IV. Lessons of New Research for the Coming Debate over Labor Law

Quick Votes and Union Certification Drives in Canada

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Abstract

This paper reviews the use of quick votes in Canada and the evidence of their effects on union organizing. Most Canadians now work in provinces where mandatory elections, including provisions for quick votes, are in place. In fact, all provinces except Alberta, past and present, that use mandatory elections have such provisions. In most cases, the election must take place within only one week of the application date. The evidence suggests that compliance with this requirement is very high; however, employer actions are a strong correlate of noncompliance. Overall, quick-vote elections appear to reduce certification success rates by around 20 percentage points in the private sector, while elections may have little effect in the public sector. A key area for future research is to gain a better understanding of what factors underlie the relationship between the union recognition regime and union organizing outcomes.

Introduction

With the debate over the Employee Free Choice Act continuing, and a growing consensus that union recognition under the National Labor Relations Board (NLRB) is broken, there is considerable interest in the U.S. on alternative union recognition procedures. Some analysts are arguing in favor of a pure card-check-based system, without elections but with a higher percentage (than the current 30%) of the proposed bargaining unit required for certification (or with elections only required for a certain range of this fraction, such as 45–55%). Others are suggesting that mandatory elections be maintained, but with provisions that the election must take place within a short period (such as one week) from the application date. Such a system is often referred to as "quick votes."

As is widely known, Canada has traditionally used a card-check system where the proposed bargaining unit is certified without a vote—often referred to as "automatic certification"—if some minimum fraction of the unit (e.g., 55%+) signs cards. Elections have generally been required only if the card signing yielded some lesser amount (such as 45–55%), which has generally been quite rare. This has changed, however. Now, a strong majority of the Canadian workforce is covered by mandatory elections, leading to a few studies of their effects. In this session, I will review the specific parameters of the election regimes in Canada and discuss what we have learned about the effects these regimes have had on union organizing.

Mandatory Elections in Canada: Process and Outcomes

Two Canadian studies have received considerable attention in the labor law reform debate: work from Susan Johnson (2002) and Chris Riddell (2004). Johnson examines organizing success across Canada (public and private sectors) for 1976 to 1996. The results suggest that mandatory elections reduce union

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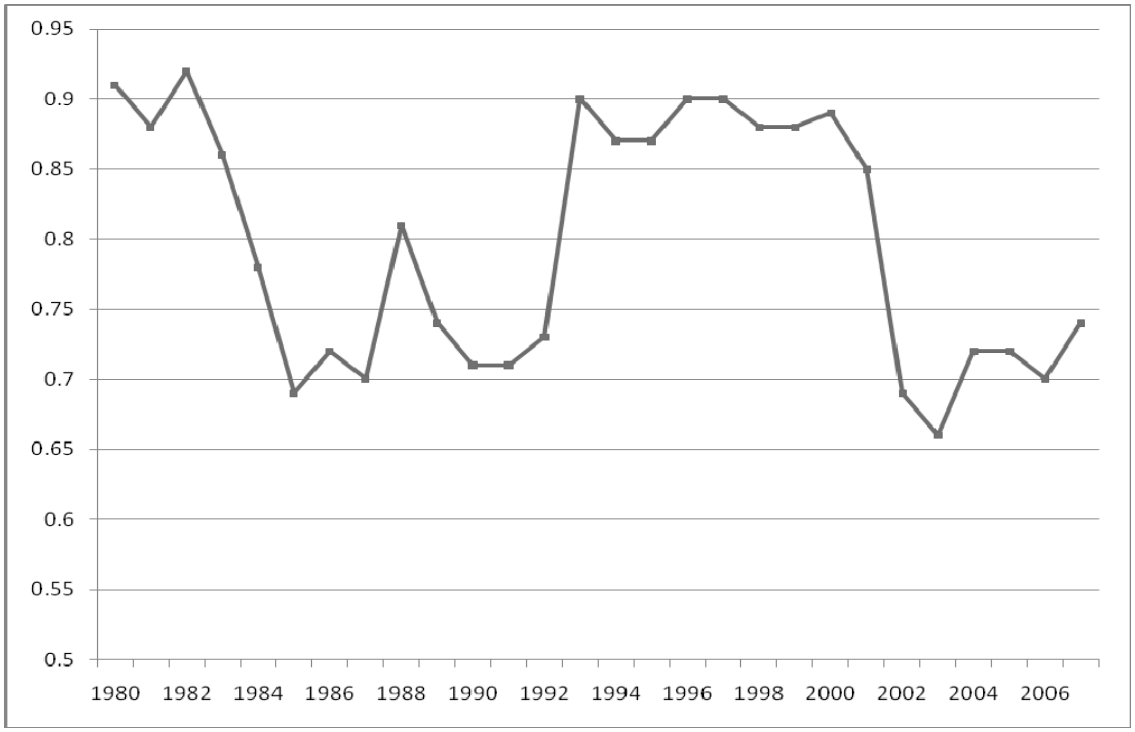
certification success by about 9 percentage points. In Riddell (2004), microdata on individual organizing drives is used to analyze heterogeneity in the role of elections and to examine the effects of unfair labor practice (ULP) charges against the employer under a card-check system versus an election system. One key finding is that the effect of elections is almost entirely felt by the private sector. In the case of British Columbia, the mandatory election regime reduced success rates by just under 20 percentage points, while there was virtually no effect on organizing in the public sector. I turn to the ULP evidence at the end of the talk.

In fact, British Columbia made another change to their union recognition system in 2002, going back to the same mandatory election regime (including quick-vote parameters) that existed between May 1984 and 1992. There is now therefore a rare four-switch transition in legislative regimes to examine. Figure 1 shows overall certification success rates (private plus public sector), excluding withdrawn applications, over the 1980 to 2007 period. The trends in the figure are striking; indeed, the relationship between the union recognition regime and certification success rates is one of the most striking I have seen in labor relations.[1]

FIGURE 1
Certification Success Rates in British Columbia, 1980 to 2007



But a central feature of elections in Canada that has been missed in much of the literature and recent debate: with the exception of Alberta, all mandatory election regimes in Canada, past and present, are quick-vote systems.[2] Table 1 summarizes the mandatory election systems in Canada from the first such regime introduced by Nova Scotia in 1977. In all cases except Alberta a quick vote is required, with the window ranging from five to 10 days. There are some differences in the formal language—from the legislation or regulations as opposed to board policy—surrounding the reasons that can lead to an election being delayed beyond the statutory requirement, as well as some other related procedures.[3]

It is therefore very important to emphasize that—to the extent Canada is a reasonable laboratory along other dimensions such as labor markets, related institutions, attitudes towards unionization, and the like—the Canadian evidence may provide only a partial story of what the U.S. might look like under card check since the NLRB election process is very far removed from the quick-vote systems in place across Canada.

A clear follow-up question to the evidence I have discussed is how the Canadian quick-vote systems perform. Is "compliance" with the statutory requirement on election timing high?[4] What affects "noncompliance"? In a recent paper—Campolieti, Riddell, and Slinn (2007)—colleagues and I investigated these issues for two large provinces, British Columbia and Ontario. The bottom line is that compliance is very high: around 75% in Ontario and over 95% in British Columbia.[5] However, some problems, from a neutral standpoint of a fair and efficient system, exist. For instance, despite high compliance, two key correlates of noncompliance are employer challenges (of various sorts, for instance to the voters list) and ULP charges. Indeed, one lesson from that study is that some policy instruments—such as double-sealing ballots of voters who have been challenged by the employer, holding the election in a timely manner, and sorting out the complaints later—that already exist are not always being used. Nevertheless, the provincial labor relations boards appear in general to be administering elections very efficiently, and certainly election delay in Canada is not comparable to the U.S. NLRB system.[6]

TABLE 1
Summary of Quick Votes in Canadian Mandatory Election Regimes

Alberta	British Columbia	Manitoba	Newfoundland	Nova Scotia	Ontario
Elections required since 1988	Elections required from May 1984 and December 1992; reverted to card check; required again since 2002	Elections required between September 1996 and 2000; reverted to card check in 2000	Elections required since December 1993	Elections required since 1977	Elections required since October 1995
Vote to be held "as soon as possible"	Vote to be held within 10 days of application date (in both regimes)	Vote to be held within 7 days of application date	Vote to be held within 5 business days of application date	Vote to be held within 5 business days of application date	Vote to be held within 5 business days of application date

It is important to conclude with some comments on why mandatory elections reduce certification success rates. Overall, we know very little concrete about the reasons for the striking trends in Figure 1, although many analysts in Canada do find it suspicious that the elections effect seems to be almost entirely felt by the private sector. The lone empirical evidence comes from the study I conducted (Riddell 2004), as noted above. The finding was that ULP charges versus the employer were twice as effective in reducing the probability of a union win under elections relative to card checks. While the latter result is consistent with the firmly held belief among labor that elections are conducive to employer abuse, the reality is that we do not have much evidence in Canada on the role of employer actions (or anything else) in the election versus card check debate.

Conclusion

Mandatory elections have been found to be associated with lower union certification success in Canada relative to the traditional Canadian card check approach. The magnitude of this effect is substantial, such as 20 percentage points for the private sector in the case of British Columbia. Missed in the discussion of the Canadian evidence is that all election regimes in Canada except Alberta have been quick-vote systems. Moreover, quick votes in Canada involve only a 1- to 2-week window (typically one) from the application date to the election date, and "compliance" appears very high. Nevertheless, in the private sector, quick-vote election systems appear to play a fundamental role in union organizing outcomes. Unfortunately, we still have only a limited understanding of what factors underlie this effect. Future research needs to gain a better understanding of why union certification success rates respond so dramatically to the union recognition regime. Finally, because the distribution of election delay in Canadian election systems is likely very different from that in the U.S. (at least in NLRB elections), analysts should be cautious in using the Canadian evidence

to predict what might happen to private sector organizing outcomes in the U.S. under the various Employee Free Choice Act models being discussed.

Endnotes

1. For brevity here I only show the figure using total, aggregated certification data from the British Columbia Labour Relations Board. For a variety of reasons it is methodologically more sound to use microdata; see Riddell (2004). As can be seen in the figure, the effect of elections in British Columbia appears stronger than perhaps what has been seen in other provinces, based on Johnson (2002). However, the effects seen in British Columbia are similar to the largest Canadian province, Ontario, whose experience with elections was not incorporated in the Johnson study (due to the time period). It may also be that withdrawn applications have biased some previous results; see Riddell (2004) for a discussion of these issues. It should be emphasized that the figure includes the public sector, and in the case of both British Columbia and Ontario, there is a crucial differential in the elections effect across sectors.

2. To be clear, while all mandatory election systems in Canada have had provisions for quick votes, elections that have been held under card-check systems (i.e., when support was below the automatic threshold, such as 55%) have generally not had expedited procedures.

3. For instance, some provinces have mandatory pre-election hearings (unless all parties consent otherwise); some provinces eliminate the quick vote if the election is being held by mail; language differs as to the circumstances and board's power to delay the election, and so on.

4. Some caution is required in using the term "compliance" since some provinces do have allowances for delays.

5. These compliance rates are not entirely comparable since British Columbia uses a 2-week window and Ontario only one week. But if one uses a 2-week window for Ontario, the compliance rate is still 84%.

6. That said, from an empirical standpoint, our knowledge about the distribution of election delay in NLRB elections is, unfortunately, somewhat dated.

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V. Meeting Today's Healthcare Challenges through Innovations in Employment Relations and Information Technology

Introduction and Discussion

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My contribution forms an introduction to four research projects that have links across their conclusions on aspects of healthcare. The four papers illustrate common issues that face healthcare systems in developed economies. In turn, my introduction raises an issue that is paramount in all healthcare systems: the drive for higher quality and the pressure to reduce costs. Based on the research evidence in other sectors, such as airlines (e.g., Bamber et al. 2009), higher quality and reducing costs can be also compatible in healthcare.

There are many pressures on healthcare provisions common throughout developed economies. Among these are the following:

1. Medical science is advancing at an unprecedented rate, and our ability to treat, inhibit, and defeat disease and illness is under constant change. We can, with a measure of confidence, predict some of the next steps. For example, stem cell development will make redundant some organ transplant procedures.
2. The rapidly escalating cost of healthcare is another feature held in common. All developed economies have healthcare provision with costs increasing faster than their national inflation level. Some of this inflationary pressure arises from new drug development costs, the introduction of new technology, the treatment of previously untreatable illness, and an aging population.
3. There is a struggle in every advanced society to cover the ever-rising expectation of treatment, with some of that expectation now fueled by patient access to medical information from the Internet.

Against that dynamic background is another common factor observed in the British system that I also encounter in working relationships with hospitals in the United States and elsewhere in Europe. That factor is the "resistant insularity" of hospital management systems to the lessons on operational management efficiency that are there to be learned from each other and from enterprises unrelated to healthcare. Competition between acute healthcare providers in the U.S. does not necessarily work to achieve efficient operational management of hospitals. The more serious cases of medical negligence and the high incidence of avoidable death are, in part, systems failures. The introduction of provider competition in the British system will introduce improvements but, judged by countries where that competition exists, it is unlikely alone to fundamentally improve resource management.

This criticism is not aimed at the skills of the medical profession. Nor does it question the capability of hospital managers. Having worked in organizations as diverse as healthcare, construction, engineering, waste management, and confectionary production and acted as consultant in many others, I can attest to both the high level of complexity involved in hospital management and the required quality of management demanded by that complexity. Some of the best managers I have encountered have been in healthcare.

In most advanced countries the healthcare systems draw patients through quality treatment at a rate that generally meets public expectation. In most systems devolved budgets are generally balanced. This is the case in Britain, where the National Health Service, providing taxation-funded universal care, has seen its

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national budget increase from £53.5 billion in 2001–02 to £90.7 billion in the current 2007–08. This has been accompanied by stringent performance standards and an unprecedented pay improvement for employees. Quality standards are undergoing radical improvement under the guidance of government minister and practicing surgeon Lord Darzi. Alongside that, a new operating framework has set quality standards. Independent reviewers have recently marked the UK NHS as one of the best-performing health services in Europe.

Significant progress has been achieved in the past 10 years in Britain in breaking down some of the professional occupational barriers. "Practitioners" have been accepted in place of doctors, overall increasing capacity and the quality of care. Together with these changes, the legitimization of evidence-based practice, reinforced by the establishment of the National Institute of Clinical Excellence (NICE), has translated into important steps in resource management.

Despite all that substantially improved performance and international standing, a recent analysis concluded that savings in the region of £8 billion were achievable in the UK through more effective management of resources. My contention is that most healthcare systems could make major savings and operate more effectively were they to absorb operational management methods that are now common in many other industries and services. The large size of the healthcare sector is one reason for its tendency to be insular and its retention of traditional organizational methods. The NHS is the largest employer in Europe; it has over 1.3 million employees. Medical schools do not help by largely ignoring resource management as an educational need.

It is, of course, a generalization to emphasize the insularity of hospital operational management systems, and there are notable exceptions to the general pattern. In Britain consultants, such as McKinsey's, have brought in experience and standards nurtured outside healthcare. Some institutions in crisis have looked externally to reform in order to survive. The chief medical officer in England has spearheaded the drive to improve patient safety by referencing airline safety procedures and pilot operating standards. In my own region of the NHS we have taken the Toyota production system (TPS) as a way of promoting reform and are developing a no-fault, no-waste approach to healthcare management. Other NHS regions have recognized the issue and have also proposed major changes. We were attracted to the TPS through its emphasis on conjoining higher quality with lower cost. It adds strength to our conviction that the pursuit of value for money in healthcare does not inevitably impact quality and service.

The drive to change management systems does not imply constant and expensive changes in organization. A current example of a simple, universally applicable but effective change has been sponsored by the World Health Organization (WHO) and led by the Harvard School of Public Health (HSPH). It involved eight hospitals in cities around the world and included Imperial College London. The procedure required the use of a single-page checklist to be completed at three stages of operative care—before anesthesia is administered, before skin incision, and before the movement of the patient from the operating room.

The results of the implementation of the procedure across the eight hospitals were significant. Major complications fell from 11% to 7%, and patient deaths following operations fell 40%, from 1.5% to 0.8%. Of the procedure Donald Berwick, of Harvard's Institute for Healthcare Improvement, said, "I cannot recall a clinical care innovation in the past 30 years that has shown results of the magnitude demonstrated by the checklist." The procedure is cheap and simple. The HSPH research team estimated that the implementation of the checklist across all operating theaters in the U.S. would produce an annual cost saving between $15 and $25 billion.

From the relationship with Toyota and building on the contribution of the Institute of Medicine (IoM) and the work of Donald Berwick, we have designed seven objectives:

1. No barriers to accessing healthcare and well-being
2. No avoidable deaths or illness
3. No avoidable suffering or pain
4. No helplessness
5. No unnecessary waiting or delays
6. No waste
7. No inequality

These seven objectives may be challenged as unachievable aims, but they follow the Toyota principle of zero tolerance for defects and for waste in resource and material. The seven objectives set a direction of reform and require a major change in attitude and behavior. Inherent in that change is the adoption of continuous improvement at every level, and that drives change from the bottom upwards in an organization.

To further strengthen our adoption of the TPS in our healthcare systems, we have a partnership with the Virginia Mason Medical Center (VMMC) in Seattle. That hospital has seven years of experience applying the TPS to every aspect of its organization and is a sound mentor. A short visit is enough to demonstrate the wide physical and organizational changes available through the adoption of TPS to healthcare. Fundamentally though, the essence of the change at VMMC is to be discovered in the commitment of every individual to the TPS principles of lean production and the elimination of waste. At the center, of course, the patient's interests are paramount, and the patient is the major beneficiary of the organization's transformation.

The adoption of the TPS (or any such adapted scheme) requires the engagement of every person in the improvement of the work he or she does. Given the right context and incentive, staff can best see the opportunity for improvement and can demonstrate up the management line and across to colleagues the value of changes. The commitment of all staff is an essential aspect of the improvement process. At VMMC they began the process by engaging staff in an evidence-based analysis of current practice, leading in to an evaluation of the potential gains to be made from adopting the TPS. That staff engagement was then formed into a compact.

From an industrial relations perspective, this whole approach has features in tune with the mutual-gains-style productivity bargaining of the late 1960s and early 1970s that was developed in parts of British industry and services. In common are the potential gains to be made from improved working practices and a radical improvement of the service to customers/patients. Productivity bargaining arose within the adversarial relationships in British industry, where distributive collective bargaining inadequately provided communications between workforce and management. Many industries had inflexible work rules and traditions that inhibited change and in consequence produced a very low rate of productivity improvement.

When Allan Flanders (1964), an Oxford academic, published his analysis of productivity bargaining in oil refining, he demonstrated a method for developing radical change in work practices and behavior. A central tenet of his thesis was that for management to gain control, they must be prepared to share it. That concept implies shared objectives and is common to the TPS and to the way it is applied in the VMMC.

Unhappy doctors, a phenomenon worldwide, are hugely important influences of any change, and bringing them wholeheartedly into the productivity objectives is the same challenge so many industries have faced with their traditional workforces. Jack Silversin and Mary Jane Kornacki (2000) have written widely on the need for a compact to support the deep cultural change we are addressing in health service management.

Productivity bargaining also required a thorough analysis of working arrangements, operating procedures, work rules and traditions, payment systems, and management practices, along with the local collective bargaining structures. An interpretation would be made and a debate initiated with workforce and management. If led well, a compact would arise from that analysis and interpretation; this aimed to commit all stakeholders to an agreement on the change to new working practices. The basis on which the productivity gains would be shared between workforce and company would then be agreed.

While the circumstances and focus of TPS and productivity bargaining differ, there is enough in common for health professionals to cast back and learn from that earlier attempt at reform. The first common principle is that individuals need to be fully engaged in framing the changes to their own work practices. The second is that traditional behavior and systems are best challenged by evidence-based analysis. Third, the customer/patient has to be at the center of any reorganization and be the main beneficiary.

There are clear distinctions between the two processes. One major distinction is the introduction of *Kaizen* (continuous improvement) by TPS. The concept of continuous improvement is an essential feature of TPS, one that aims to create a dynamic improvement in organizational performance. It was a feature of the productivity bargaining process that it engaged all levels of an organization in reform, but usually only as a single exercise. It was about the gains and what would be given up at a specific point in time. In contrast, TPS produces a compact that is value based, and it establishes an organizational mission that seeks successive gains on a continuing basis. It assumes the achievement of higher quality linked to lower costs and can best be sustained over time, through staff engagement in continuous improvement.

Another distinction between TPS and the earlier productivity bargaining process is the method of introduction. Productivity bargaining was welcomed in many British workplaces, but it was often facilitated by third-party intervention (management consultants and/or state mediators). While the strength of TPS lies in the commitment of a high proportion of the individuals in an organization, its general initiation within a large healthcare system might require centralized encouragement.

If the assumptions are valid that major gains, both in quality and in costs, are there to be made in the operational management of healthcare provision, then we should be able to draw lessons from that productivity bargaining experience and might need to consider the promotion of third-party intervention to initiate the changes. The lessons from productivity bargaining and the continuous improvement from current TPS practices could be combined to reduce costs, raise quality, and manage resources more effectively, to the mutual benefit of patients, employees, and taxpayers. Such an approach offers many advantages, not least in view of the international financial crisis that now faces us.

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Human Resources Management Aspects of Hospital Ward Managers' Jobs

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Abstract

What is the line manager's role in terms of human resources management (HRM)? A new contribution calls for reconceptualizing HRM as signals that management send to employees rather than systems, practices, or bundles. That contribution argues that HR professionals operate at a conceptual level and also in terms of a more specific practices level. We examine a large hospital and suggest that the The Hospital executives disseminate mixed signals. In the decentralized HR environment, it is the growing role of the ward (line) manager as an HR practitioner to interpret, diffuse, and convey such signals to the front-line employees. This role leads to a commitment of the staff to the ward and the ward manager. The ward-based employee relationship may include much clearer and stronger signals than are apparent in the relationship employees have with The Hospital more broadly, bearing in mind that the latter seems to convey "mixed signals."

Introduction

A new contribution calls for reconceptualizing human resources management (HRM) not as practices or bundles, but as signals that management send to employees (Haggerty and Wright 2009). We suggest that in complex modern organizations, it is incumbent on the professional HR employees to operate at a conceptual level and also at a more concrete practices level. These HR professionals will require deep analytical capabilities and intuitive capacities in addition to functional knowledge to perform this role effectively. Where the HR professionals perform these duties effectively and consistent signals are sent to employees, a "strong situation" is said to occur (Bowen and Ostroff 2004). The strong situation allows more uniform interpretations by staff members of signals and consequently more positive performance outcomes.

This paper is based on a case study of an Australian hospital where a range of internal and external pressures have contributed to a high level of mixed signals being relayed to the front-line personnel. These ward-level staff receive signals from a variety of sources. Corporate documents, upper and middle managers (including HR), and other staff are just a few of the sources of signals. We argue that the ward manager role is critical in interpreting, diffusing, and disseminating signals to the ward staff at "The Hospital". This critical, decentralized HR role allows a situation with limited "noise" and therefore, while a strong situation might not occur within the organization, it can occur at the ward level.

The Field of Human Resources Management

The field of HRM has decades of history and development. Until the mid-1990s the primary research focus was on HR practices (Huselid 1995). At this time, however, there began a shift toward viewing and understanding how HR systems worked, rather than the sole focus being on particular practices. Scholars have linked bundles of HR practices to organizational-level outcomes such as turnover, productivity, and

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financial performance (Porter 1985, Cappelli and Singh 1992, Bamber et al. 2009). Typically, the role of the HR function is not adequately explored or is neglected altogether (Haggerty and Wright 2009).

There is a wealth of literature that offers a vast array of typologies, frameworks, and models for understanding HR. Overall, perhaps the best summary of the extant body of work is that HR is a complex area, where some functions are similar in name only and the context of each organization (product/service, economic environment, institutional and regulatory frameworks, and so on) leads to an understanding that HR can be extremely heterogeneous.

Haggerty and Wright (2009) suggest a reconceptualization of HR that simplifies matters significantly. Rather than viewing it through complex or amorphous understandings of practices, or systems, or bundles in combination with hard/soft dichotomies, we can view HR as signals sent from management to employees in groups or individually. In the modern organization, people employed as HR professionals will require the functional knowledge of their responsibilities, but also deep analytical and intuitive capacities to ensure staff members are receiving the appropriate signals. Where the HR professionals perform these duties effectively and consistent signals are sent to employees, a strong situation is said to occur.

Bowen and Ostroff (2004) suggest that a strong situation is one where the variation of possible responses to any number of stimuli is reduced. Organizational climate is a key mediator allowing "employees to understand the desired and appropriate responses and form a collective sense of what is expected" (p. 204). Bowen and Ostroff look at both the individual and the organization to understand the complex relationship. Employees' experiences and interpretations of those experiences form their psychological climate (Schneider 1990, Schneider 2000); the shared perception of what is important in relation to the policies, procedures, practices, and rewards of an organization make up the organizational climate (Bowen and Ostroff 2004). HRM policies and practices are vital in influencing climate perceptions, which are linked (related, if not clearly causal) to organizational performance indicators (Bowen and Ostrof 2004). When disseminated to those people for whom the policies and practices have no relevance, the process of articulation is diluted. Efforts to make all policies and practices available to all employees means that much of the communication will come in the form of "white noise" and will be ignored by employees (Haggerty and Wright 2009).

Bowen and Ostroff (2004) and consequently Haggerty and Wright (2009) base their argument on the work of Mischel (1973, 2004) who in turn uses Lewin, Lippit, and White's (1939) concept of situational strength. According to this earlier work, individual conscientiousness measures vary as situational factors change. Weak organizational situations will allow greater levels of inconsistency of employee actions through individualized interpretation and responses to signals. For a situation to be strong, "employees must hear the message as it was intended, and must accept it prior to choosing an appropriate response" (Haggerty and Wright 2009). Hence, according to the argument, strong situations will lead to a more uniform interpretation of signals and, consequently, more positive performance outcomes.

What managers *should* be able to have is a greater control over the signals that they send to employees. In short, it appears that Haggerty and Wright are suggesting a "top-down"-driven culture of *clear signals* leading to a *strong situation* when compared to a culture that is influenced by all actors. We would suggest that Haggerty and Wright are certainly making a contribution to the ongoing development of the HR performance–outcomes link, however, their conceptualization is perhaps more a "relabeling." Nevertheless, their work provides the space for an interesting debate. Our empirical evidence will also contribute to that debate. It also highlights the need for a greater understanding of the "black box" area of investigation (Purcell and Kinnie 2007).

The suggestion of HR as signals provides an excellent framework for understanding the experience of ward staff at The Hospital. Haggerty and Wright contend that strong situations will lead to the desired organizational outcomes, such as growth, profit, and market value. We encourage the exploration of alternative conceptualizations of the HR function and offer data that will, in part, go some way to support Haggerty and Wright's thesis. We present a case study in which the executive level of management sends mixed signals to employees. As a result, strong situations do not arise, and the role of HR in generating competitive advantage is undermined. We argue that the role of ward manager is critical in interpreting, diffusing, and disseminating signals from upper management to front-line staff. Ward managers are not HR professionals, nor are they generally chosen for their HR skills. Consequently, quite often ward managers lack

the combination of analytical, intuitive, and functional skills required to interpret complex messages for the front-line workers under their direction. There has been a shift from The Hospital to the ward as a focus of strong relationships and indeed, The Hospital presents signs of a weak situation, but focusing on the ward we have an alternative view. The role of ward managers as de facto nonprofessional HR practitioners in carrying out their line management functions allows them to develop strong situations within their wards.

Research Methods

The interview data collection for this research project took place in two main stages**.** First, 10 interviews were undertaken with a range of upper management personnel in The Hospital, including the general manager and four directors, including HR, medical services, support services, and nursing services. In addition, a range of other middle managers were interviewed, including the assistant director of nursing. Generally these interviews were conducted by one or more experienced interviewers in the offices of the respondents. Interviews through this stage of the research were broad-ranging in scope and lasted typically one hour.

The second, more focused stage of interviews was conducted on a ward level with operational staff members. Throughout this stage of the research the questions were focused on the subjective views of staff members toward various factors, including the role of HR in The Hospital, the manner in which The Hospital's approach to HR influences an employee's commitment (exploring notions of multiple commitments), intent to leave, experiences of discretionary effort, and the role of ward managers. Through this second stage of data collection, 22 staff members were interviewed. In the first instance we drew a sample of four wards in The Hospital, two medical and two surgical. In each ward we interviewed the ward manager, two nurses, an orderly, and an administrative staff member. Following this, we interviewed the ward managers from an additional two wards. These interviews each lasted between 30 minutes and one hour. All interviews were transcribed and analyzed using NVivo. In addition, a range of secondary sources, including The Hospital's websites and internal organizational documents, were accessed for supporting information.

The Hospital

The Hospital is medium-sized, with almost 500 beds and approximately 2,000 staff members and a substantial but fluctuating body of volunteers. In the last decade it has faced a range of market pressures that have at times required opposing or contradictory managerial strategies, the result of which has been a growing environment of mixed signals. Pressures include retaining a faith-based organization (while also adopting more of a corporate approach), the nationwide change of funding arrangements (Bloom, Canning, and Sevilla 2003), expansion plans, international nurse shortages (Townsend and Allan 2005), and current low unemployment, leading to domestic labor shortages for all categories of employee (O'Brien et al. 2008). Hence, at a time when the HR department was becoming more integral to The Hospital's strategic planning and shifting to models more akin to high performance HR, there were also significant pressures on budgets leading to pressures preventing the implementation of such models.

Throughout this time, the HR department has worked to shift from the traditional personnel management style of HR common to hospitals in Australia's centralized industrial relations (IR) system. On the basis that there is a spectrum of HR possibilities from personnel management to high performance HRM (Marchington and Wilkinson 2008), The Hospital's HR system is at the early stages of shifting along the spectrum. It is well recognized within the HR team that they are doing some things very well (for example, work–life balance) and other things not so well (for example, performance management). However, when considered on the list of nine "best practice" high performance HR components (Marchington and Wilkinson 2008), the market pressures mentioned earlier lead to significant tensions with the development of high performance HR.

There are many junctures within the complex hierarchy and communication chain in The Hospital where the "mixed signals" can be mediated or diffused. The purpose of this paper is to discuss an intermediary of significant import, interpreting and relaying the mixed signals from upper management to front-line workers. Our focus is on an important part of the high performance HR black box—the line managers—who in hospital wards may be called ward managers.

The Hospital's change in its HR approach has come at the same time as a significant alteration of funding arrangements. The Hospital receives its vast majority of revenue from private health funds, while, as is the case with other private hospitals, the remainder comes from patient "out-of-pocket" arrangements and from government or statutory bodies (Bloom et al. 2003). The reliance on negotiating contracts every couple of years with the private health funds has placed enormous pressure on The Hospital's budget. According to the general manager:

> The dynamics of the private hospital world has changed significantly from probably around about 1999 where we started to have contracts with private health insurance funds. . . . Each time that we've gone into that negotiation with private health insurance companies we really haven't got any major gains. . . . So if hospitals, say their rates are going up or their costs are going up by five percent, [the health funds] give them four percent. As a result of that our margins have gone down.

Coinciding with the change of funding, The Hospital also faced a change in its corporate structure. Having operated for close to 100 years as a church-based organization, the mission culture has faced enormous growth and has been transformed in the last decade to incorporate more of a corporate model. The shift was an attempt to maintain success in an increasingly competitive environment. Throughout this time, the HR department has attempted to shift from a diffuse, decentralized system of policies and practices to a uniform, organization-wide approach to the HR function. The Hospital formally maintains its faith-based approach to patient care while developing an increasing level of financially driven business acumen. As we will see later in this paper, this shift has meant changes for ward staff in two areas: first, a focus growth of The Hospital, and second, a greater awareness of budgetary restraints leading to the perception, real or otherwise, that finances are more important than the patients or the staff. We suggest that this perception is a central factor in the interpretation of mixed signals. The commitment of employees has shifted from The Hospital as an employer toward the ward and ward manager.

Throughout The Hospital's development from a church-based organization to adoption of a more corporate approach, the executive began to pay greater heed to the role of the HR department in developing strategic goals and planning. Progressively, the HR department has had some success in focusing executive attention on the strategic HR plans. However, the HR manager recognizes that the cultural change and development of having HR as a central function has been ad hoc and slow. Nevertheless, progress is being made, including having the HR manager included in the executive team.

Furthermore, in such a competitive business environment and competitive labor market for highly skilled staff, the "ratcheting up" of HR policies and practices is often seen as little more than keeping up with the market. According to the HR manager:

> We know just to keep up with the industry, we have to have a broad-ranging approach on a number of different fronts. If we don't have a well-being program, if we don't have support for certain educational activities, if we don't have, um, good car parking facilities, or child care facilities, we are just not in the game, because that is what the baseline expectation is, and it makes it a real challenge then in terms of how we differentiate ourselves, because everyone is trying everything.

As indicated earlier, many factors have over the last decade contributed to the current experiences of ward personnel in The Hospital. The altered funding arrangements have meant that The Hospital sought areas to reduce expenses—front-line ward staff including nurses has been one of those areas. The Hospital has been expanding substantially in the last decade and is currently undergoing an expansion worth more than $140 million. This expansion has placed financial pressures on management that have reverberated throughout the organization. According to the director of medical ervices, the expansion means that "we've got a $750,000 interest bill every month and we've got to make money, The Hospital has got to make money in a not-for-profit environment."

The general manager concedes that, along with the previously mentioned health funding arrangements, the reductions in government contributions and the pressures from building costs mean that "we can either decrease our margin or we actually reduce the amount of labor we use in delivering our

service, so it's sort of a fine balance between the right amount of labor, the quality of the staff, and then the quality of the service and then the actual volume of labor that you have working on a daily basis."

Combined reduction in labor and capital expenditure costs have resulted in significant pressures on budgets and reduction in patient–nurse ratios. As such, there are very clear, competing mixed signals coming from upper management. Two important mixed signals are the primacy of patient care on one side, and—the competing pressure, given just as great an import—the financial imperative to reduce costs, on the other. We are not suggesting that the strategic decision and indeed operational imperative to "grow" The Hospital is problematic or a poor decision. Rather, we are recognizing that when such decisions are made, the dynamics within the organization change and the signals sent to employees become far more complicated and potentially incompatible to ward-level personnel.

Human Resources Management

One of the central components of this black box is the role of middle managers, who face an increased level of decentralized, or devolved, responsibility (Guest 1987). Employee experiences of HR will be significantly influenced by their middle manager, so researchers point to the importance of studying the employee–line manager relationship (Hyde et al. 2006).

The problematic nature of management arises in this industry, as in many others, when skilled clinicians are promoted to ward manager roles away from the bedside—the precise area where they are experts (Laurent 1992, cited in Willmot 1998). Storey (1992) suggests that the people-management decisions made within organizations must not be treated as "incidental operational matters" or be left to the HR department. Rather, line managers must understand their role as the "signaler" between the strategic direction of the organization and the management of front-line staff members. As such, they have a "responsibility" to act accordingly in the way they manage people (Thornhill and Saunders 1998). As HRM is seen as a component of all managerial jobs, it is reasonable to assume that the line manager position is one that sees the actual delivery of HRM to the greatest number of workers. Employee perceptions of HR practices are those that are applied by line managers (Purcell and Hutchison 2007). Hence, it can be reasonably assumed that line managers are critical intermediaries in shaping overall performance (Currie and Procter 2005). We suggest that the line manager is a critical area where the signals from management must be interpreted, diffused, and disseminated among the front-line ward personnel. Furthermore, ward managers in hospitals are in a position to create their own clear signals and strong situations and reap the benefits.

Factors mentioned in the previous section weigh heavily in the data collected from ward-level staff. Our data suggest that the combined thrust of growth of The Hospital and pressures on costs have induced two developments: first, a shift of employee commitment from the hospital to the ward; and second, as a consequence of this ward-level commitment, a growth in importance of the HR role of ward managers, a function that they are often ill-prepared for performing. Ward managers recognize that they play an important role in the decentralized HR function of The Hospital. For example:

> From the HR point of view I am probably a go-between from the staff at ward level who are going to HR if they have any particular queries to do with payroll, leave entitlements, further studies, access to grants, that sort of thing. From an HR point of view I would liaise often for them with HR and get information for them.

In addition, some ward managers find a chasm between HR and the ward reality: "I found with the HR that we have here, I just found that they are sort of a world away from the wards."

Ward managers recognize the complexity of the competing pressures that they must manage and the way their actions as front-line HR managers send signals to the workforce. They also find their "role" in the HR function frustrating at times. The following from a ward manager illustrates those frustrations:

> You just end up being the sandwich in the middle sometimes. Keeping to budget I am in between, keeping the relationship to my boss on a good keel because I am sticking to my budget, but then I get the flack from the nurses, and then there are times when I think well stuff the budget, we need this amount of people, saying to the nurses we need this many people, I don't know.

The staff make the point that the ward is not The Hospital and The Hospital is not the ward. There are important, distinct differences between the two domains. There is a common theme among employees suggesting that, despite sometimes being attracted to work at The Hospital because of its reputation in both clinical and personnel management realms, their commitment is no longer to The Hospital, rather to the ward and ward manager. As one ward receptionist who has been employed at The Hospital for more than 15 years says:

> Personally, I don't do anything for The Hospital. I am happy to do extra hours, you don't put in for overtime, you don't put any of that, it is just normal and you are happy to do it, because the ward functions better, and that is the nurse manager, so all the staff put in that little bit extra, but then she gives a little bit extra to the staff, that maybe other wards don't get.

An orderly who has worked in The Hospital for more than 10 years says, "I feel [The Hospital] is going backwards, just based on what it was like when I first came here, and it may be for a number of reasons, financial constraints, costs and all the rest of it."

The role of the ward manager is central as a communication link between management and staff. If the ward manager does not agree with the managerial approach, then a selective distribution of managerial messages is likely. Commonly, ward managers state that they will pass on the messages and information that *they* think employees must know, while providing access for employees to find the information the employees might want. This "filtered" direct communication provides full access to information, but also means the ward manager is in a very strong position to determine which signals reach employees and how they are delivered. Given this approach and the individual decision-making in judging "important" information, it is not surprising that such organizations tend to convey an array of mixed signals, which can be contradictory and confusing for employees.

But despite the overwhelming majority of employees' claiming that they did not share a commitment to the organization, they also did not suggest that they were ready and willing to leave their employment. On the contrary, employees voiced an overwhelming commitment to their employment through their relationship with their ward manager. Indeed, the ward manager appears to be a conduit that provides employees with a high level of proximal commitment in place of organizational commitment.

As one registered nurse says, "It is more the ward manager in the area that you are working. In fact, I am sure that has got the biggest influence on whether people here stay or don't stay."

When asked specifically about why employees decide to stay employed at The Hospital, a ward manager suggests that "I think it comes down to individual wards, and the relationships that they make on the wards, and how well they get on with their manager."

A study by Chen, Tsui, and Farh (2002) drew attention to the loyalty to supervisors as an important predictor for employee outcomes in Chinese workplaces. This reinforces Becker's (1992) suggestion that people have a commitment to what is closest—i.e. their supervisor before their commitment to the organization—which is certainly clear in our study. Redman and Snape (2005) suggest that "there may . . . be a general tendency for the more cognitively proximal focus (i.e. supervisor or team) to exert greater influence over employee behaviour."

The combination of The Hospital's growth and the increased importance of the ward manager role means the commitment of employees is to their ward colleagues and ward manager rather than The Hospital. Consequently, the import of line manager skill development and consistent signals are compounded in the attempts of the HR role to generate competitive advantage. The following comments indicate the way that the proximal commitment of employees is intensified at the ward level, rather than the organizational level. Comments from registered nurses include these:

> I feel like you are treated as a number rather than a person most of the time. . . . I would have to say the exception is my manager; she makes me feel like I'm important to the running of the ward. I suppose I feel sometimes we are distanced from that level [The Hospital management].

As one orderly suggests:

> Sometimes if it has been a real hectic week, I have known [my ward manager] to just say to me on a Friday . . . "You are good for finishing at 12 today," and I will say "No, I don't think so," and she will say, "Yes, you will be, make sure you sign off at 3 pm." That is her recognition of hard work, so if, for instance, she says one day can you stay back until 3:30 pm to 3:40 pm to help with beds or helping patients, I don't feel dirty about it so to speak. . . . You go the extra mile for her, and that is why I think she is a good nurse manager.

To some extent, this is another in a line of rhetoric versus reality case studies. For front-line staff in The Hospital, the rhetoric and mixed signals of managers influence but are far from the reality of their day-to-day work on the ward. At The Hospital, there has been a sustained lack of investment in developing the HR and other management skills of ward managers. At a time when the role and expectations of ward managers has grown significantly, the development of competencies for this level of employee has been neglected. Nevertheless, the six ward managers we spoke to have clearly grown into their roles, making mistakes and learning along the way. They have developed the skill of managing upward and downward in the hierarchy and are able to make clear signals to their ward staff about what is important on their ward. Furthermore, the ward staff know that they and their ward managers are facing pressures from the mixed signals. The ward managers have developed strong situations within their wards and the "shop floor collective" support each other through the pressures imposed by upper and middle management. These factors indicate that there is significant opportunity for The Hospital management to concentrate on the ward manager level as a means of sharpening the focus of the HR signals sent to staff and improving the opportunity and role that the HR function can play in generating competitive advantage.

Our case study data indicate that, using the signals approach to understanding the HR black box of line manager and employee relationships, the presence of mixed signals certainly limits the possibilities that could occur if a strong situation was present organization-wide. Our findings support in part Haggerty and Wright's thesis of strong situations, which demonstrate the presence of mixed signals within the organization and the associated weak situation for the role of the HR department as signalers and the development of a strong situation emerging between the ward managers and the ward staff. However, we also acknowledge that we are offering only one case study, and generalization is impossible. More empirical research is required in organizations where signals are clear and the situation would be considered strong.

The role of the ward manager in The Hospital is crucial in the conceptualization of HR as signals. These experienced clinicians are often placed into a role that requires people-management skills, as well as a significantly increased administrative function. All too often, they are not provided with adequate training and support to fulfil their new duties, so progression is often through trial and error. Unfortunately for The Hospital, this can lead to poor HR outcomes (for example, staff dissatisfaction and high staff turnover). Furthermore, this critical role requires interpreting, diffusing, and disseminating signals from the upper levels of management to the ward-level staff.

We have found that the ward managers in this workplace are certainly receiving problematic mixed signals. Patient care is central to their clinical professional ethic, HR functions are central to their people management role, and managing budgetary issues is central to their commitment to The Hospital's financial position. All three areas are central to their job; all three are essential to the high performance model of management . All three have competing pressures and constraints. Perhaps this is an organization, or indeed an industry sector, where the complexities of funding arrangements, labor markets, and competitive product markets might prevent strong situations from developing. Alternatively, with the complexities outlined, this is perhaps the ideal environment in which to invest in ensuring a culture of clear signals and to develop a strong situation, allowing the organization to reap the rewards of competitive advantage that some of the HR literature has for so long promised.

Conclusions

There are several current debates in HRM, including the conceptualization of HR as policies, practices, or bundles, among others. This paper has contributed to these debates through supporting the

notion that HR can be reconceptualized as "signals" sent from management to workers individually or in groups. Haggarty and Wright (2009) suggest that where management develops "strong situations," the signals can be sent without a large amount of interference or noise.

Supporting previous research that recognizes the importance of the line manager in the HR function, we have found that The Hospital equivalent—the ward manager—has a significant and critical role in The Hospital's delivery of HR signals. Interestingly, while the mixed signals delivered by upper management lead to a "weak situation" in the organization overall, we suggest that the critical role of ward manager allows the ward to become a "strong situation." The direct managerial role of the ward manager means that this individual is in a position to deliver clear signals to the staff on the ward. The performance outcome of this strong situation is a commitment to remain employed within the ward, rather than The Hospital in general. This commitment means that The Hospital could benefit significantly through clearly defining and investing in the HR skills of the ward manager.

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