The Effects of HR Autonomy on the Discrepancy Between Intended and Implemented HRM Practices in the Public Sector: An Exploratory Study of Public Hospitals in Pakistan

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Abstract

Public sector reforms in the 1990's suggested that more strategic choice and managerial autonomy over employment relations should be given to public managers. However, the continued dominance of government through government directives, accountability measures, performance management and resource allocation limit the managerial discretion and strategic choice of HRM in public sector organizations. This leads to a major challenge during the process of HRM decentralization, resulting in HRM practices not being implemented as originally intended. This is true for the public health sector, which has a highly complex structure and a strong influence of government policies that further limit the organizations' (i.e., the hospitals') managerial autonomy to effectively adopt and implement HRM. However, very little academic research is available on effective HRM policies and practices to improve public service delivery, especially in the context of public hospitals.

The study provides an empirical understanding of the causal complexity between the HR autonomy of the organization, external control and internal HR decentralization which ultimately affects the gap between intended and implemented HR Practices. Furthermore, the study identifies the perceived constraints of middle and line management in implementing HR practices. A qualitative research approach is employed to collect data from multiple levels (top, middle and line management) in two autonomous public hospitals in Pakistan through document analysis, semi-structured interviews and a short complementary questionnaire. The result reveals that more HR autonomy of the organisation with less external control can lead to high internal HR decentralization, which may improve the implementation of HR practices by reducing the gap between intended and actual HR practices. The study suggests to focus on a balanced approach between organizational HR-autonomy and external control to achieve better results.

Key Words: HRM autonomy, public personnel policies, internal HR decentralization, intended and implemented HRM, public hospitals

1. Introduction

The effectiveness and efficiency of public sector organizations is increasingly questioned which leads to several reforms. Since the last few decades, New Public Management (NPM) has been a popular administrative reform, and one of its doctrines is a disaggregation of units in the public sector (Hood, 1991). The core idea of this doctrine is that of giving managerial autonomy to public sector organizations to increase their efficiency and effectiveness, while being subject to performance contracting (Pollitt and Bouckaert, 2004; Lægreid and Verhoest, 2010). At the same time, public sector organizations face external control such as result control, accountability, strict adherence to government directives, and even red tape, that limit the managerial discretion of top management. In addition, it is argued that more organizational autonomy is expected to lead to more internal decentralized organizational structures and increased managerial autonomy for lower hierarchical levels (Ingraham, 2005; Meyer and Hammerschmid, 2010), while more external control will increase the need for centralization (Wynen, Verhoest and Rübecksen, 2014). Due to the presence of external control, top management may impose internal hierarchical control and limit the discretionary power of middle or lower managerial levels to develop and implement policies according to the needs of the organization. This entails that although public organizations are given managerial autonomy in the presence of external control, they often still function under "old" bureaucratic forms with very little managerial discretion given to lower hierarchical levels (Wynen et al., 2014).

One aspect of managerial autonomy concerns human resource management, which will be the focus of this study. Human resources are the backbone of every organization. Effective and efficient managing of human resources is a serious concern in the public sector (Truss, 2013). It is argued that effective management of HR can only be possible when HR policies are made according to the needs of the organization. Public sector reforms in the 1990's suggested that more strategic choice and managerial autonomy over employment relations should be given to public organizations. As stated above, it is expected that more HR autonomy at the organizational level will lead to an internal decentralized structure, giving managerial autonomy to HR and lower managerial levels with regards to the development and implementation of HRM (Meyer and Hammerschmid, 2010). As a result, less discrepancy between intended and implemented HR practices is expected. *However, the question arises as to how much autonomy the HR department actually has to develop and implement HR policies.*

This issue is especially interesting in the case of the public health sector. As such, the public health sector has a highly complex structure and a strong influence of government policies, which limits the organizations' (i.e., the hospitals') managerial autonomy to develop and implement HRM policies proactively (Bach, 2001; Stanton, Young, Bartram and Leggat, 2011). However, very little academic research is available on effective HRM policies and practices to improve public service delivery (Knies and Leisink, 2018) even more so in the context of hospitals, especially in developing countries. Rees (2013) argues that core HR activities in the public sector can be similar in both developed and developing countries, yet the challenges and constraints on the public sector in developing countries are likely to be radically different. Therefore, we aim to study public hospitals in Pakistan, an example of a developing country, to explore **how the level of HR autonomy of the organization (in the presence of external control, e.g.: government directives) affects the internal HR decentralization, and to what extent this ultimately affects the discrepancy between intended and implemented HR practices.**

There has been a gap in exploring the link between HR autonomy, external control and internal HR decentralization especially in the public health sector. 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) and recently few studies in the public sector (for example: Piening, Baluch and Ridder, 2014; Vermeeren, 2014). However, the effect of autonomy on the discrepancy between intended and implemented HR practices has still not been explored. Additionally, there is a call for a more in-depth case study approach from a qualitative perspective (Stanton et al., 2011; Wynen et al., 2014). In this research, we will, therefore, try to partially fill the gap using qualitative case study data from two public hospitals in a developing country, namely Pakistan which is an under-research country in terms of HRM reforms in public health-care.

2. Theoretical Framework

2.1 HR Autonomy and External Control

Traditionally, the public sector is recognized as a highly centralized and rigid hierarchical system which leads to several reforms. Among many other public sector reforms, NPM has been quite a popular one that focuses on a combination of reforms such as managerial autonomy, structural disaggregation, decentralization and agencification. The core idea of the reforms is structurally disaggregating the public organization from the parent ministry by extending managerial decision-making authority to the organization and making it subject to performance contracting (Pollitt et al., 2004). As a result of granting organizational autonomy, NPM claims to enable public sector organizations to replace their highly centralized, hierarchical organizational structures by a decentralized managerial environment, where managers are given more decision-making autonomy, which at the same time is believed to enhance organizational performance (Christensen and Lægreid, 2001); Gregory, 2003). There are several sceptical views about the success of NPM reforms, however, which often call for re-centralization or de-marketization (Lægreid and Verhoest, 2010; Mikuła and Kaczmarek, 2018). Additionally, the generalizability of NPM reforms is doubtful particularly in developing countries (Manning, 200; Drechsler, 2005).

One possible explanation is that public organizations superficially take on the characteristics of the NPM style structure. In reality, public sector organizations are never given full autonomy, they are always controlled by external constraints (Dan, 2015). The external control affects not only the autonomy of the organization (granted by the parent ministry to the top management) but also the internal decentralization within the organization (granted by top management to middle and lower management) (Wynen et al., 2014). Some examples of external control are strict adherence to government directives, result control, performance and accountability measures, etc. (Kessler, Purcell and Shapiro, 2003; Truss, 2008; Verhoest et al., 2004). However, in this study, we will focus on one specific external control, which is strict adherence to government directives related to HR, because it is expected to directly influence HR autonomy (both in terms of development and implementation of HR practices) and often lead to red tape. For example: in the context of HRM, public sector organizations have to follow government directives (e.g. formal procedural rules for hiring, selecting, training and performance management, etc.), all of which limit the flexibility of the HR policy makers to make policies according to the needs of the organization. Moreover, this also leads to unnecessary rules which require excessive paperwork and unjustifiable

delays, a common term of red tape (Bozeman, 2000). As a result, these burdensome rules negatively affect organizational performance (Rainey, 2009; Brewer and Walker, 2010a).

Tompkins (2005), for example, argues that procedural rules and formal reporting tend to reduce the timeliness of hiring decisions and limit the ability to reward the best worker, which ultimately denies the flexibility and decision-making ability of management within the organization to actually follow and implement these rules and regulations. Research claims that releasing the organization from these burdensome rules and providing them flexibility would enhance performance (Knies and Leisink, 2018). However, sometimes these procedural rules also serve as standardization and provide equal employment opportunity which is the aim of public sector organizations as model employers (Vermeeren, 2014). Based on the literature, *we assume that external control such as strictly following government directives leads to red tape and becomes a constraint for organizational autonomy and limits the internal decentralization in the organization*.

According to Verhoest et al. (2004) organizational autonomy is defined as the extent to which an organization can decide independently of its political and administrative principals on the choice and use of resources, and thus, also refers to the managerial decisions senior managers can make. It is then referred to as managerial autonomy. They define two types of organizational (managerial) autonomy concerning decision making: one is HR managerial autonomy, and the other is financial managerial autonomy. In this study, we will focus on HR autonomy that is the autonomy of an organization (e.g., hospital), or more specifically the head of the organization, to make and implement decisions concerning human resources without government interference. With regards to internal HR autonomy in the organization there are two main, interrelated concepts: internal HR decentralization and HR devolution. Decentralization has a different meaning in a different context, in this paper we will focus on vertical decision-making decentralization. In this sense, by internal HR decentralization we mean the extent to which HR, middle and lower managerial levels in the organization are involved in HR decision making (Rainey, 2009; Wynen et al., 2014). HR devolution is defined as the transfer of HR responsibilities from the HR specialist to middle and line management (Hall & Torrington, 1998, Op de Beeck, 2017). Both these concepts are essential to discuss when referring to HR autonomy in the organization.

2.2 Internal HR Decentralization

Once the autonomy is transferred to the public sector organization, the question arises to what extent HR decision making is centralized at the top level or decentralized to lower managerial levels. It is expected that decentralized managerial autonomy of the middle or lower level management in decision making will enhance the efficiency and performance of the organization (Ingraham, 2005; Meyer and Hammerschmid, 2010). Also, it is argued that more organizational autonomy is expected to lead to more decentralized organizational structures, while more external control will increase the need for centralization (Wynen et al., 2014). Structural contingency theory, for example, explains that organizational structure and the degree of internal decentralization are contingent upon the degree to which top managers are subject to external control (Agranoff, 2005; Tompkins, 2005). Research found a clear relationship between external control and decentralized managerial autonomy within the organization, the higher degree of external control the greater likelihood that authority is centralized at the top and vice versa (Pugh et al., 1969; Wynen et al., 2014). This is because the external control of public organizations is

imposed "systemwide" and not concentrated to one managerial level. However, even with a similar degree of organizational autonomy, there may be a difference in internal HR decentralization within the organization, because it is dependent on the discretion of top management and level of external control.

With regards to HRM, there are different roles played by managers at different levels to integrate and manage human resources in the organization. The HR department in consultation with top management develops the policies and sets out the strategic direction of HR functions. The lower-level management translates them into practice by implementing the policies and performing day-to-day employee management activities (Gilbert, Winne and Sels, 2011). As a result, it is expected that HR functions are tailored to the specific needs of the organization, with less complex procedures and faster decision making. Consequently, this is expected to increase organizational performance, efficiency and effectiveness by giving flexibility to the managers to manage.

It is argued that HR functions improve the performance of the organization when adopting a more proactive (strategic) role. HR department do not have to consign to the administrative role by applying government rules and following directives. Instead, they can make and implement policies according to the needs of the organization (Truss, 2008). This can only be possible when top management decentralizes the HR autonomy to lower – level management and includes them in the decision-making process. As a result, the HR department can further devolve HR responsibilities (implementation) to middle and line management and adopt a more strategic role (policy making) in the organization. In this way, HR can act as a consultant for other managerial levels to help integrate HRM into the organization and ensure that HR practices are implemented as intended, leading to higher organizational productivity and efficiency (Khilji and Wang, 2006). *However, the major question arises to what extent HR functions are actually decentralized or devolved to middle or lower managerial levels in the presence of external control (e.g. government directives).* HR policymaking in the organization can be very centralized and made at the top level, but implementation may be done at the middle or line manager levels. On the contrary, HR policies can be decentralized to the lower managerial level, but due to strict procedural rules and regulations, may middle and line management have less autonomy to perform HR functions. Research however reveals that managers with more autonomy to make and implement HR policies can have a strong impact on performance. For example, managers that have the power to select new employees will also know how to make them work to achieve the goals of the organization (O'Toole and Meier, 2014; Knies and Leisink, 2018).

This means that the level of HR autonomy impacts the HR policies (intended) made at the top managerial levels and HR practices (implemented) by lower managerial levels. To help understand this impact, Wright and Nishii (2013) developed an interesting model that explains the discrepancy between the HR policy that is intended and the implemented HR practices. The model also assumes that not all intended HR practices are implemented and that those which are implemented often differ from the intended ones.

2.3 Intended HR Policies

Wright and Nishii (2013) explain that intended HR practices are the outcome of HR strategies that attempt to design an HR system to motivate employees to improve organizational performance. Several actors are involved in designing HR policies such as top management and HR and middle

management. When developing HR practices, the decision makers proactively analyze the situation and induce that these intended practices will produce the desired outcomes, as a reaction of employees, for organizational success. Furthermore, the model claims that these policies could be determined by extraneous influences (Wright and Nishii 2013). In the public sector context, such external influences for example may include the organization following standard public personnel policies, even if these are not always according to the needs of the organization (Nasi, 2011).

2.4 Actual HR Practices

Actual practices mean HR practices implemented in the organization. It is argued that organizational performance increases only if HR practices are properly operationalized, integrated and implemented in the organization (Khilji and Wang, 2006). The goal of implementing HR strategy is to institutionalize intended HR practices in the organization, that may give consistent employee performance across the organization (Wright and Nishii, 2013).

Implementation of HR practices is done by several actors (the HR department and line managers) in the organization, who translate and communicate intended HR practices and bring them to action. Traditionally, HRM implementation was the primary responsibility of the HR department (Larsen and Brewster, 2003). In modern HRM, however, line managers are formally involved in implementing HR practices, because of their close connection with employees and potential to influence employees' behavior (Poole and Jenkins, 1997; Andersen, Cooper and Zhu, 2007). This is also referred to as HR devolution. Recent studies also acknowledge the role of different line managers: such as top, middle and front-line management in implementing HR practices in the organization (BOS-Nehles, 2010; Op de Beck, 2017).

Thus, HR and different line managers are responsible for implementing HR practices in the organization, and if managed effectively, the synergic effect of their efforts ultimately enhances the performance of the organization (Papalexandris, 2005; Chen, Hsu and Yip, 2011). It is important therefore to see how practices are implemented, which ultimately effects employees' perception, reaction and performance.

2.5 The Discrepancy Between Intended and Actual HR Practices

The SHRM model of Wright and Nishii (2013) explains that intended HR practices developed by the HR department in consultation with top management often are different from the actual practices implemented. The empirical evidence shows discrepancy is due to several factors such as limited discretion to implement practices, personnel red tape, organizational communication, lack of people-oriented competencies and commitment, leadership style, management skills, time capacity, several actors who implement HR practices not being consistent in their implementation efforts, etc. (Wright and Nishii, 2007 Lansbergen, 2010; Fahrenholz, 2011; Gilbert, Winne and Sels, 2011; Piening, Baluch and Ridder, 2014 and Makhecha et al., 2016). In public sector organizations, the implementation of standardized public personnel policies has always been problematic due to a huge gap existing between the intention of policy makers (government) and the implementation of practices (organization) (Nasi, 2011). Thus, lack of involvement of implementers in the policy-making may lead to high discrpancy between intended and implemented HR practices.

Based on the review above, *we assume that more HR autonomy of the organization with less external control leads to more internal HR decentralization. Moreover, the internal HR decentralization is assumed to reduce the discrepancy between intended and implemented HR practices.* There has been little empirical evidence available on this aspect. The present study will be one of the first studies that will explore this causal complexity between the HR autonomy of the organization, external control, internal HR decentralization and discrepancy between intended and implemented HR practices qualitatively. The conceptual framework used in this research is presented below.

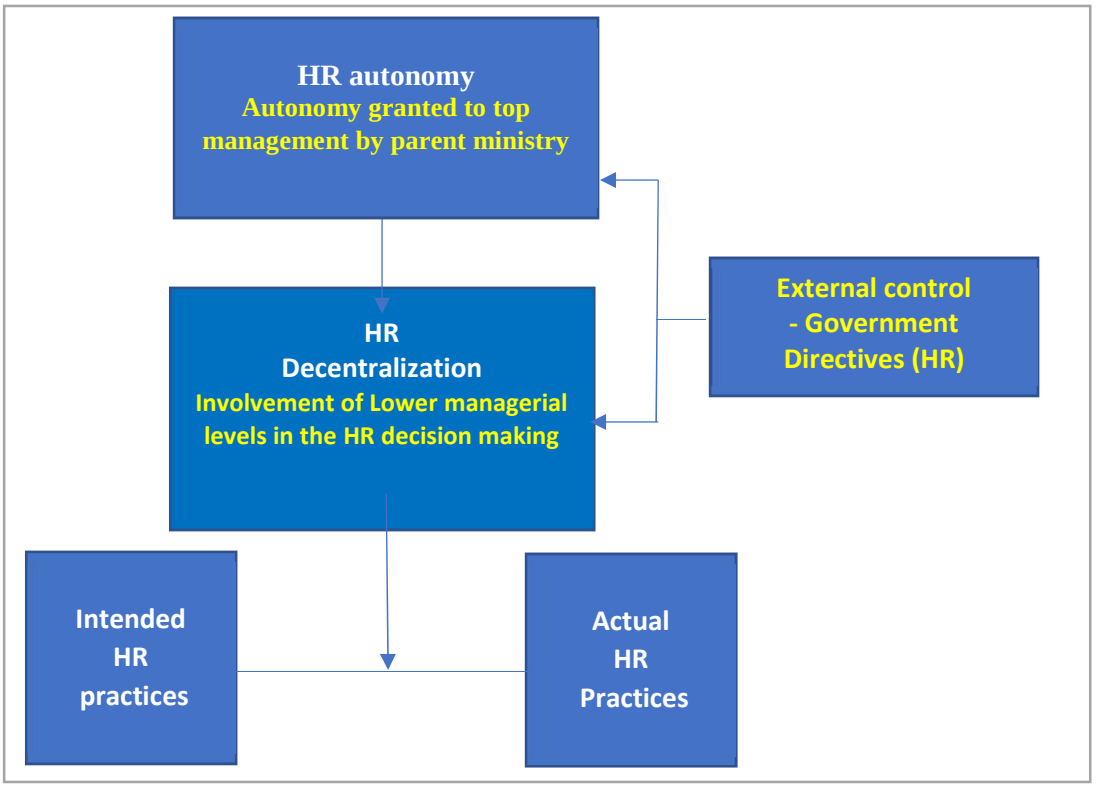


Figure 1: Conceptual Framework

3. Methodology

In this study, we employed a multiple-case study design that provides detailed empirical evidence and rich opportunities for generating new insight into the research area. A qualitative research approach was used for collecting and interpreting the data on the effect of HR autonomy on internal HR decentralization, and possible effects on intended and actual HR practices. Below, we briefly introduce the scenario of the Pakistan's public hospitals and discuss the case selection. Afterwards, we elaborate on the data collection and analysis.

3.1 Pakistan Scenario and Case Selection

Pakistan is a centralized administrative-politico system. Hospital autonomy reforms were initiated under 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 autonomy was structurally devolved from federal government to provincial government in which teaching medical hospitals were declared autonomous under their respective provincial acts.

Since the beginning of structural devolution in 2001, various hospital autonomy reforms were initiated in all four provinces of Pakistan, yet major reforms were introduced in the province of Punjab and Khyber Pakhtunkhwa (KPK). In Punjab, employment arrangements are now determined by the Ministry of Health (MOH) and other regulatory bodies (Suhail and Azhar, 2016). KPK initially had a similar system controlled by the Ministry of Health (MOH). Later in 2015, all managerial functions were devolved to the hospital board (MTI Act, 2015). However, there is little or no empirical evidence available on the results of these reforms (Abdullah and Shaw, 2007). Moreover, both provinces have different provincial governments that require empirical evidence on the development of hospitals reforms. Therefore, in this study, we will compare HR autonomy in autonomous public hospitals in these two provinces in Pakistan. We selected one large autonomous public hospital from Lahore (capital of Punjab) and another one from Peshawar (capital of KPK) for comparison.

The first case study is the largest general (tertiary care) public hospital in Peshawar, in the province of KPK. It was given autonomy under the Medical and Health Institutions Reforms Act 1999. There have been several hospital reforms, yet the Medical Teaching Institute (MTI) reforms in 2015 brought revolutionary changes in the structure of the public hospital in KPK. Hospitals were given full autonomy to make decisions and implement them according to the needs of the organization, both financially and managerially. As a result, the hospital introduced a more decentralized organizational structure under MTI Act 2015 (KPK Medical and Teaching hospital Reform (Amendment) Act, 2015).

The second case study is the largest general (tertiary care) public hospital in Lahore, in the province of Punjab. It was given autonomy under the Medical and Health Institution Reform Act (MHI) 1999. Currently, the Medical and Health Institution Reform Act 2003 is practiced in this hospital. Based on the reports, the hospital is declared an autonomous public hospital.

We purposely selected similar cases in three aspects regarding status (autonomous public hospitals), category (general hospitals) and size (large). This selection approach increases the comparability of our cases since it will allow us to analyze within similar context (public autonomous hospitals).

3.2 Data Collection Method:

The study used a combination of qualitative research methods for data collection. These methods involve semi-structured interviews and document analysis including reports on autonomy and HR policy and procedure manuals. In addition, a small complementary questionnaire was sent to the top management of each hospital to measure the level of HR autonomy. The measure for HR

autonomy was adapted from Zahra and Jadoon (2016) according to the requirement and relevance of this study.

In this exploratory research, actors from different levels of the organization were included to measure the level of autonomy, internal HR decentralization, intended and actual HR practices. More specifically, one respondent from each level was interviewed due to limited time and acessability. It will be expanded across the organizational hierarchy in further research to gain deeper understanding. Top management (Hospital Director and Dean) was consulted on the level of autonomy through interview and a complementary questionnaire. For intended HR practices, HR policy makers (HR Director and Assistant Medical Superintendent) were interviewed and HR policy documents were reviewed. For actual HR practices, two respondents who implement practices were interviewed (Head of the Department (HOD) and the Supervisor). All interviews were recorded with the permission of the interviewees and debriefing was done at the end of each interview. A separate interview guide was prepared for all three managerial levels (top management, HR policy makers and line managers).

	Top Management	**HR Policy Makers**	**HR Implementers**	**Total number of interviews**
Case 1	1 Respondent Hospital Director	1 Respondent HR Director	2 Respondent Head of the Department and Supervisor	4
Case 2	1 Respondent Dean	1 Respondent Additional Medical Superintendent	2 Respondents Head of the Department and Supervisor	4

Table 1: ***A Total Number of the Interviews in Both Cases***

3.3 Data Analysis:

The data were analyzed in three stages. Firstly, interviews were transcribed. Secondly, patterns and themes were generated. Later, coding was done based on the themes established in the interview guide and new themes emerged from the data using NVIVO qualitative research software. The process was followed for each case to draw similarities and differences across cases. Finally, the interpretation was given based on data analysis.

4. Results and Findings

4.1 Case study 1 (CS1)

4.1.1 Level of HRM Autonomy in the Organisation

CS1 is one of the largest public autonomous hospitals in Pakistan, which contain approximately 1760 beds. The hospital is governed by the Board of Governors (BOG), comprised of 5 members. All the members of the board are non-governmental officials appointed by the selection committee. The hospital was given full HR autonomy under the Medical Teaching Institution (MTI) reform Act 2015.

Level of HR Autonomy According to Employee Categories:

Category of employees	Autonomy to make HR policy	Autonomy to implement HR practices
[1]**Civil servants**	No	To some extent within the rules of government directives
Institutional	Yes	Yes
MTI	Yes	Yes

Table 2: Level of Autonomy to make and implement HR policies and Practices

The table above shows the level of HR autonomy related to the three categories of employees. The first category includes civil servants, who were hired by the government before the MTI ACT. They are called civil servants because they were recruited through the Public Service Commission, a provincial body that appoints all public employees. The second category includes institutional employees, who were hired by the hospital in 2003. At that time, the hospital had limited autonomy to perform HR functions. The third category includes MTI employees, who were hired by the hospital after the MTI Act 2015, when hospital had full HR autonomy.

After the MTI Act 2015, all employees (civil and institutional) were given the option to choose MTI or remain in their respective cadre. A majority of the employees from both categories opted for MTI, while only a few civil employees chose to remain in their respective cadre.

As top management commented: "*We have given options to all employees to choose among their respective cadre or MTI, 95% chose MTI while 5% of the civil servants opted to remain in their respective category*." (interview).

The table also shows that the hospital has full autonomy to make HR policies and implement them after approval from the board specifically for institutional and MTI employees. However, the hospital cannot make policies for civil servants but can instead implement them by following government directives. All employees, except the civil servants' category, follow HR policies and practices made by the hospital (questionnaire from top management).

4.1.2 Decentralization in the Hospital:

Before the MTI Act, there was no formal HR department in the hospital, and the administration performed all HR functions. Since 2015, when full HR autonomy was given to the hospital, the top management established an HR department and decentralized the managerial autonomy to lower managerial levels. Currently, the hospital has a strategic HR system, where the HR director develops HR policies according to the needs of the organization, and then implementation responsibility cascades down to lower managerial levels (middle and line managers). The HR director assists in educating the implementation staff and in operationalizing HR policies, listens to their needs and provides advice on employment relations. It is indicated by respondents during

[1] 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.

the interview that top management and the HR director are found to be motivated to adopt modern HR practices and to encourage open communication in the hospital.

As the line manager stated: *"Lower managerial levels are empowered by top management through open-door policy, one to one communication, ensuring employees' involvement and providing full support and commitment in implementing HR practices. HR provides support in implementation and the resolution of all complaints from department heads and supervisors."*

The hospital does not face external control to follow government directives concerning HRM specifically for MTI employees. It is because the hospital develops HR policies and implement them after approval from the board members without government interference. However, it is not the same for civil servants as stated by HR director: "*The hospital has to face several constraints for the civil servants who still follows government directives for all HR functions which leads to excessive paperwork and lengthy procedures"*.

4.1.3 The Discrepancy Between Intended and Implemented HR Practices:

Specifically related to performance management, the hospital has full autonomy for MTI employees to make policies related to salary, incentives, promotion and dismissal of employees and implement them accordingly. In contrast, the hospital has no autonomy to make policies for the civil servants. Instead, they follow government rules and directives for pay, promotion, incentive and dismissal/transfer (questionnaire from top management).

4.1.4 Intended HR Policies

Performance Management is an important practice in the hospital, especially for MTI employees. "We consider performance appraisal an important practice for open discussion between employee and management." (Interview with the HR director). Central is performance appraisal is the one-page form that needs to be completed by the supervisor based on the day-to-day activities of the employees. The head of the department should countersign it and send it to the HR department by the end of each year. For promotion, a department promotion committee 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 system should be according to the performance objective of employees within the given budget of the hospital.

4.1.5 Implemented HR Practices

It is highlighted by the HR director during the interview that the supervisor gives high importance to performance management. In addition, supervisors indicated that they evaluate employees using a performance appraisal form on a monthly basis and compiling an annual report, which is sent to the HR department by the end of each year. The Department Promotion Committee reviews all reports and makes recommendations to the Board for salary increments, incentives and promotions. "*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."* (interview with line manager). Salaries and rewards are based on the results achieved by the employees.

We found a low discrepancy between intended HR policies and practices implemented in the hospital for MTI employees (based on the document review and interviews). We found that written HR policies in the document are very similar to the practices performed by middle and line managers.

Findings of the study also shows that implementation staff are involved in HR decision making. The HR department considers the proposals of middle and line managers in developing new practices. We found a strong open communication between the HR department and the different managerial levels.

As highlighted by the middle manager (HOD): *"Whenever I go to the HR director with my proposal, he listens to me carefully and always consider it."*

Also, the open-door policy is encouraged in the hospital between top management, the HR department, middle management (HOD) and line management (supervisors). As indicated by the middle manager: *"Anyone can directly email their concern to the top management or HR department"*.

However, for civil servants, we found a high discrepancy between intended and implemented HR practices.

4.1.6 Perceived Constraints of HR Managers/ Administration in the Implementation of HR Practices

One of the major constraints found in the implementation of HR practices is resistance to change, as employees want the best of both systems (old civil servant system and new MTI). The HR director commented that: "*Employees want to do cherry-picking from both systems, which is not acceptable*. This leads to several challenges during implementation."

Another constraint faced by the hospital is performing dual practices simultaneously. On the one hand, the hospital follows public personnel policies for civil servants. On the other hand, for MTI employees, the hospital makes their own HR policies, which are according to the needs of the organization. It makes the system complicated and burdensome for the HR department. As top management indicated: "*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), we have introduced more strategic HR in the hospital"*.

4.2 Case Study 2: (CS2)

4.2.1 Level of HRM Autonomy in the Organisation

CS2 is also one of the largest public hospitals in Pakistan, containing 1700 beds approxmiately. The hospital was given autonomy in 1999 under the Punjab Medical and Health Institution (PMHI) Act 1998. The hospital is governed by a Board of Governors (BOG), where the majority of members are government officials. According to the Act, the hospital was given all powers to make administrative and financial decisions (PMHI, 2003).

Category of employees	Autonomy to make HR policy	Autonomy to implement HR practices
Permanent	No	To some extent within the rules of government directives
Contractual	To some extent within the rules of government directives	To some extent within the rules of government directives

Table 3: Level of Autonomy to make and implement HR policies and Practices

The table above shows that the hospital has two main employment categories, permanent and contractual. Permanent employees are recruited through a central body – Punjab Public Service Commission. All public personnel policies are centrally administered such as recruitment, lifetime employment, salary, promotions and reward systems by the government. The hospital only implements HR practices according to the rules and regulations of the government. For contractual employees, the hospital can make policies by following the rules and regulations of government and implementing them accordingly (questionnaire from top management). However, there are a very minimal number of contractual employees in the hospital.

As indicated by top management: "*Our hospital doesn't have the autonomy to make HR policies instead we follow public personnel policies. We have to follow government rules and regulations for implementing HR practices, because if we do not follow them, several sanctions will be imposed on the hospital*" (interview).

4.2.2 Internal HR Decentralization in the Hospital

The hospital has no formal HR department, and the hospital administration assumes HRM responsibilities. Since the hospital has limited autonomy and also faces high external control (government directives) to implement policies, the top management is reluctant to establish a formal HR department. Therefore, the internal structure of the hospital is very centralized, and top management is personally involved in HR tasks. As indicated by hospital administration: "*The top management of the hospital is reluctant to establish a formal HR department because they think it is not needed.*" Middle and line managers are involved in HR activities such as filling out Annual Confidential Reports (ACR), sending their recommendations for promotions and updating the administration about the vacant seats.

We found that the Medical Superintendent (MS) is the top manager, who controls all the practices and ensures that all government rules and regulations are followed at different hierarchical levels". As middle managers highlighted that: "*Top management has created more Standard Operating Procedures (SOP's) to ensure compliance with the government policies."*

4.2.3 The Discrepancy Between Intended and Implemented HR Practices

Specifically related to performance management, the hospital has no autonomy to make policies related to performance evaluation, promotion, salary increase or dismissal/transfer. There is a high discrepancy between intended and implemented HR practices. We found the public personnel policies of the government are different from what is perceived and implemented by the implementation staff.

4.2.4 Intended HR Policies

Performance management intends to be a rigorous exercise and annual activity through which performance is gauged. The Performance Evaluation Report (PER), also known as an Annual Confidential Report (ACR), is an important tool for development of a balanced approach between actual performance and rewards. Promotion, training, deputation, refresher courses and ex-Pakistan leave are dependent upon the evaluated performance mentioned in the ACR / PER. It needs to be filled according to the approved and notified job responsibilities and duties of the incumbents. Promotion is based on standardized criteria for each grade level mentioned in the provincial government policy documents.

Evaluated performance of employees mentioned in the PER/ACR has a distinct impact on salary increment, rewards and compensation. Fixation of salary or pay is the responsibility of a specific pay commission. Reward schemes such as an employee of the month, leave preparatory to retirement or leave encashment, benefits given by the Punjab Government Servants Housing Foundation and the Punjab Benevolent Fund are practiced.

4.2.5 Implemented HR Practices

Performance management is done just as a formality and not directly linked to performance. It is an obligatory practice done annually because of the compliance with government directives; not all reports are analyzed and evaluated regularly. "*ACR is a standardized form for all government employees not specific for medical professionals which do not record the day-to-day performance of doctors*." (interview with middle management). Salary is based on government rules which includes minimal benefits. However, no incentives are given based on performance evaluation. The Ministry of Health (MOH) finalizes the promotion based on seniority and the number of seats available in each grade level. The hospital has no autonomy to give promotion or incentives. This means a junior employee will not be promoted due to seniority-based promotion; even he is eligible. It was indicated by interviewees that due to lack of proper promotion and evaluation system employees are demotivated to work harder.

We found a high discrepancy between intended and implemented HR practices. Data from both the interviews and the questionnaire shows that the government makes HR policies which are followed in the hospital and implemented by the hospital administration and line managers. Also, because government HR manuals are outdated, as indicated by the middle manager (HOD): "The m*ajority of the HR policies are outdated and not directly linked to performance. However, we still have to follow government rules and regulations to avoid sanctions*".

Another reason is that the hospital has a more centralized system, because top management makes all the decisions about HR without any involvement of lower managerial level. Although line managers are involved in the implementation of HR practices, they fail to implement them properly, due to their lack of involvement in the decision-making process. In addition, line managers are found to be demotivated to perform HR responsibilities.

Hospital administration stated that: "*Supervisors are often reluctant to perform HR related tasks, in that they think it is not their duty.*"

4.2.6 Perceived Constraints of HR Managers/ Administration in the Implementation of HR Practices

There are several constraints in the implementation of HR practices. Respondents reported the major challenges are lack of autonomy, centrally-controlled HR policies and regulations, lengthy and excessive paperwork to follow government procedures (red tape), outdated policies and the lack of motivation of line managers.

The lengthy rules and procedures related to HR, which are mostly outdated, make the system slow. This means considerable "red tape" persists when following lengthy rules and regulations that adds little value to the system. As indicated by the line manager: "*The hospital has to follow complex legislation and instructions for the implementation of HR policies, which are very outdated, and many times, very time-consuming."*

Moreover, line managers receive insufficient support from top management and hospital administration, that results in a lack of motivation to perform HR functions. However, the hospital administration thinks that: "G*overnment directives (SOP's) which are followed by every public organization makes the procedure standardized."* (interview with hospital administration). It indicates that the government impose several SOP's to maintain the image of a model employer.

5. Discussion

In this section, we will compare the two cases studied and answer the research question based on the findings. The result indicates the link between the degree of autonomy, external control and internal HR decentralization in the organization. Moreover, our results indicate an effect of internal decentralization on the discrepancy between intended and implemented HR practices. In the theoretical framework, we assumed that a high degree of organizational autonomy and low external control would lead to higher internal HR decentralization, ultimately reducing the gap between intended and implemented HR practices. We will see this in two autonomous public hospitals in Pakistan.

Dimension	**Case 1**	**Case 2**
Number of Board of Governors and Government representation in it.	Five members and all from the private sector (Medical professionals, retired officers, practitioners from the health sector)	Seven members in which five are government representatives and two private sectors (medical professional, a retired officer and others)
Level of autonomy	high	low
The Degree of Internal Decentralization	high	low
Presence of External Control	low	high

The Discrepancy Between Intended and Implemented HR practices	low	high
Perceived Constraints in Implementation of HRM	Resistance to change, running new and old system simultaneously, employees want the best of both systems.	Lack of real autonomy, high compliance with government directives, red tape, outdated system and lack of motivation of line managers

Table 2: Results of the Study

5.1 Level of Autonomy and the Presence of External Influence

In comparing these cases, the first point is the level of HR autonomy of the hospital. Verhoest et.al., (2004) argue that the highest level of organizational autonomy takes place when the Board of Governors (BOG) is independent of any government representation, and the organization enjoys full autonomy to make and implement policies according to their needs without the interference of the government. Results reveal that CS1 has more HR autonomy as compared to CS2.CS1 has the highest level of HR autonomy, as all powers to make financial and administrative decisions are given to the Board of Governors (BOG), which is independent and has no representation from government. Low external control of compliance with government directives resulted in higher autonomy to make and implement HR practices according to the needs of the organization. In contrast, CS2 has a low level of autonomy. This hospital is also governed by a Board of Governors (BOG), yet the majority of the members are government representatives. CS2 has no autonomy to make HR policies. Instead, it has to strictly follow government directives for all HR practices.

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

Findings of the study reveals that CS1 has high HR autonomy and less pressure to follow government directives. Accordingly, CS1 has a more strategic HR system with decentralized HR autonomy extending to lower managerial levels. The HR director is empowered to make policies in consultation with top and lower managerial levels. As a result, the HR department has devolved implementation of HR function to line managers. Based on the data a causal linkage could be seen between high HR autonomy and less external control and more internal HR decentralization. Additionally, internal HR decentralization also depends upon the leadership style of top management and the expertise of the HR department, which influences the internal structure of the organization. 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 is that when top management is freed from bureaucratic control and faces less pressure from the government to comply with procedural rules and regulations, they are inclined to decentralize decision-making authority related to salary level, evaluation and promotion.

In contrast, CS2 has low HR autonomy and high external control, based on the data it seems to lead to low HR decentralization. CS2 has no formal HR department and all the responsibilities of the HR are carried out by the hospital administration and line managers. Due to the lack of autonomy and the heavy pressure to comply with government directives relative to HR, top

management has centralized the decision making and has kept the hierarchical control in their hands. Our findings seem to be in accordance with previous literature who found that with less autonomy of the organization and more pressure to comply with government directives, the autonomy of top management is limited, as a result further keeping the control in their hands by adding more hierarchical control on the lower managerial levels (Tompkin, 2005; Wynen et al., 2014).

Wynen et al., (2014) claim that organisation size and age play a significant role in internal decentralization. The old organisations have a stronger identity than younger ones and are thus less likely to decentralize internally. However, in our study, we found that wihle the two cases studied are of similar size and age, their internal decentralization is different. The reason could be because CS1 has been recently given full autonomy after several amendments in the autonomy act. Therefore, the hosptial is able to decentralize HR autonomy to lower managerial level. In contrast, CS2 is following the autonomy act of 2003 which has fewer amendments and provides less autonomy. Consequently, the rules are rigidly followed in the hospital which makes it more centralised. Thus, in our study, we found that differences in degree of internal decentralization are not linked to size and age of the organization, but instead are more associated with degree of autonomy given to the organization and external control.

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

CS1 has a higher degree of internal HR decentralization, where the HR director makes the policies in consultation with top and line management. Moreover, the HR department has empowered line managers to implement policies by extending their full support. Also, an open-door policy is encouraged in the hospital, as well as the involvement of implementation staff in the decision-making process, resulting in a low discrepancy between intended HR policies and HR practices. Khilji and Wang (2006) argue that HR can act as a consultant for different managerial levels to help integrate HRM into the organization and to ensure that HR practices are implemented as intended. .

On the contrary, CS2 has a low degree of internal decentralization where top management controls the policy implementation and gives no autonomy to the lower level management. There is high internal centralization due to pressure from the government to follow their rules and regulations strictly. This might be explained by there being limited communication between top management and lower managerial levels and a lack of support provided to line managers to implement HR practices. As a result, there is a high discrepancy between intended and implemented HR practices. Another explanation is that the hospital does not have the autonomy to make HR policies according to their needs, but rather follows standard public personnel policies. Similarly, implementers are not involved in the policy making. Consequently, the policies perceived and translated by the implementation staff are different than actually intended, which results in a high discrepancy between intended and implemented HR practices. Results of the study are supported by other authors (see Wright and Nishii, 2007; Nasi, 2011).

Our findings support the assumption that high HR autonomy and less external control leads to more internal HR decentralization, which reduces the gap between intended and implemented HR

practices. Conversely, low HR autonomy and more external control seem to result in high centralization and an increased gap between intended and implemented HR practices.

5.4 Perceived Constraints of HR Managers/Administration in the Implementation of HR Practices

There are some additional constraints identified that hinder the successful implementation of HR practices. In CS1 the major constraints are resistance to change and the implementation of dual (old and new) systems simultaneously resulting in duplication of practices in the organization.

However, in CS2 the major constraint is a lack of autonomy to make and implement practices according to the needs of the organization. Similarly, there is a lack of involvement of implementers in the policy making which also leads to high discrepancy between intended and implemented HR practices. Additionally, considerable red tape persists, due to the presence of external control specifically and to the compliance of government directives, negatively affecting organizational performance (Rainey, 2009; Brewer and Walker, 2010a). There is a lack of communication and support of hospital administration and top management provided to the implementation staff. This leads to demotivation and reluctance of line managers to implement HR practices, which is additional work for them.

These perceived constraints do not allow the successful implementation of HR practices which also increases the gap between intended and implemented HR practices.

5.5 Policy and Practical Implications

The resultant findings have some policy and practical implications.
Based on the findings, it is suggested when granting autonomy to public organizations (hospital) policy makers should maintain a balance between the degree of autonomy and external control (following government directives). While too much autonomy and too little external control can lead to misuse of authority, we found that too less autonomy and too much control undermines the creativity and adoption of modern practices.

Top management should grant internal autonomy to the HR policy makers and also involve lower managerial levels in the policymaking. This may lead to more employee-friendly policies and reduce the gap between intended and implemented HR practices.

Although line managers are often involved in HR functions, top management and HR should still provide full support and training to perform HRM functions efficiently and effectively. This will also reduce the discrepancy between intended and implemented HR practices, ultimately enhancing organizational performance.

6. Conclusions and Contributions

In this paper, a qualitative exploration was conducted to assess the effect of the level of HR autonomy on the internal HR decentralization in the presence of external control (government

directives). Moreover, an effect of internal HR decentralization on the discrepancy between intended and implemented HR practices was also explored.

The results indicate that more HR autonomy of the organization, with less external control, may lead to high internal HR decentralization, ultimately reducing the gap between intended and implemented HR practices. A possible explanation is that when top management is freed from external control they are inclined to find best ways to steer the organization and inconsequence adopt modern HR practices such as HR decentralization and employee engagement. Thus, it is important to engage the HR department and lower managerial level in decision making to achieve effective implementation of HR practices.

Moreover, the level of HR autonomy, the leadership style of top management and the expertise of the HR department will influence internal HR decentralization. A high internal HR decentralization means involvement of HR and lower level management in decision making and may lead to less discrepancy between intended and implemented HR practices.

On the contrary, low HR autonomy combined with high external control decreases the likelihood of internal HR decentralization, negatively affecting the gap between intended and implemented HR practices. Additionally, when the organization follows standard public personnel policies, not based on the needs of the organization, 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 top management increases the gap between intended and implemented HR practices. The result shows that government directives make the procedures standardized yet outdated policies lead to excessive paperwork, burdensome practices and red tape, especially for lower managerial levels.

The perceived constraints identified in the implementation of HR practices are a lack of autonomy, lengthy procedures and strict adherence to government directives, red tape, lack of visionary leadership to adopt modern HR practices, limited involvement of implementers in the policy making, resistance to change and less support from top management that leads to a lack of motivation of line managers to implement HR policies. All these constraints contribute to poor implementation of HR practices which also increases discrepancy between intended and implemented HR practices in the organization.

The article contributes to the literature in several ways. Firstly, the results support the assumption that more HR autonomy of the organization, with less external control, can lead to high internal HR decentralization, ultimately reducing the discrepancy between intended and implemented HR practices. Secondly, the core idea of NPM that both organizational autonomy and external control (often in the form of government directives) are important to become internally decentralized is not supported by the findings. Since lack of autonomy and too much external control leads to rule-bounded behavior, this became the reason for public sector reforms. Instead, the claim that more organizational autonomy with limited external control can lead to higher internal HR decentralization is validated. The proof of this claim can be seen from the findings of CS1 where the hospital has full HR autonomy and less pressure to follow government directive (external control). The high degree of internal HR decentralization ultimately results in less discrepancy between intended and implemented HR practices. Thirdly, the study also contributed to the call

for qualitative research, using a multiple case study approach to understand the impact of HR autonomy on internal HR decentralization in the presence of external control (Stanton et al., 2011; Wynen et al., 2014).

Despite the contribution above, the study has some limitations. Firstly, the sample size is small, in that it is an exploratory study, consisting of only two cases (hospitals) being studied with only one respondent from each managerial level in the two autonomous public hospitals being consulted. Similarly, there can be potential social desirability bias in the responses because only one respondent from each hierarchical level was consulted who might have given socially desirable answer. Therefore, further research will be expanded across more respondents and managerial levels to gain deeper understanding. Additionally, on the basis of two cases we cannot claim causality between HR autonomy, external control and internal HR decentralization. Future research can expand the number of cases and adopt quantitative method to achieve generalizability.

Secondly, the research did not consult government officials which might have another perspective on the need for external control (government directives) and level of autonomy.

Thirdly, only one external influence (government directives) was considered to see the effect on autonomy. It is recommended that future research consider other external influences; such as stakeholders, performance evaluation, result control and accountability. Additionally, future research can also test this general framework of how HR autonomy impacts internal HR decentralization, in other sectors besides public health.

7. References

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