The Effects of Human Resource Autonomy and Decentralization on the Discrepancy Between Intended and Implemented HRM Practices: An Exploratory Study of Public Hospitals

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Abstract

Public sector reforms of the 1990's suggested to give managerial autonomy over employment relations to public sector organizations. However, in practice the continued dominance of government through government directives related to HR, limits the managerial discretion of top management. This leads to major challenges in terms of HRM decentralization within the organizations, further challenging the extent to which HRM practices are being implemented as originally intended. The study explored *if and how, in the presence of external constraints such as government HR directives, the level of HR autonomy of an organization affects its internal HR decentralization?; and to what extent this ultimately affects the discrepancy between intended and implemented HR practices?*

The research adopted qualitative approach to collect data from multiple sources including document analysis, a short complementary questionnaire and 70 semi-structured interviews with multiple hierarchical levels (top, middle and line management) in three public hospitals in Pakistan. NVivo qualitative research software was used for coding and analyzing the data. Drawing upon this multiple-case study, the result reveals that more HR autonomy of the organization, with less pressure to comply with HR government directives, may lead to high internal HR decentralization, ultimately reducing the gap between intended and implemented HR practices. It is also found that the leadership of top management plays a major role in the adoption of modern HR practices. The research suggests that when granting autonomy to public organizations, policy-makers should maintain a balance between the degree of autonomy and external influences.

The paper fits the conference themes: "HRM of professionals in today's society" as the study analyzes how varying level of autonomy influences the implementation of HR practices by management and medical professionals in public hospitals.

Key Words: HR autonomy, government directives, internal HR decentralization, intended and implemented HRM, Public hospitals

1. Introduction

The effectiveness and efficiency of public sector organizations have been increasingly questioned in the past few decades. This has led to several reforms, including restructuring public organizations by granting them managerial autonomy. Highly centralized, hierarchical organizational structures are replaced by a decentralized managerial environment with the aim of enhancing organizational performance (Christensen and Lægreid, 2001; Meyer and Hammerschmid, 2010). One aspect of managerial autonomy concerns human resource (HR) management, which allows a public organization to make and implement HR decisions according to its needs. The public sector, however, is known for its constraints on managerial autonomy, including conformity to HR government directives, detailed personnel policy regulations, and a traditional administrative role of HR (Kessler, Purcell and Shapiro, 2003; Rainey, 2009; Knies and Leisink, 2018). These constraints limit the managerial HR autonomy of top management, which according to Wynen, Verhoest and Rubecksen (2014), is consequently more inclined to centralize HR decision making at the top level of the organization. In other words, the extent to which the organization enjoys HR autonomy is expected to impact the degree to which HR responsibilities are further decentralized within the organization itself. In turn, decentralization of HR responsibilities within the organization is assumed to empower lower managerial levels to implement practices as intended (Knies and Leisink, 2014). As a result, it may reduce the discrepancy between intended and implemented HR practices in the organization (Khiliji and Wang, 2006), a topic on which a dearth of literature is available.

This led us to conduct an exploratory study, with the goal of answering the questions: *if and how, in the presence of external constraints, such as public personnel policies, the level of HR autonomy of an organization affects its internal HR decentralization?; and to what extent this ultimately affects the discrepancy between intended and implemented HR practices*?

The public health sector typically comprises a highly complex structure and is strongly influenced by government policies, which limit the hospitals' managerial autonomy to develop and implement HR policies proactively (Bach, 2001; Stanton, Young, Bartram and Leggat, 2011). This sector therefore becomes a critical case to explore the link between HR autonomy, external constraints and internal HR decentralization. Moreover, there are many studies that have explored the discrepancy between intended and implemented HR practices, but mostly in the private sector (see for example Khilji and Wang, 2006; Wright and Nishii, 2013; Makhecha, Srinivasan, Prabhu and Mukherji, 2016), with only a few studies recently being set in the public sector (Piening, Baluch and Ridder, 2014; Vermeeren, 2014; Op De Beeck, 2017). However, the effect of HR autonomy and decentralization on the discrepancy between intended and implemented HR practices have, to our knowledge, not yet been explored. Additionally, there is a call for studying HR practices through a more in-depth case-study approach, using a qualitative perspective (Stanton et al. 2011). In this exploratory research, we will, therefore, partially fill the gap by using qualitative case study data collected in three public hospitals in Pakistan, which is an under-researched country in terms of HRM reforms in public health-care.

2. Theoretical framework

2.1. HR Autonomy and HR Decentralization

Contemporary public sector reforms call for more organizational autonomy and further decentralization of managerial responsibilities within the organization to enhance organizational

performance (Pollitt and Bouckaert, 2004; Lægreid and Verhoest, 2010). One aspect of managerial autonomy concerns HR management. In that sense, the purpose is to enable top management to decide independently from external actors, such as political and administrative principals (Verhoest, Peters, Bouckaert and Verschuere, 2004), on the choice and use of human resources. According to Verhoest et al. (2004), the highest level of managerial autonomy takes place when the board of governors is free of any government representation and the organization's top management enjoys full autonomy to make and implement policies, according to the organization's needs without governmental interference. Once autonomy is granted to a public sector organization, the question arises as to what extent HR decision-making within the organization itself is centralized at the top level or decentralized to lower managerial levels. The extent of decentralization is defined here as the hierarchy of authority and the degree of participation by lower managerial levels, who ultimately implement HR policies, in actual HR decision-making (Carter and Cullen, 1984). This implies that implementers participate in HR decision-making, but they have no autonomy to make decisions on their own (Demmke, Hammerschmid and Meyer, 2006).

The structural contingency theory explains that one of the major factors upon which the organizational structure and the degree of internal decentralization is contingent is the extent to which top management faces external control (Agranoff, 2005; Tompkins, 2005). External constraints such as the need for compliance with public personnel policies and government directives related to HR, combined with strict control over financial and other resources, set limits on the managerial autonomy of top management (Truss, 2013; Rainey, 2009; Knies and Leisink, 2018). Consequently, decision-making authority may be more likely to be centralized at the top level in the organization. In contrast, when top management has more autonomy and is freed from bureaucratic regulations, it is more inclined to decentralize decision-making by involving lower managerial levels in decision making (Wynen et al. 2014). The decentralization is anticipated to lead to a more empowered, committed and motivated workforce (Zoghi and Mohr, 2011; Knies and Leisink, 2014), which is expected to enhance the efficiency and performance of the organization (Meyer and Hammerschmid, 2010).

2.2. HR Decentralization, Intended and Actual HR practices

Recent research, however, highlights the potential discrepancy between the HR policies as intended by the organization's top level and the actual HR practices implemented at lower managerial levels (Piening et al. 2014; Makhecha et al. 2016). Wright and Nishii's process model (2013) explains that the top management and the HR department are involved in designing HR policies. Khilji and Wang (2006) argue that organizational productivity and efficiency increase only if these intended HR practices are properly implemented in the organization. However, not all the intended HR policies are implemented and those which are implemented, often differ from the intended ones (Wright and Nishii, 2013).

Traditionally, the implementation of personnel management has been the primary responsibility of the HR department (Larsen and Brewster, 2003). With more HR autonomy and a decentralized organizational structure, the HR department can adopt a more strategic policy-making role and devolve responsibilities for HR implementation to middle and line management in the organization (Truss, 2008). Research argues that line managers should not only implement practices, but also

act as strategic partners and contribute in policy-making to achieve the implementation as intended (Ramachandra, Mansor and Idris 2011; Ulrich and Brockbank, 2005).

Research found that limited involvement of implementers in HR decision-making is the most frequently high-lighted reason for the discrepancy between intended and implemented HR practices (Khilji and Wang, 2006; Wright and Nishii, 2013; Makhecha et al. 2016). A logical assumption is that implementers' involvement in HR decision-making leads to a better understanding of intended HR policies, which ultimately guides them in the implementation of policies and reduces the gap between intended and actual HR practices (Khilji and Wang, 2006). Since participation in decision-making is an essential aspect of internal decentralization, the literature indicates that HR decentralization can positively impact the extent to which HR policies actually get implemented.

Therefore, investigating the effect of internal HR decentralization on the discrepancy between intended and actual HR practices becomes a reasonable premise.

2.2. Conceptual Framework

Based on the review above, *we aim to test the assumption that more HR autonomy of the organization (implying more autonomy granted to the top management by higher level government such as a parent ministry, and less external constraints such as pressure to comply with public personnel policies), leads to more internal HR decentralization (involvement of lower managerial levels in the HR decision making). In turn, internal HR decentralization is assumed to reduce the discrepancy between intended and implemented HR practices.* The conceptual framework used in this research is visualized in Figure 1.

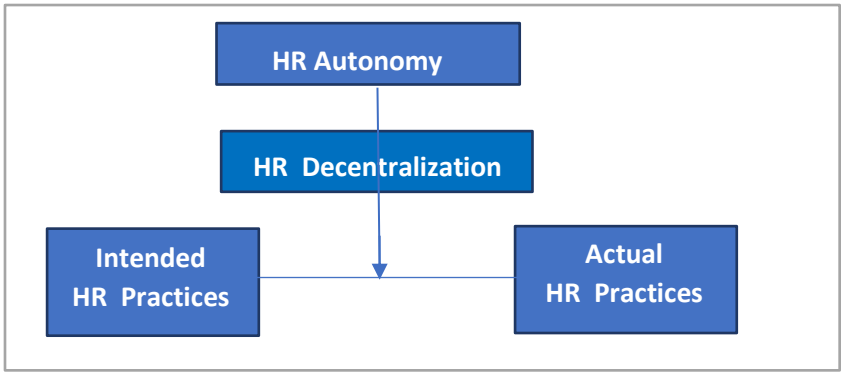


Figure 1: Conceptual Framework

There has been limited empirical evidence available on this premise. The present exploratory research aims to study the complex linkages through a case study in three public hospitals in Pakistan.

3. Methodology

A multiple-case study design was used to explore the complex linkage between the HR autonomy of the organization, external constraints, and internal HR decentralization, and the latter's impact on the discrepancy between intended and implemented HR practices. Furthermore, the study also identified perceived constraints in the implementation of HRM practices in the three hospitals. Below, we briefly introduce the background of public hospitals in Pakistan and discuss the case selection. Afterwards, we elaborate on the data collection and analysis.

3.1 Case Selection

Pakistan has a centralized administrative-politico system. Hospital autonomy reforms were initiated in 1998, however not officially implemented until the Devolution Act of 2001, as part of a structural adjustment program sponsored by the World Bank (Tarin, 2003). As part of these reforms, hospital governance was devolved from the federal government to the provincial level. Since the beginning of structural devolution in 2001, various hospital autonomy reforms were initiated in all four provinces of Pakistan, while major reforms were introduced specifically in the provinces of Punjab and Khyber Pakhtunkhwa (KPK). However, there is little empirical evidence available on the results of these reforms (Abdullah and Shaw, 2007). In order to address this gap, we study one large general public hospital in Peshawar, the capital of KPK province, and two large general public hospitals in Lahore, the capital of Punjab province.

Since we aim to understand the impact of different levels of autonomy on internal decentralization, the cases selected differ in terms of their level of autonomy. We compare two hospitals in Lahore which have a similar level of autonomy, to one hospital in Peshawar which has a higher level of autonomy. While differing in terms of actual autonomy granted, we purposely selected similar cases regarding their status, their size and their level of specialization, with all three cases being large general public hospitals. The purpose of this selection is to identify the differences in internal decentralization and implementation of HR practices across the three cases and to understand, if such differences relate to distinct levels of actual autonomy granted to these hospitals.

3.2 Data Collection and Analysis

Data collection was based on semi-structured interviews, a complementary questionnaire, and document analysis. A total of 60 semi-structured interviews were conducted with key actors in the three hospitals studied. Respondents from three managerial levels were consulted. Top management, more specifically the Hospital Medical Director, the Medical Superintendent and the Principal, were consulted on their perception of the level of autonomy provided to the hospital. In addition, a complementary questionnaire, specifically on HR autonomy, was administered to cross-check information. This questionnaire was adapted from the COBRA survey – a standard questionnaire used to measure the level of autonomy in public organizations (see Verhoest et al. 2004). In order to gain insight into the intended HR practices, HR policy makers and government officials were interviewed in the three hospitals. These policy makers included the HR Director, the Assistant Medical Superintendent, the Deputy Medical Superintendent and government officials from the health department. Additionally, autonomy acts and HR policy documents, both from the provincial government and from within the hospital, were reviewed to explore the intended HR policies. To understand actual HR practices implemented in the hospitals, eight departments with similar specializations were selected in the three cases. In each of these

departments, key actors who implement HR practices were interviewed, including Heads of Department (HOD) and first-line managers. Respondents were also asked about the perceived constraints in implementation of HR practices. Similarly, for internal HR decentralization, both the top management and key actors who implement HR practices were consulted.

Additionally, since the employment arrangements of hospitals in the Punjab province are determined by the Punjab Health Department (Department of Provincial Government) and other regulatory bodies (Suhail and Azhar, 2016), ten interviews were conducted with key informants from the Punjab Health Department. In contrast, autonomous public hospitals in KPK are given full autonomy to make and implement their own HR policies with no influence from the Provincial Ministry of Health. Hence, we did not consult the KPK Ministry of Health. Using multiple data collection methods and sources allowed us to gain a full range of perspectives and to cross-check information, to reduce potential biases and to enhance validity (see table 1 below)[1].

In our research, we focus on one specific field of HR practices, i.e., performance management, since all three hospitals studied are involved in implementing employees' performance assessments. In the two hospitals in the province of Punjab, other HR functions such as recruitment, selection, training and career development are directly administered by the Punjab Health Department.

	Top Management	**HR Policy Makers**	**HR Implementers (HOD and First-line managers)**	**Total number of interviews**
Case 1	2	5	8 +5	20
Case 2	2	4	8+5	19
Case 3	3	3	9+6	21
Punjab Health Department	Punjab Policy Makers and Implementers			10
				70

Table 1: Total Number of Interviews

The data was analyzed in two stages. First, the interviews were transcribed. Second, coding was done based on the themes established in the interview guides, using NVIVO qualitative research software. When new themes emerged from the data analysis, they were also considered. Finally, case similarities and differences were observed and interpreted.

[1] The majority of the interviews were recorded with the permission of the interviewees, and debriefing was done at the end of each interview.

4. Results

Since the level of autonomy granted to the hospitals is different in the two provinces, we discuss them separately to better understand the impact of HR autonomy on internal decentralization and the discrepancy between intended and implemented HR practices. First, we report the results of the study of Case 1, a public autonomous hospital in Peshawar, in the Khyber Pakhtunkhwa (KPK) province. Afterwards, the results of the two public autonomous hospitals in Lahore, in the Punjab Province, are discussed together. We indicated any observed differences between the hospitals and shared the contradictory perspective of the Punjab Health Department (Provincial Government).

4.1 Case Study 1(CS1) – Autonomous Public Hospital in Peshawar – KPK Province

4.1.1 Level of HRM Autonomy

Containing approximately 1760 beds, CS1 is one of the largest public autonomous hospitals not only in Peshawar, but also in Pakistan. The hospital is governed by a Board of Governors (BOG), comprised of six members. All members of the board are non-governmental officials, appointed by a selection committee constituted by the government, including medical professionals, retired officers and practitioners from the health sector.

The hospital was given full HR autonomy under the Medical Teaching Institution (MTI) reform Act (2015). Table 2 shows the level of autonomy in the development and implementation of HR for each of the employment categories: civil servants, institutional employees, and Medical Teaching Institution (MTI) employees.

Category of Employees	Develop HR Policy	Implement HR Practices
Civil Servants	No Autonomy – Follows Public Personnel Policies	No Autonomy - Follows Public Personnel Policies
Institutional Employees	Full Autonomy	Full Autonomy
MTI Employees	Full Autonomy	Full Autonomy

Table 2: Level of Autonomy to Make and Implement HR Policies and Practices. (Source: Questionnaire from Top Management)

The first employment category includes civil servants, who were hired by the government before 2002. They were recruited as civil servants[2] through the Public Service Commission (PSC), a provincial body that appoints all public employees. The hospital cannot make nor implement HR policies addressing these employees except for performance assessment. Middle managers in the hospital can only implement public personnel policies as outlined at the health department at provincial level. The second category, institutional employees, were hired by the Institutional Management

[2] These are permanent doctors recruited through Public Service Commission and following standard public personnel policies. Although they do not strictly adhere to the internationally used concept of 'civil servants', for clarity we use the term 'civil servants' in our analysis as this is also the way these permanent doctors are addressed by the hospital.

Committee (IMC) of the hospital in the period 2003 to 2015. The hospital was given autonomy to make and implement HR practices for this category of employees, however the KPK health department was involved until 2015. The third category includes MTI employees, who were hired by the hospital after the MTI Act 2015, and for whom, the hospital has full autonomy to make and implement HR practices. After the implementation of the MTI Act 2015, the new board of the hospital replaced the IMC and has full autonomy to make and implement HR policies for both institutional and MTI employees. The civil servants' category still follows its own system. Because there is only a very small group of civil servants (5%) in the hospital, we focus our analysis on the HR management of institutional and MTI employees.

4.1.2 Decentralization in the Hospital

Before the MTI Act, there was no formal HR department in the hospital, and the general administration performed all HR functions. Since 2015, when HR autonomy was given to the hospital, the top management established a HR department and decentralized HR decision making to lower managerial levels. The HR director indicates he assists in operationalizing HR policies, educating implementers, listening to their needs and providing advice on employment relations. Interview respondents found top management and the HR director motivated to adopt modern HR practices and to encourage open communication in the hospital. This is reflected in the following comment:

"Lower managerial levels are empowered by top management through an open-door policy, one-to-one communication and consultation, providing full support and commitment in implementing HR practices. (HOD – H.2)

4.1.3 Intended HR Policies

According to the hospital's HR manual and the interview with the HR director, performance management is an important practice in the hospital. Besides the job description, objectives for each job must be set at the beginning of the year in consultation with the supervisor. Central to performance appraisal is a one-page form that needs to be completed by both employee and supervisor, based on the day-to-day activities of the employee. The head of the department should countersign it and send it to the HR department by the end of each year. A department promotion committee, consisting of the head of the department, the dean, and the head of the institute should be established, which evaluates all reports and makes recommendations to the board for promotion and incentives. If an employee meets the eligibility criteria, he/she must be promoted without waiting for a vacant seat. Salary and reward systems should be set according to the performance within the given budget of the hospital. For institutional employees, except for promotion and compensation, all other practices are the same. According to the HR director: " We are trying to make and implement the same policies for MTI and institutional employees."

4.1.4 Implemented HR Practices

As with the intended HR policies, largely the same procedures are followed in HR practices for establishing performance objectives and performance appraisals. Performance appraisal is considered an important practice for open discussion between employees and supervisor. All the reports are reviewed by the department promotion committee, and recommendations are made to

the Board for salary increments, incentives and promotions. A respondent highlighted that this system is more efficient as compared to previous systems.

"*Promotions are not based on seniority or vacancy-based as in the old system. The Department Promotion Committee must meet even for one eligible candidate and give their recommendation to the board."* (HOD – H.3)

Despite these indicators of implemented HR practices closely following intended HR policies, respondents who are responsible for implementing HR think that hospital criteria for promotion are too high and should only be based on minimum criteria of the Pakistan Medical and Dental Council (PMDC) and College of Physician and Surgeon Pakistan (CPSP)[3].

However, there are some differences between MTI and Institutional employees concerning performance management. For institutional employees, the salary increment and promotion are fixed according to the previous policies made by the Institutional Management Committee (IMC) before MTI ACT 2015, which are still followed in the hospital.

4.1.5 Discrepancy Between Intended and Implemented HR Practices

The following table shows the intended and implemented process concerning personnel performance management in the hospital.

Process of Performance Management	**Intended Practices as outlined in the documents & explained in the interview with the HR Director**	**Implemented HR Practices as described by HOD's and first-line managers**
Performance Targets	Performance objectives are set in the beginning of the year.	Performance objectives are set in the beginning of the year.
Performance Appraisal	Single page form records day to day performance	Single page form records day to day performance
Promotion	Promotion based on evaluated performance based on both PMDC and hospital's criteria for MTI. Institutional employees don't follow hospital criteria.	Promotion based on evaluated performance based on both PMDC and hospital's criteria for MTI. Institutional employees don't follow hospital criteria and their promotion is delayed.

[3] Medical regulatory bodies develop minimum acceptable criteria for recruitment, selection and promotion, which is followed nationally for all categories of medical employees.

Compensation and Rewards	Compensation based on performance within the limits of hospital budget. For Institutional employees, compensation is standard and given by the government.	Compensation based on performance within the limits of hospital budget. For Institutional employees, compensation is standard and given by the government.

Table 3: Performance Management as Intended and Implemented in Case 1 for MTI and Institutional Employees

We found a low discrepancy between intended HR policies and practices implemented by HOD in the hospital. For institutional employees, promotions are not exactly followed as intended because they still follow policies made by the previous board, wherein the hospital doesn't have enough seats to give them promotions.

According to employees, there is open communication between the HR department and different actors, who implement HR practices (middle and lower managerial levels). It should be noted that the HR department considers the proposals of line managers in developing new practices.

"Whenever I go to the HR director with my proposal, he listens to me carefully and always considers it. (First-line managers- H.3)

Some institutional department heads, however, perceive that not all implementation staff is involved in HR decision-making, which causes implementation problems. As reflected in the following comment:

"*Top management has a biased attitude in employee engagement, because not all HOD are on board [with the vision of the top management]. Sometimes, we face problems in implementation, but cannot communicate them."* (HOD- H.4)

4.1.6 Perceived Constraints in the Implementation of HR Practices

A major constraint in the implementation of HR practices pointed out in the interviews, is the resistance to change as employees want the best of both systems, the old civil servant system and the new MTI system.

"*Employees want to do cherry-picking from both systems (MTI and Civil), which leads to several challenges during implementation."*(HR Department)

Another constraint faced by the hospital is the simultaneously performing two different practices. On the one hand, the hospital follows public personnel policies for civil servants. On the other hand, the hospital makes its own HR policies for MTI employees, according to the needs of the organization.

"*We find it very challenging to implement policies for civil servants, as they belong to the old system (government rules). But for our employees (MTI and Institutional), we have introduced more strategic HR in the hospital."* (Top Management- T.2)

Not only does this make the system complicated and burdensome for the HR department, but also for line managers, who perceive that rapid changes in the intended practices are introduced by top management without proper training of implementers.

"There is a need to train and educate implementers about the benefits of introducing new HR practices. Once they understand, they will adapt more easily." (HOD- H.8)

4.2 Case 2 and Case 3: Autonomous Public Hospitals in Lahore, Punjab Province

4.2.1 Level of HRM Autonomy in the Hospital

CS2 and CS3 are two large public hospitals containing 1700 and 1560 beds respectively. They were both officially declared autonomous in 2001 under the Punjab Medical and Health Institution Act (PMHI) 1999. Currently, the Medical and Health Institution Reform Act (PMHI) 2003 is practiced in these hospitals. According to this act, the hospitals are governed by a Board of Governors (BOG), comprised of six members, of which four are government officials and two are private sector individuals (e.g. a medical professional and a retired officer). The BOG has limited powers to make administrative and financial decisions (PMHI, 2003).

Category of Employees	**Develop HR Policy**	**Implement HR Practices**
Permanent	No Autonomy – Follows Public Personnel Policies	No Autonomy - Follows Public Personnel Policies
Contractual	No Autonomy - Follows personnel policies for contractual employees	No Autonomy - Follows personnel policies for contractual employees

Table 4: Level of Autonomy to Develop and Implement HR Policies and Practices (Source: Questionnaire from Top Management)

The table above shows the level of autonomy in the development and implementation of HR for each of the two main employment categories, permanent and contractual personnel, in both hospitals. Permanent employees are recruited through a central body, the Punjab Public Service Commission. All public personnel policies such as recruitment, selection, training, salary, promotions and reward systems are centrally administered and are also implemented by the Punjab Health Department (Punjab Service Rules, 2004), with the exception of employees' performance assessments, which hospitals implement by following public personnel policies.

Contractual employees are recruited by the hospitals. Like permanent employees, policies for contractual employees are also made by the Punjab Health Department; and implemented by the hospitals by following personnel policies for contractual employees. However, there is a minimal number of contractual employees in both hospitals. Having to follow government rules and procedures, leaves hospitals with limited autonomy to implement HRM for both permanent and contractual employees, clearly substantiated by the following comment:

"*In fact, there is no autonomy. All the practices are highly centralized and controlled by the Health Department. All HR functions must follow a complex plethora of state regulations and*

lengthy procedures under strict rules. If we do not follow them, several sanctions will be imposed on the hospital." (Hospital Administrator- CS2.1).

According to respondents from the Health Department, public hospitals are not capable of generating their own revenue, and therefore, cannot be given full autonomy. Similarly, they think that HR policies maintain standardization, while sanctions help in monitoring and control. The following comment best describes this:

"Public autonomous hospitals rely on government budget; therefore, they cannot be fully autonomous. Through government directives, we monitor public hospitals and impose sanctions, if they don't follow rules properly. Without consequences, every hospital could make its own rules and there would be no standardization." (Health Department - Officer1)

4.2.2 Internal HR Decentralization in the Hospital

We found that the internal structure of the hospitals is centralized, and the hospitals follow public personnel policies given by the Health Department. The hospitals have no formal HR department and the hospital administration assumes HRM responsibilities in both hospitals. The Medical Superintendent, who is the administrative head of the hospital, acts as a disseminator of HR information from the Health Department to the hospital. However, the top management understands the need for having a HR department that can adopt modern HR practices, but feels restricted and inclined to work in a traditional manner.

"The Health Department doesn't like modern HRM practices nor allow us to establish a HR Department, that can work according to the needs of the organization, which would increase efficiency. Even if we give proposals for adopting modern HR practices, it is not encouraged by the Health Department and they show resistance. Getting approvals for minor things and following government directives limits our ability to be creative" (Top Management – CS3.1)

In contrast, the Health Department states that all HR practices are kept under their control, because they feel that hospitals don't have qualified HR staff, nor the budget, to establish a HR Department.

Despite having the same structure, there exist differences in perceptions of respondents across the two hospitals, related to the leadership of top management. In CS2, the top management is perceived to be more supportive as compared to CS3, which also affects the internal structure of the organization.

"Top management is very supportive, yet I think sometimes they are powerless to respond to all queries. They only approve things which are of high priority and within the hospital budget." (HOD – CS2.4)

"*Everything depends upon the leadership of top management. Sometimes we get top management support, while other times they don't listen to our demands*." (HOD – CS3.8)

This in fact is supported by interviews with the Health Department, as they indicated that leadership at the hospitals is decisive.

"*I think that hospitals have their own hierarchy and follow chains of command according to their own structure. Strong leadership at top management determines the structure of the organization*." (Health Department – Officer 4)

For the implementation of HR practices, we found internal decentralization to a certain extent in both cases. For permanent employees, HODs are involved in HR activities, such as filling out Annual Confidential Reports (ACR) and sending their recommendations for promotions. Due to lack of a HR department in both hospitals, there is no direct support provided to the line management. Remaining implementation of HR activities is carried out by the Health Department as mentioned earlier.

4.2.3 Intended HR Policies

According to the Public personnel policy manuals (made by the Punjab Health Department) and the interview with actors in the Punjab Health Department, HR policies related to performance management, such as promotion, salary increase, compensation or dismissal/transfer are centralized, and are developed and implemented by the Health Department. However, the performance assessment is implemented by the reporting officer (HOD) in the hospital, following personnel policies. Performance management tends to be a rigorous annual assessment activity. The Performance Evaluation Report (PER), also known as the Annual Confidential Report (ACR), is an appraisal tool that determines rewards. Each employee must set targets at the beginning of the year in consultation with the reporting officer. Appraisal forms should be completed by the reporting officer, counter-signed by the head of the institution and sent to the Health Department. Promotion should be based on standardized criteria for each grade level; based not only on performance, but also on seniority, eligibility and vacant seats. Different reward schemes exist, such as an employee of the month, preparatory leave for retirement or encashment leave for compensating employees.

4.2.4 Implemented HR Practices

The respondents interviewed in the two hospitals shared that appraisal is an annual obligatory practice, to comply with public personnel policies, and yet it is done just as a formality and not directly linked to performance. Generally, there are no performance objectives set for employees in the beginning of the year, with doctors vaguely aware of employee duties (interview-First line manager CS2). An appraisal form is filled out by the employee and evaluated by the reporting officer, which is usually the head of the department. It is then counter-signed by the head of the institute and sent to the Health Department for promotion and compensation. The actual implementation process is found to be consistent in both cases as they follow standard personnel policies given by the Health Department.

"*The Performance Evaluation Report (PER) is a standardized form for all government employees, not specific for medical professionals, which does not record the day-to-day performance of doctors. Appraisal forms are filled out as a ritual, which has no link to performance.*" (HOD - CS2.5)

The Health Department finalizes the promotion, based on seniority, eligibility criteria and the number of seats available in each grade level. However, major flaws are highlighted by the following interviewee.

"*There is a standard criterion for promotion, but it is not implemented properly. Everything depends on the discretion of the Health Department. Even if we are eligible, we cannot get promotions, due to a lack of vacant seats. Delayed promotions decreases our motivation to work hard.*" (HOD- CS3.4)

We found contradictory views of respondents in the Health Department, where it is stated that promotion is delayed because few candidates are eligible, and often there are no vacant posts available in the hospitals where doctors are currently employed. If there is a vacant seat in a small city, no one wants to get that promotion and doctors request to stay in their current position, which further delays promotion.

"*We check vacant posts in the province of Punjab, and wherever it is available, we try to give promotion to doctors. However, doctors in large cities want regular promotion in their own district to keep their private practice, therefore, they do not accept promotion in smaller cities. As a result, they stay in their respective cadre for longer periods than intended*." (Health Department- Officer 8)

Salaries and increments are standardized and include minimal benefits. According to interviewees, doctors have to do private practice, due to low salaries.

"We all receive standard government increments annually, regardless of our performance evaluation. Salaries are low, as compared to the inflation rate; therefore, we have to do private practice. If salaries are increased, I doubt anyone would still continue private practice".(HOD-CS3.8)

In contrast, the Health Department thinks that as doctors earn dual incomes from combining government jobs and private practice, they often neglect their government jobs and are found to be more inclined to do private practice, since they earn more from it.

4.2.5 The Discrepancy Between Intended and Implemented HR Practices

Table 5 shows the process of performance management intended, and its implementation as perceived by the Health Department and implementers in both hospitals in Lahore, Punjab.

Process of Performance Management	**Intended Practices (as outlined in the documents & interviews in the Punjab Health Department)**	**Implemented HR Practices (as describe by the Punjab Health Department)**	**Implemented HR Practices (as described by Hospital administration, HOD, and first-line managers)**
Performance Targets	Targets are set in the beginning of the year in consultation with the reporting officer.	Targets are given by the HOD. Even if no targets are given, doctors know their duties.	No performance objectives are made, employees vaguely know their work.

Performance Appraisal	Appraisal is an annual activity and intends to be a rigorous exercise.	Filled appraisal forms are sent by the hospital annually.	Mostly done as an obligatory practice annually.
Promotion	Promotion is standardized and eligibility criteria are strictly followed.	Promotion is standardized and eligibility criteria are strictly followed. Promotion is irregular due to non-eligibility, lack of vacant seats, and unwillingness of doctors to move to other hospitals.	Promotions are mostly irregular. Criteria are not followed properly, and promotion mainly depends on discretion of the Health Department.
Compensation and Rewards	Several rewards schemes are practiced based on performance.	Standard increments are linked to performance (e.g., if one receives a negative performance (s)he does not receive any increment).	Standard increments are not linked to performance.

Table 5: Performance Management as Intended and Implemented in CS2 and CS3

The table clearly shows a discrepancy between the intended and implemented HR practices as perceived by both the Health Department and hospitals, yet also highlights different views on how HR policies are actually implemented. According to respondents in both hospitals, the discrepancy exists because the Health Department, which makes the policies, neither communicates with the hospitals, which implement them, nor with the hospital's staff. As a result, policies tend to be implemented according to the implementers own understanding, rather than actually intended. As described in the following comment by hospital administration in case 2 and confirmed by case 3:

"As supervisors (HOD) are involved in the implementation of HR practices, they fail to implement them properly, primarily due to limited understanding of policies. Difficulty increases due to lack of communication and support from the Health Department." (Hospital Administration – CS2.1).

The implementation officer of the Health Department also has similar views:

"Policy makers do not explain the policies nor communicate with us. We implement them based on our understanding of the policies. Of course, sometimes it differs from the intended because of the situation." (Section officer1- Health Department).

4.2.6 Perceived Constraints in the Implementation of HR Practices

There are several constraints in the implementation of HR practices. Findings show that hospitals follow centrally-controlled personnel policies and send reports to the Health Department, often causing delays and loss of data. There is a lack of autonomy and high dominance of the Health Department, which controls the entire HR process. The following comments best describe this:

"*The hospital has no HR autonomy and we have to go to the Health Department for small issues, which should be resolved within the hospital. Since there is a lack of communication between the hospital and the Health Department, sending a request to the Health Department and hearing back from them sometimes takes 3-5 months, resulting in delayed decisions.* (Hospital Administration – CS2.5*)*

Furthermore, the entire HR system including the performance evaluation is manual in both hospitals, which increases both paperwork and chances for human error and biases, resulting in high dissatisfaction.

"*I have seen people retiring as senior registrars (grade 18), because they never got promotions, either due to biased evaluations by supervisors, lost ACR reports, or no vacant posts available in their entire career. Can you imagine that in the 21st century, we are still working manually? Of course, this all leads to a highly dissatisfied workforce".* (HOD – CS3.6)

In contrast, respondents in the Health Department perceive the incompetence of top management is the major constraint in implementation of HR practices in the hospitals. Respondents state that the hospital heads do not have the right education to handle HR issues. Moreover, they indicate that doctors don't want to adopt modern HR practices, because they like to enjoy benefits of government employees, especially lifetime job security.

5. Discussion

In this section, we will compare the three cases studied and answer the research questions based on the findings.

Dimension	**Case 1**	**Case 2 and 3**
Level of HR Autonomy	High	Low
Number of Members of the Board of Governors, and Government Representation in it.	Six members, all from the private sector.	Six members: four are government representatives and two are from the private sector.
Compliance with HR Government Directives	Low	High
Degree of Internal Decentralization	High	Low
Discrepancy Between Intended and Implemented HR Practices	Low	High
Perceived Constraints in Implementation of HRM	High resistance to change, and running a new and old system simultaneously	Lack of real autonomy, manual system and dominance of the Health Department.

Table 6: Results of the Study

5.1 Level of HR Autonomy and Presence of External Influence

In comparing these cases, the first objective of the research was to explore the level of HR autonomy in the hospitals, following Verhoest et al. (2004), who argued that the highest level of autonomy is when the Board of Governors (BOG) is independent of any government representation, and the organization has full autonomy to make and implement policies according to their needs without governmental interference. Results reveal that CS1 has more HR autonomy as compared to CS2 and CS3, since it has low representation of government officials in the Board of Governors (BOG) and a low level of HR government directives with which to comply.

5.2 Impact of HR Autonomy and External Influence on Internal HR Decentralization

Second, we focus on internal HR decentralization. CS1 has more HR autonomy with less pressure to follow public personnel policies. The top management has established a more strategic, decentralized HR system extending to lower managerial levels. Top management and the HR director are found to be motivated to adopt more modern HR practices and to decentralize the HR system to enhance the performance of the organization. A possible explanation, following Wynen et al. (2014) is that top management is freed from bureaucratic control, faces less pressure from the government to comply with public personnel policies and is, therefore, more likely to involve lower managerial levels in HR decision making.

In contrast, CS2 & CS3 have no formal HR department. All the HR responsibilities are carried out by the Health Department and only performance assessment is implemented by the Head of the departments in the hospital. Top management has centralized the decision-making and has kept the hierarchical control in its hands. Our findings seem to be in accordance with previous literature (see Truss, 2008; Rainey, 2009; Wynen et al. 2014) since in these hospitals low HR autonomy and high external influence to follow public personnel policies seems to lead to low HR decentralization.

However, comparing CS2 and CS3, we found that even with similar degrees of organizational autonomy and external constraints, there is a difference in internal decentralization. Our results indicate that the leadership of top management might have an important role herein. In CS2, top management is perceived to be more supportive and to listen to the needs of the employees, resulting in a structure of the organization which is less rigid as compared to CS3.

5.3 Effect of Internal HR Decentralization on the Discrepancy Between Intended and Implemented HRM

Third, we analyzed the extent to which there is a discrepancy between intended and implemented HR practices in the hospitals. In CS1 the HR director makes the policies according to the needs of the organization. Implementation staff are not only involved in HR decision-making, but also have full support, resulting in a comparatively low discrepancy between intended and implemented HR practices for hospital employees. However, institutional employees hired before the MTI Act 2015, think that not all implementers are included in HR decision-making and perceive this causes some problems in implementation.

On the contrary, CS2 & CS3 follow standard public personnel policies given by the Health Department, which are not perceived as being according to the needs of the hospital. There is

limited involvement of line management in the HR policymaking and a lack of communication between policy-makers and implementers, resulting in policy being implemented according to implementers' own understanding rather than according to the intention of policy makers. In both hospitals, this seems to result in a high discrepancy between intended and implemented HR practices, especially as perceived by actors in the hospitals. Interviewees from the Provincial Health Department hold distinct views, but admit that sometimes HR policies don't get implemented as intended.

The comparison of our data across the three cases supports the assumption that a higher level of internal HR decentralization leads to lower discrepancy between intended and implemented HR practices.

5.4 Perceived Constraints in the Implementation of HR Practices

Fourth, through the interviews, we identified some additional constraints in the successful implementation of HR practices, which increase the gap between intended and implemented HR practices. In CS1, the major constraints perceived are resistance to change, lack of training provided to implementers, and the implementation of dual (old and new) systems simultaneously resulting in increased complexity for the HR department.

In CS2 & CS3 the major constraint from the hospital perspective is lack of autonomy because of the high involvement of the Health Department in HR policymaking and implementation. Additionally, however, considerable red tape persists, due to the need for compliance with standard public personnel policies and reliance upon a manual system. All these are perceived as increasing the dissatisfaction among employees. From the Health Department's perspective, in contrast, the major constraints in the implementation of HR practices identified, are the incompetence of top management and the resistance of doctors to adopt modern HR practices.

6. Conclusions and Contributions

Based on the study of three public hospitals in Pakistan, our data supports the assumption that more HR autonomy provided to an organization, with less pressure to comply with public personnel policies, may lead to high internal HR decentralization (involvement of lower managerial levels in decision making), ultimately reducing the gap between intended and implemented HR practices. The hospital studied in Peshawar seems to fit this description. On the contrary, in the two Lahore-based hospitals studied, where low HR autonomy was combined with high pressure to comply with public personnel policies, we found low internal HR decentralization, negatively affecting the gap between intended and implemented HR practices. Additionally, we found that when the organization follows standard public personnel policies which are not based on the needs of the organization itself, the gap between the decision-makers' intent and that of the implementers' is likely to increase. Even if the line managers perform HR functions, their lack of involvement in decision-making and the limited support from policymakers at centralized government levels increases the gap between intended and implemented HR practices. Finally, stepping beyond the theoretical framework which combined insights on HR autonomy, decentralization and implementation of HR policies, our data suggests that another factor at play in the actual adoption of modern HR practices is the leadership of the top management. The latter

more specifically references the extent to which middle and lower managers perceive they are supported by top management in implementing HR policies.

The main contribution of this article is the provision of empirical evidence from a developing country perspective on the complex linkage between the level of HR autonomy provided to an organization, compliance with public personnel policies, internal HR decentralization within the organization, and the impact on discrepancies between intended and implemented HR practices. Moreover, the study contributed to the call for qualitative research, using a multiple-case study approach in public hospitals, still a little researched area (Stanton et al. 2011; Wynen et al. 2014). At the practical level, our findings suggest that when granting autonomy to public hospitals, policy-makers should maintain a balance between the degree of autonomy and external influences. Leadership training should be given to the top management and should be encouraged to involve implementers in HR decision-making. For effective implementation, regular HR trainings should be organized.

Despite the contributions above, the study has some limitations. First, this is an exploratory study, based on the perception of respondents regarding HR autonomy of one specific HR practice (performance assessment) based on three cases (hospitals) set in one country, and one policy sector. Therefore, we cannot claim generalizability of our results. Additionally, comparing two hospitals from one province with a third hospital from another province also creates the ambiguity that, rather than being due to the level of autonomy granted to the hospitals, results may be due to other differences in the provincial context. However, having collected data from interviewees at different managerial levels in three large public hospitals in two different provinces and from officials of Punjab provincial government, our study provides a reasonable understanding of the general linkage between organizational autonomy, internal decentralization, and HR policies and practices. Our research indicates that leadership style of top management, including political will and cultural context, can be considered to strengthen the general framework. Future research, thus, could not only expand the number of cases and adopt quantitative methods to achieve generalizability, but could also include leadership style as an important factor, influencing the relationship between managerial autonomy and responsibilities, on the one hand, and implementation of HR policies on the other hand.

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