more efficient. |
| Observations | - Due to the obliged acceptation of clients the relative budget per person can vary from time to time.<br>- | - Budget cuts are the main issue to delivering high quality cure in the hospital. All kinds of issues arise from this.<br>- Reorganization is done due to a budget cut, this led to insecure workers and jobs changing. The HR professional notes that turbulent times like this show a rise in sickness rate.<br>- It is not logical that if a business unit manages to save money, the saved money gets cut from the budget. Although it might seem logical that the unit did not need this money the managers of the units are now unwilling to save money because it will lead to a budget cut.<br>- Doctors being in partnerships lead also to a lot of politics and issues. They have different interest from the hospital which makes working with them hard. I won't go much deeper into this since it is not the main topic of study. |
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| control | | Heavily audited organisation, it is important that it can be shown that the required quality is met. This is why education is so important. |
| | | The cut of a layer of managers led to a larger span of control. This leeds to the fact that managers have more people to look after. For the example of the sick employees this makes it more challenging to stay on top of the situation while sick. |
| Observations | - The control of the company is at the board but the control of the primary processes mainly rests on the shoulders of the director. Which is in direct contact with the HR-professionals so they can influence the day to day HRM that the employees notice a lot. | - There is a lot of control from the outside through audits, hence the academy in house for maximizing quality.<br>- Since the merge of the hospitals control is harder because the locations doubled and so did the workers, but the people who control haven't doubled. |

## Appendix 4 – Differences and similarities

| Differences/similarities |
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| At the care organization the HR responsibilities are decentralized and teams of employees are responsible for HR, while in the cure organizations a manager is. In the care organization a HR professional only gets involved with the employees and internal process if they call for it (pull) while in the cure organization HR professionals constantly try to improve internal processes (push). |
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| At the care organization the HR advisor has very close ties with the director and together they set out the strategy/new practices. At the cure organization the HR advisor has to convince the HR manager and the board of directors of the sense of a HR practice before this top management passes the message on to the business managers of the different departments of the hospital. The road from idea to implementation is way longer in the cure organization and the implementation of HR practices slower. There are much more factors and people involved to achieve the same. |
| In both care and cure organizations the size of the organization has a huge impact on HRM and the implementation of HRM. The smaller the company the less formalized HRM is and the small cure organization does not even have a full time HR professional. |
| Both care and cure organizations struggle to provide to the same standards while budgets are being cut, also the change of the sector towards transparency in the process and high quality brings along struggles for the organizations. The is a continues trend towards doing the same work with less people. |
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| In the care organizations the director provides a framework for the people in which they have to do their job while in the cure organization the tasks are described and the employees are managed by a manager. |
| In the cure organizations HR professionals try to involve people in policy making and HRM activities in order to stimulate their motivation and sense of shared responsibility. In the care organizations the employees already bear the responsibility over a lot of HRM activities and execute these. For instance, hiring and firing of people is already done by the self-managed teams. |
| After the setting of the goals of HR both care and cure organizations note that is hard to follow up on them and measure their outcomes. It is hard to isolate the drivers that impact certain situations, for example the sickness rate. |

## Appendix 5- Coding Scheme

| Code: | meaning |
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| CURE1 | HR advisor 1 of cure organization |
| CURE2 | HR advisor 2 of cure organization |
| CARE1 | HR advisor 1 of care organization |
| CARE2 | Coach of care organization |
| CURED | Director of cure organization 2 |

## Appendix 4 – interview guide

I introduce myself and tell something about myself and the research that I am doing.

This will be an interview about HRM in your organization. I want to ask you a couple of questions that are related to the HRM activities withing your organization and what role you play in those. It is very important to me to hear your honest opinion to form an overall view. Ofcourse the confidentiality of your information will be conserved and I will not distribute this information to anyone. Is it okay if I record this interview?

General

- Could you tell me something about yourself?
- For how long have you been working in this company?
- What is your role in HRM in this organization?
- What is the structure of this organization?

HRM implementation

- What actors are involved in HRM?
- What is your role in HRM implementation?
- Who would you say formulates the intenstions for HRM?
- Who realizes the implementation of HRM?
- What are difficulties in the implementation process?
- Are there practices that are not implemented well?

What is the role of doctors?

Do you experience budget cuts a lot or in your daily work?

What is the focus of the organization? Strategic goals?

What is the most troubled HR practice?

These are just topics, the interviews can persue other topics aswell and questions can be asked more times if there are no clear answers given.