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An Inductive Investigation of the Driving People Management Issues of a Third Sector Health Care Organisation

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Abstract
The health care industry within Australia is facing critical workforce issues. The context of the health care industry is also chasing with reforms that have been working through the public sector now making way to the third sector. There is very little in the way of tested models of predictors of employee behaviour in third sector organisations in the health care industry. Subsequently an inductive methodology, convergent interviewing, is used to generate a variety of issues that employees within a third sector health care organisation felt were the critical people management issues of the day. The set of issues converged after six rounds of interviews and a further round was conducted to ensure that all of the common people management issues had been generated.
Introduction
This project investigates employee perceptions of their workplaces in medium and large hospitals in a private third sector organisation. The study is focussed on the people management aspects of these third sector health organisations due to the direly critical shortage of trained staff, among other problems.

Over the last two decades public sector organisations have implemented a number of changes to their managerial structures, systems and processes, including organisational restructuring, performance auditing and program management (Osborne & Gaebler, 1992). These sets of practices, inter alia, are collectively known as “new public management”/NPM (Kearney & Hays, 1998). Similarly, TSOs have tended to come late to the idea of management (Lewis, 2003), but have recently been subject to a modernisation agenda embracing many NPM elements (McLaughlin et al., 2002). Hospitals in Australia come from all three sectors of the economy, although a major consequence of the introduction of NPM has been a blurring of the public–private divide and the emergence of increasingly complex relationships between public, private and third sector organisations/TSOs (Brown & Barnett, 2004).

The many aspects of reforms present in Australia suggest that the post-NPM environment will be increasingly complex (Steane & Carroll, 2001). This situation begs the answer to the deceptively simple question of “what is a public service organization?” The general conclusion is that there is an overlap in the characteristics between the sectors, which exhibit within as well as between sector variation, suggesting that publicness is multi-dimensional not uni-dimensional (Ferlie et al., 2003)

Prime examples of the complexity of “sector-ness” are Australian hospitals. While narratives of purity - public, private - have their uses, the nature of hospitals is better understood in terms of hybridity (Brown & Barnett, 2004). For example, governments have management and leasing arrangements that vary by degree across the many forms of co-location, such as contracts with private companies to manage and operate public hospitals, and companies that have leased public hospitals and run these as private for-profit facilities (Collyer & White, 1997). The overall effect is that Australian hospitals now operate in an environment that has ‘blurred’ the traditionally binary categories of ‘public’ and ‘private’ (Brown & Barnett, 2004).

Health Industry
Overall, national expenditure on health was 9.7% of GDP in 2003-4 (AIHW, 2006) compared with 8.7% in 1998-9 and 8.1% in the early 1990s (AIHW, 2004). The health care industry is already facing critical workforce problems, including severe workforce shortages, generally high levels of employee stress and an ageing workforce. For example, Australia is experiencing the greatest shortage of nurses since World War II, requiring an additional 10,000 nurses to meet current demands (RMIT, 2003; Chang, 2005). The proportion of the medical workforce over 45 years old increased from 41% to 46% from 1996 to 2003 (AIHW, 2005a), and stayed at 46% in 2005 - considerably higher than the overall workforce average of 35.5% (AIHW, 2006). The most rapidly ageing occupation was nursing where the proportion of the workforce older than 45 years increased from 29% to 46.5% between 1996 and 2003 (AIHW, 2005b) and is now up to around 47.4% (AIHW, 2006). Critically, nurses represent almost two-thirds of the health workers in the health services industry (AIHW, 2006).
If the baby boomer cohort of nurses leaves the workforce at the same rate as previous generations, more than half the current nursing workforce will have retired within the next 15 years, a problem exacerbated by the decline in nursing undergraduate commencements over the 10 years to 2003 (Schofield & Beard, 2005).

Increased employee turnover is one of the key contributors to this shortage, with poor retention levels due to a number of factors, including unsupportive working environments, non-family-friendly working hours and increased levels of stress and dissatisfaction (Cheung et al., 2004). Job stress is a particularly serious problem in the health industry with health care professionals having higher absence and sickness rates than staff in other industries (Edwards & Burnard, 2003). The strain experienced by health professionals is not only felt by employees themselves. Stressful working environments are one of the major reasons why health service employees fail to function at an optimal level of effectiveness and have been associated with deteriorating patient care (Happell et al., 2003; Salmond & Ropis, 2005). With the importance of examining how hospital staff, especially nurses, could stay in the workforce longer and the centrality of the stressful nature of health work, a model that is likely to be powerful in this context is the Job Strain Model - one of the most widely-used and proven predictors of well-being in the literature (Fox et al., 1993).

However, the project team is also looking at the health industry because there is a lack of research in the area of work design that explicitly focuses on managing an ageing workforce (Kanfer & Ackerman, 2004). Subsequently, an inductive methodology was employed to surface the common issues across the organisation that may help to address these critical people management issues in a third sector health organisation (TSHO). The focus of the methodology was the question: “what are the most pressing people management issues in your workplace?”

**Method**
The interviewing technique used in this research was convergent interviewing (Dick, 2000). Convergent interviewing is a qualitative technique that attempts to address research topics that lack theoretical underpinning and is an inductive, flexible, evolving research instrument (Dick, 1990). The content of convergent interviewing is unstructured and the process is semi-structured (Williams & Lewis, 2005). The structure in the process is derived from an embedded, ordered route of design and analysis.

A panel of advisers was used to inform the researchers of the initial subjects and the order in which they are interviewed. The panel consisted of the Chief Executive Officer, the Director of Human Resources, senior managers from each major facility and union representatives. Interviews commenced in the order of the list provided by the advisory panel of those interviewees who were regarded as most informed and most different to one another at the top of the list.

Participants in convergent interviewing are asked to share their views on the research topic with the interviewer. The one-to-one interviews last for at least an hour, in order to reach the level of detail and importance necessary for identifying the key issues (Dick, 2000).

The sample frame of the current study covers all the employees working for a TSO in the health industry, with the majority of employees working at hospital facilities. Of the 27
employees initially asked for interviews, 21 employees participated. A wide range of facilities and positions were represented – including the various hospitals and aged care facilities.

The Interviews
At no time during or after the interviewing process did any managers or executives from the organisation ask the researchers for information about the nature or content of the interviews. Interviews were conducted in private, usually in an office in the respondent’s general work area. The researcher began by thanking the respondent for their time, introducing themselves and explaining why the respondent was invited to participate. The nature and duration of the interview was confirmed and an explanation provided of the notes to be taken and how the data was to be used. The confidential nature of the interview was repeated, the way the data would be de-identified was explained and an informed consent form was signed by both the researcher and the respondent, with a copy kept by the respondent.

Interview questions themselves have three minimum requirements. Interview questions should be specific in their clarity and focus, appropriately patterned to suit the experiences of the interviewees. The wording – but not meaning – behind the interview questions should be adaptable to the interviewee’s experiences (Lazarfeld, 1954).

The initial interview question was “what are the most pressing people management issues in your workplace?” The open-ended character of this question forestalled the researcher’s bias on the topic and allowed respondents to determine the scope and depth of issues. When the first or second issue had been raised and explained, if required, the question was asked again to give respondents the opportunity to reflect on additional issues. The interviewees were encouraged to keep talking by the use of active listening techniques, such as maintaining good eye contact, nodding, repeating key words spoken by the respondent, the use of appropriate verbal encouragers such as “umms” and “ahhs”. To generate more thoughts and ideas in the respondents, generalised probing questions were used, such as “Can you tell me more about that?”, “Can you give me some examples?”, and “In what ways does that happen?”

At the end of each round of three interviews and in accordance with advised practice on convergent interviewing (Dick, 2000), two approaches to generating more detailed secondary or specific probe questions were used. They were:

- When respondents appear to agree on a key issue, it is important to determine whether it is generalised or coincidental agreement. Respondent’s agreement was tested with other respondents by specifically seeking exceptions to the agreed issues. For example “Is there ever a time when XYZ (say, pay or recognition) does not matter?” and

- When respondents agreed on key issues but disagree on the nature or direction of the issue, the specific probe to explain the disagreement was used. For example “Others have said XYZ (e.g., difficult to deal with change) is a problem. What do you think?”

All interviews lasted at least an hour, with most lasting 90 minutes. The interviews ended by summarising the key issues raised in the interview, clarifying any points of uncertainty or ambiguity to the researcher, thanking the respondent for their time and repeating the confidential nature of the research.

After each round of interviews, the common issues in that interview round were analysed. Where both respondents raised an issue, that issue was regarded as a key issue. Probing
questions were created to enable thorough investigation of these key issues. Subsequent rounds of interviews added new issues where convergence could be found and probed for deeper understanding of the key issues already identified. In that way, an expanding list of key issues was generated, with additional detail on the nature of the key issues. When no new common ideas occurred at round six, a check round was conducted to confirm no new key issues were raised (an overview of the process, based on the standard two interviewees per round, is summarised in Figure 1).
organisation and had only a minimal prior knowledge of one interviewee. The interviewer placed a significant effort on building the relationship at the start of the interview to ensure the interviewee had enough time and opportunity to ask questions of the interviewer. The researcher used nods, agreements and slight interjections to indicate familiarity with many of the issues raised by the interviewer. As the interviews progressed and the researcher probed more deeply into previously raised topics, interviewees appeared to respond freely.

Results and Discussion
The issues that were common are listed below in order from most common to least. It should be noted that participants were asked to detail the key issues that were affecting The TSHO/their own workplace; hence there was often limited information on the positive aspects of the organisation.

Workload
This was the largest issue across all facilities/occupational groups. The majority of participants felt that there was excessive workload caused by a lack of funding, limited staff and changes to the nature of their work (i.e. more documentation or employees completing work that they do not feel completely competent with). It is possible that this finding is specific to the not-for-profit, public-serving industries, where “staff provide a considerable amount of unpaid overtime for the benefit of their patients and the existing public hospital system”, which they could not be expected to provide for private sector for-profit operators (AMA 1999, Sect. 4, as cited in Grbich, 2002).

Support
The amount of support ‘floor’ staff received from upper management was a concern. Employees often felt that there was adequate support from their direct managers and team members. They noted that in the majority of areas teamwork was exceptional and the level of support that team members provide each other was great. In many areas however, a significant lack of support was reported between upper management and middle management. A further issue was that there are limited opportunities for inter-team/discipline socialisation.

Training
Participants felt that there could be more opportunities for training in non-medical aspects of the organisation. Managers and administration staff in particular felt that they would be able to perform their roles better (e.g. give recognition to staff, provide support, use new technologies) if they had training in the relevant skills. For example, managers felt that they needed more training to deal with their teams more effectively. Often managers felt that they knew that they needed to recognise their employee’s efforts and the issues that may be affecting their work performance but felt that they lacked the skills necessary to do so. Participants noted that administration staff are required to do increasingly complex tasks with inadequate training to help them adjust. On a more positive note, participants said that there were ample opportunities for professional development within the medical staff. In particular opportunities such as mentoring programs that are available to early career staff within the nursing and allied health occupations were noted as having a positive impact on employee’s sense of support and satisfaction at work.

Staffing/Skill Mix
The staffing/skill mix was a major issue in all facilities. Interviewees felt that there was not the right mix of skills within departments (particularly nursing, midwifery and aged care). The main issue is with nurses and the need for more highly-skilled nurses to train and support the graduate or lower grade nurses. Some participants mentioned that due to the limited number of highly qualified staff, employees are increasingly required to do tasks that they do not feel completely competent in and ultimately end up feeling stressed. Most agreed that the root cause was a lack of (external, i.e., predominantly governmental) funding that is at the core of the issue, however, they also think that more experienced staff would ease some of the stress. Both staff and management would like more staff.

**Communication**

There are not really any problems with the level of communication that employees receive from their direct managers. The issue is mainly around how much information is passed on, and in fact how it is passed on, from upper management to the floor staff. Floor staff and occasionally middle management often feel that when they receive information about decisions that effect them it is too late for them to have any input. They felt that they could make positive differences in the organisation if they were given opportunities to influence decision-making.

**Recognition**

A common issue raised in the interviews was the level of recognition that staff receive. This was common across all employees whether they were middle management, senior employees or floor staff. Employees felt that overall they needed more recognition. Participants noted that verbal recognition would probably suffice, however they also noted that written recognition or recognition in terms of pay and benefits is needed, especially in the case of unpaid overtime and promotions. In particular, there seemed to be a need to recognise those who do large amounts of overtime.

**Pay**

Participants mentioned that there are a number of employees who are dissatisfied with the level of pay they receive. Many believe that they are not paid at a competitive rate. They also believe that if they were paid at a competitive rate then there would not be as many issues with attracting staff who are well qualified and who are willing to work harder.

**Resistance to Change/Dealing with Change**

There was a lot of mention of changes that have happened within The TSHO and the difficulties that employees felt with these. Participants mentioned that they were still uneasy about the changes in locations/management. Many of the interviewees, and the employees they were referring to, are still not certain for the reasons for the changes. Participants mentioned that there was a great deal of staff who felt insecure when changes were occurring and felt that greater communication would have put them at ease. Some participants also mentioned that employees can be resistant to changes, often because they are not fully aware of what will happen and why. In particular, some participants mentioned that there is a large cohort of nurses who have been with The TSHO for upwards of 20 years and so they are relatively resistant to change.

**Physically Dangerous Work**
Physically dangerous work is a source of stress for many employees. Participants mentioned that some employees are concerned about their physical safety when at work. They often feel threatened by patients and they often have to deal with people who are physically difficult to move which puts a strain on nurses/doctors.

**Values**
Within the various teams/professions/facilities the values are extremely important. They are what makes working at The TSHO something different from other places. This was something that was mentioned throughout the majority of the interviews. There is a perception that it is the values of the organisation that make it a special place to work (in contrast to public sector or for-profit facilities). This emphasis on believing-in and promulgating the organisation’s distinctive third-sector-based values helps to address the current distinct lack of empirical evidence available about the impact of these (potentially blurring) differences in motives and values between the sectors, especially at the employee level and in terms of management approaches (Carroll & Steane, 2000).

**Satisfaction with Work**
Participants mentioned that the majority of employees really feel a sense of satisfaction from their work. They said that they feel that they have made a difference at the end of every day and that this is a rewarding experience.

Across these main common issues a potential summarisation of the findings, with minimal researcher-intervention would be the juxtaposition of the issues and their apparent proximity to the employee. An example of the summary of these relationships, incorporating the metaphor of Lewin’s forcefield analysis is shown in Figure 2.

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**Figure 2. An Example of a Summary of the Issues Raised in terms of their Proximity to the Employee.**
Figure 2 represents a metaphor simply to aid the processing of the interrelationships between issues. The issues on the right hand side that have arrows pushing leftward tend to be negative issues and the issues on the left pushing right tend to be positive issues and in the case of the lack of recognition and providing training on non-medical issues - the issues are combined as they appear to be two sides of the same coin. Two trends arose from the analyses of the inter-relationships of the issues: (i) the covariate of degree of proximity to the employee and the importance of the issues, and (ii) the view that there were levers available for “someone” to fix the nursing shortage. The issues that are more proximal to the employee seem to be more important, whereas, working outward through the contained boxes the issues become more distal and potentially less critical to the employee. The dotted ellipse encapsulates the issues that the interviewees felt were the key levers for addressing or causing the nursing shortage.

Conclusion
Many of the drivers found in this study have been found in previous research (e.g., Cheung et al., 2004- unsupportive working environments, working hours and increased levels of stress and dissatisfaction). Notably, except for the macro-issues associated with staff shortages, none of the issues raised above appeared to be specific to the ageing nature of the health workforce (especially nurses) and nor was age raised as a specific issue (e.g. see Figure 1).

Although there may be similarities in the characteristics of organizations across sectors, several characteristics stereotypical of a TSO were found in this study (e.g., the importance of the organisation’s values, the willingness of employees to self-sacrifice in the face of demanding workloads) which tends to confirm the proposition that sector-ness is multi-dimensional not unidimensional (to apply Ferlie et al., 2003). Indeed, this third sector organisation may be a prime example of the hybridity of sector in hospitals (as per Brown & Barnett, 2004) where NPM-like forces and practices exist, yet so does the ethos of serving the public. If so, then this is empirical evidence highlighting a key characteristic of not-for-profit industries and goes some way to clarifying the alleged blurring of differences between the sectors, especially at the employee level (Carroll & Steane, 2000).

In conclusion, we would recommend that future research investigate the utility of a model that is likely to be powerful in this context, such as the Job Strain Model (one of the most widely-proven predictors of well-being, Fox et al 1993) or more comprehensive models that cover more of the issues above (e.g. Warr, 1990). The use of such surveys will allow researchers to determine how widespread these issues are within the health industry and allow the statistical analyses of the inter-relationships between variables.
References


