Taking care of innovation

The HRM innovation process in healthcare organizations

Judith van den Broek – van Dongen

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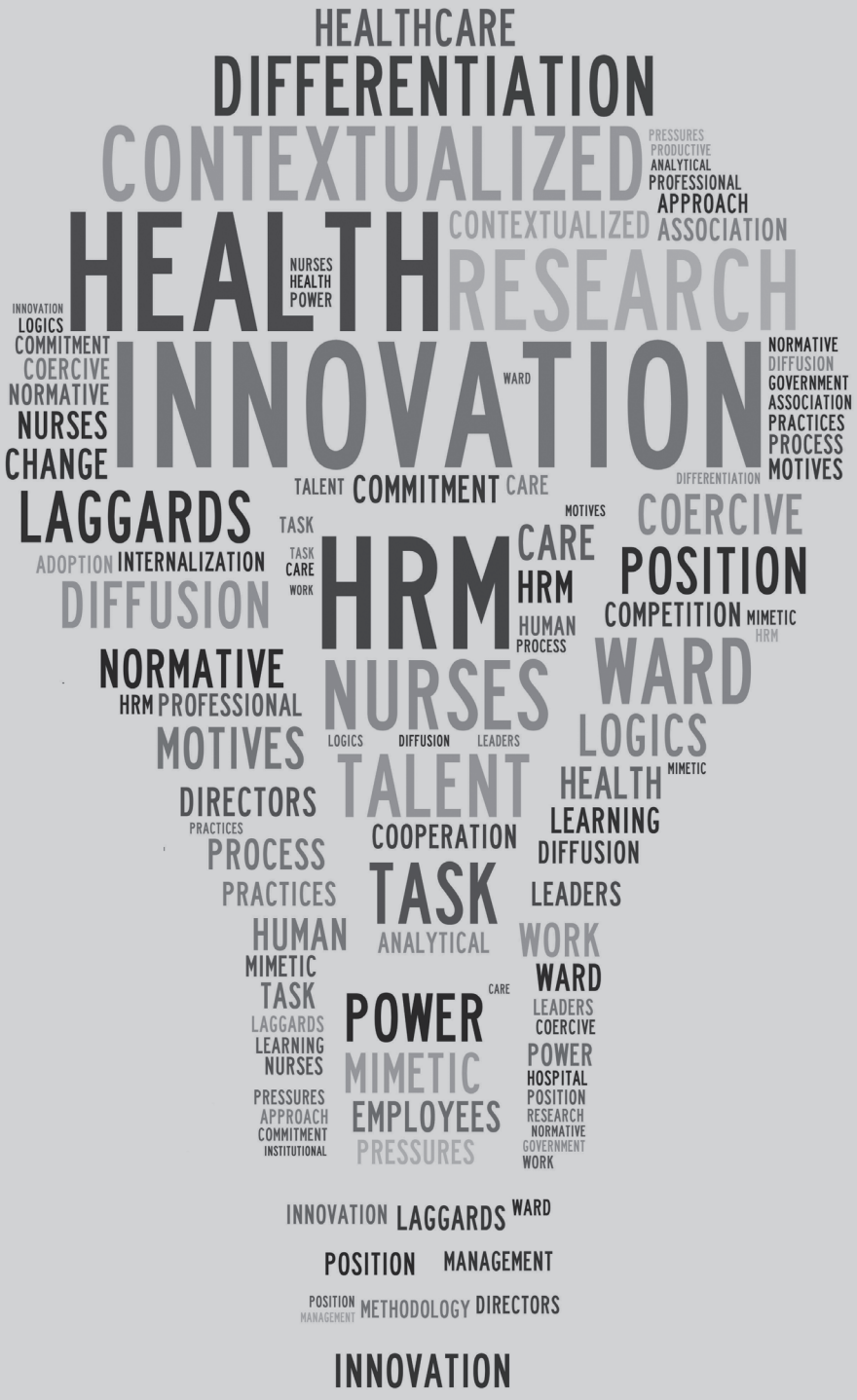
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CHAPTER **1**

Introduction

Employees are of crucial importance for the performance of healthcare organizations. (e.g. Townsend & Wilkinson, 2010). Therefore, enhancing our understanding of processes related to the management of these human resources in this sector is very relevant. Human Resource Management (HRM) can be defined as "involving all management decisions related to policies and practices that together shape the employment relationship and are aimed at achieving individual, organizational and / or societal goals" (Boselie, 2010, p. 5). Although the field of Human Resource Management (HRM) has become a widely studied research field throughout the years, there are some research areas that are in need for more investigation. In this dissertation, one of these areas will be examined in-depth.

The focus of this dissertation is the innovation process of HRM related practices. An innovation can be defined as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption" (Rogers, 2003, p XX preface). In this thesis, two types of HRM innovations will be distinguished, in accordance with the division several HRM scholars tend to agree on (e.g. Boxall & Macky, 2009; Godard, 2009). According to Boxall and Purcell (2008), "HRM encompasses the management of work and the management of people to do the work" (p. 3). This statement reflects the dichotomy of the two types of HRM innovations that can be distinguished. The first type of HRM innovations focuses mainly on work design, i.e. work innovations. Examples of work practices are autonomous jobs and quality circles, where a group of employees analyzes work problems and provides solutions for it (Boxall & Purcell, 2008). An illustration of innovations in the area of work design in healthcare are new nursing roles as a result of task differentiation and task restructuring. In addition, the second type of HRM innovations are HR or employment practices (i.e. HR or employment innovations). These practices are focused on Human Resource Management instruments, such as recruitment and selection, remuneration, training and development and appraisal practices. In healthcare, some recent employment innovations are e-learning and Talent Management Pools.

While many studies in the HRM field focus on identifying this relationship between HRM and performance, much remains unknown about HRM processes, such as the development, introduction and implementation of new employment and work practices in organizations, which is also expected to affect performance. In their book on HRM and performance, Paauwe, Guest and Wright (2013) conclude that "Such implementation issues have been largely ignored in the HRM-performance literature, yet they may be critical to developing a deeper understanding regarding this relationship" (p. 10). In addition, Guest and Bos-Nehles (2013) state that "One of the seriously under-researched topics concerns the process whereby new HR practices are introduced" (p. 100). This study aims to enhance our understanding of

the HRM innovation process by unraveling the diffusion, adoption and implementation of HRM innovations.

In this dissertation, the HRM innovation process will be studied from a combination of strategic HRM, innovation, institutional and economic perspectives. By combining these disciplines, a more comprehensive understanding of the HRM innovation process can be provided. For example, many studies on HRM processes do not take into account the influence of the institutional environment (Paauwe & Boselie, 2003). As Paauwe et al. (2013) state: "Overall, we can discern a lack of attention being paid to the institutional context" (p. 6). In this dissertation, much attention will be paid to institutional pressures, motives and logics. Especially in highly institutionalized sectors, such as the healthcare sector, it can be expected that institutional factors play an important role.

This dissertation is focused on one specific organizational field (Scott, 2008), namely the Dutch healthcare field. This field is seriously challenged by market mechanisms (including efficiency, quality, flexibility and innovation pressures) since the introduction of the new financial system in January 2006. The more than hundred hospitals in the Netherlands represent an excellent organizational field for this research since these organizations are seriously challenged to improve their performance through good people management. In this sector, several developments enhance the need for new approaches to the management of employees. For example, demographic developments such as the aging population resulting in a higher demand for care, the increasing labor shortage and governmental reforms stimulating competition in this sector create challenges in the area of HRM. In addition, economizing measures by the government and the public visibility of quality and safety incidents pressure healthcare provider organizations to enhance the efficiency and quality of care. HRM plays a crucial role in achieving these goals (Townsend & Wilkinson, 2010). Therefore, this sector provides a relevant context to study HRM innovation processes.

The focus of this dissertation is on HRM related interventions that are new for the adopting organization, which are defined as innovations in this study. Healthcare organizations are in need for such interventions, because these innovations enable them to cope with the challenges described above. The HRM interventions healthcare organizations initiate due to these challenges will be studied using the perspective of innovation processes. More specifically, the focus will be on the diffusion, adoption and implementation of these interventions in order to extend our knowledge about the management of innovations. Most studies on innovation management focus on product innovations in private sector organizations. As Damanpour and Aravind (2011) state: "… most theories and models of innovation process and outcome are based on empirical studies of technological innovations in the manufactur-

ing sector." Much less attention has been paid to studying other types of innovations in other contexts (Birkinshaw, Hamel, & Mol, 2008), such as HRM innovations. However, these models and theories are increasingly being applied in other contexts (Damanpour & Aravind, 2011). Recently, innovations in sectors such as the healthcare sector are studied more intensely (e.g. Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Länsisalmi, Kivimäki, Allto, & Ruoranen, 2006). In addition, managerial innovations also receive increasingly more attention from researchers (e.g. Barringer & Milkovich, 1998; Birkinshaw et al., 2008; Bondarouk, Looise, & Lempsink 2009).

Yet, there remain many gaps in our knowledge about the innovation process in healthcare organizations (Länsisalmi et al., 2006) and managerial innovations. According to Damanpour and Aravind (2011) "Research on managerial innovation is still in its early stage" (p. 446). One could wonder whether the application of theories and models designed for analysis of product innovations in private sector companies could be easily transferred to managerial innovations in public sector organizations. In this respect, Paauwe (2004) and Boxall, Purcell and Wright (2007) make a plea for contextually based research, which entails taking into account the context of organizations under study. Therefore, the aim of this study is to enhance our understanding of managerial innovations, more specifically Human Resource Management innovations, in the healthcare sector, by taking into account specific contextual characteristics of this sector. In order to achieve this, elements from the analytical approach (Boxall et al, 2007) are applied to the research design of this study. Important characteristics of the analytical approach are the emphasis on the need to understand context and irrational processes in HRM and the need for methodological quality and rigor. The analytical approach makes a plea for embedding research in context. This study embraces the embedded approach proposed by analytical approach scholars, but aims to take this to the next level. A contextualized process methodology is developed and adopted in order to truly embed this research in the healthcare context. This means that in the first research phase the research context is explored and elements that characterize innovation processes in this sector are traced, such as specific innovations, dynamics and tension fields. These elements will be studied more in-depth in the second phase of this study. In chapter two, this research approach will be discussed in more detail.

Research questions

The research question of this dissertation is *What characterizes the diffusion, adoption and implementation of HRM innovations in Dutch healthcare organizations and how do agents, organizations and institutions influence these phases of the HRM innovation process?*

In order to be able to answer this question, the following sub-questions are formulated:

1. *What kind of HRM innovations are adopted in healthcare organizations?*
2. *Which underlying mechanisms are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how can this be explained?*
3. *Which actors are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how do they affect this process.*
4. *Which possible tensions are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how can this be explained?*
5. *Which enablers and barriers are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how can this be explained?*

SCIENTIFIC RELEVANCE

This research provides a link between on the one hand HRM in the health care sector and on the other hand the fields of innovation and institutional theory. Adopting this multi-disciplinary approach is promising in generating new insights in the innovations process. This study aims to fill the gaps in our knowledge on the innovation processes of specific types of managerial innovations: employment and work innovations. Applying the heuristic framework (encompassing innovation literature and institutional theory) in such a sector will lead to new insights which will also be relevant to researchers who have mainly worked in the private sector. For example, the question whether the institutional setting inhibits or stimulates the adoption of innovative practices seems to be very relevant for public sector organizations such as the hospitals, but is also relevant for private sector organizations. In addition, this study takes the importance of contextualizing research seriously by introducing a methodology to unravel contextual specific elements in organizational processes, applying assumptions from the analytical approach and iterative research designs. This contextualized process methodology enables us to embed this research in the healthcare context. This methodology will be discussed further in chapter two of this dissertation. This approach could also benefit other researchers aiming to generate knowledge that takes into account context specific characteristics.

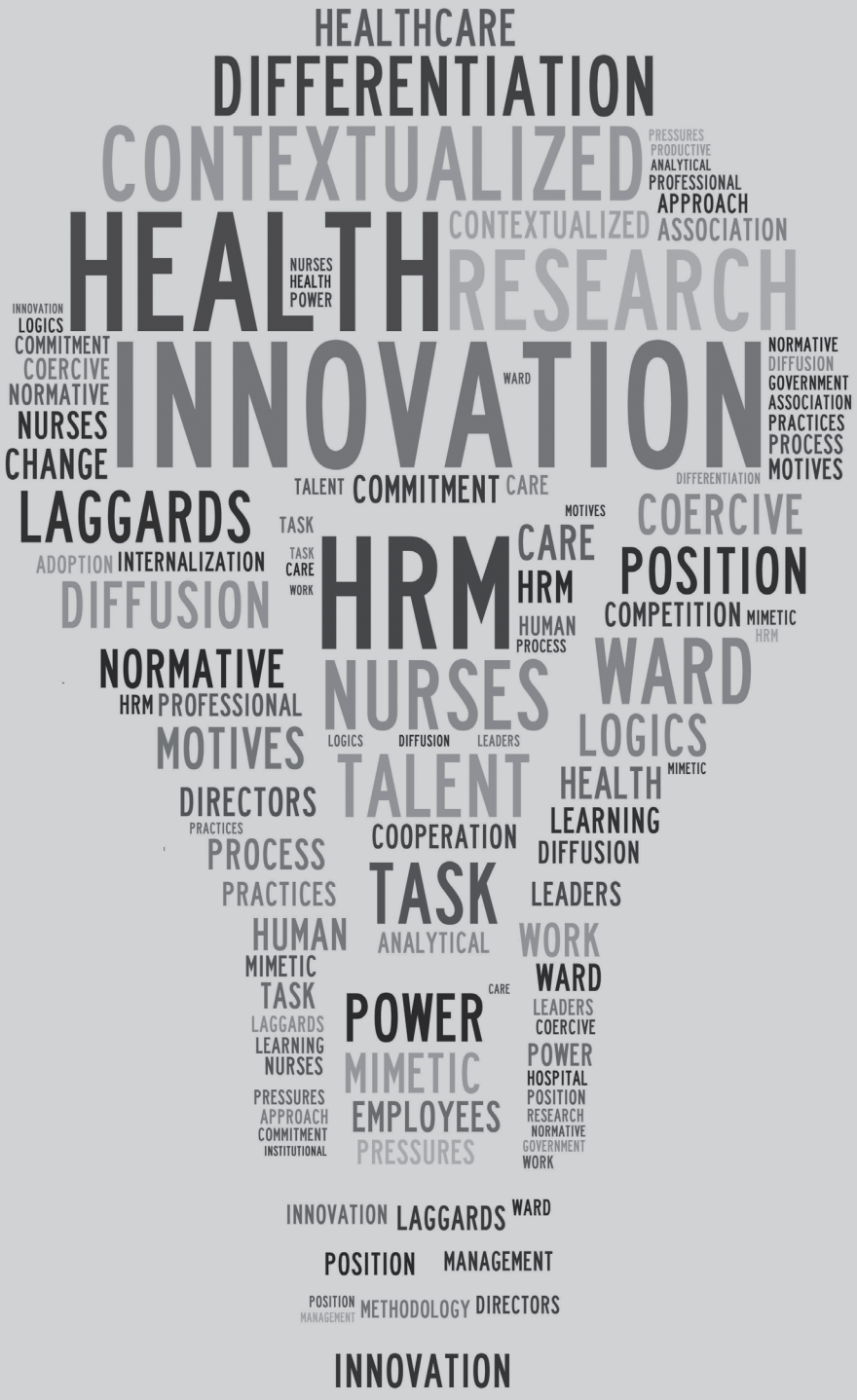
PRACTICAL RELEVANCE

From a practitioner's perspective, this study also provides relevant insights. By enhancing the awareness of the important factors and actors involved in the diffusion, adoption and implementation of HRM the innovations, this process could be followed through much

more smoothly in practice. Developments in the healthcare sector (such as changes in financing and budget mechanisms, need to become more cost-effective, benchmarking and increased competition) have given rise to the need for organizations in the healthcare sector to become more competitive and to distinguish themselves in the marketplace vis-à-vis patients, clients and healthcare insurance companies. Innovating in the area of HRM is one way of distinguishing oneself from other healthcare providers. The present and future tight labor market is one more reason to pay attention to advanced HRM practices in order to strengthen commitment, decrease staff turnover and to become a so-called 'preferred' employer. This research project will render insights into the kind of mechanisms, risks and benefits involved in adopting HRM innovations. The healthcare sector can benefit from these insights in order to improve their competitive advantage not only vis-à-vis their own relevant field (the healthcare sector) but also related to other sectors, who all fight for the same scarce resources in the labor market, i.e. present and future employees.

THIS DISSERTATION

In order to investigate these issues, a qualitative research approach is taken. Qualitative studies enable the in-depth investigation of processes and underlying mechanisms (Miles & Huberman, 1994). In order to unravel specific elements in the HRM innovation process in the healthcare sector, the findings of a large exploratory study are reported in chapter two. In this chapter, the theoretical underpinnings of the diffusion, adoption and implementation phase of the HRM innovation process are explained. In addition, the findings on specific characteristics of this process in healthcare are presented. These elements are the foundation for the following four studies of this dissertation. These studies are introduced in chapter two and are reported in the following chapters. In most studies a case study approach is adopted, where innovations such as e-learning, task differentiation, Talent Management Pool and Productive Ward: Releasing Time to Care are used as vehicles to study the innovation process. These chapters are written as papers that could be read independently. In the final chapter of this dissertation, the findings of the studies are being discussed. In addition, practical and scientific implications of the study are provided.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CHAPTER **2**

Studying the Human Resource Management innovation process: Introducing the contextualized process methodology

THE INNOVATION PROCESS CHALLENGE

Innovation and change are widely researched topics in the strategic management discipline (e.g. Van de Ven, 1992; Van de Ven & Poole, 2005). Many scholars study the antecedents of innovations or the effects of innovations on organizational outcomes. Often the aim of these studies is to test theories using quantitative methods. Yet another stream of research on this topic focuses on the in-depth investigation of innovation processes. These scholars often aim to understand the how and why of innovation processes using qualitative methods and adopt a more inductive approach. Van de Ven and Poole (2005) contrast these two approaches and label them respectively variance and process studies. These authors claim that most studies on organizational change and innovation are variance studies, but emphasize the importance of the process studies by stating that "process research is capable of tapping aspects of processes that variance research cannot" (p. 1385). For example, by conducting process research, our understanding how and why things change can be enhanced (Langley, 2007). In 1979, Weick already argued that researchers should change their focus from static organizational forms to dynamic organizational processes. More recently, several scholars also made a plea for more process research in strategic management (Langley, 2007; Meyer, Gaba, & Colwell, 2005; Pettigrew, 1992). Langley and Tsoukas (2010) observe that increasingly more attention is paid to processes in studying organizational change processes. As Orton (1997) states: "Organizational researchers are continuing to follow Weick and move away from the study of presumed causal relationships between presumed variables, and toward complex organizational processes" (p. 420).

Most process studies investigate real life processes in real organizational contexts (Langley, 1999) and use qualitative methods in order to gain in-depth understanding of processes (Langley, 2007). However, these "process data are messy" (Langley, 1999, p. 691). There are several difficulties associated with studies aiming to unravel innovation processes (e.g. Langley, 1999). This is illustrated by the observation of Langley (2007) that while there are calls for more and better qualitative research to study organizational processes (e.g. Hitt, Boyd, & Li, 2004), quantitative and variance research still dominate strategic management studies (Langley, 2007; Van de Ven & Poole, 2005). One of the challenges related to process research that Orton (1997) points out is that the research methodology underlying process studies is often implicit. Orton (1997) observed that process studies would benefit from applying what he labels 'iterative grounded theory', an approach in between deductive and inductive research that allows researchers to "cycle back and forth between process theory an process data" (p. 419). Yet, he observed that such an approach is not widely accepted yet. Orton (1997) shows that adopting a research methodology that studies organizational change process "with relatively few a priori research constraints" (p. 422) can result in interesting process studies.

This brings us to the discussion of relying on a priori theoretical frameworks before the data collection process. Deductive studies primarily rely on theoretical ideas guiding their research. Several scholars (e.g. Tummers & Kartsen, 2012) indicate disadvantages of such theoretical ideas guiding research. For example, by focusing on these theoretical ideas, other aspects that can be derived from the data are often not considered and a case selection bias can occur due to the selection of cases that are in accordance with the literature. This prevents researchers to develop new and unexpected insights that allow theory building or development. In the current study, the call for clear methodologies to investigate organizational processes will be answered, by the introduction of a two-stage research methodology which is based on an iterative research approach that prevents us from the disadvantages of only relying on a priori theoretical models. Considering the research context is a crucial element of this method.

CONTEXT AND THE ANALYTICAL APPROACH

Well-known process studies of Weick are grounded in empirical contexts, which "helped him produce an influential new review of sensemaking processes in organizations" (Orton, 1997, p. 419, Weick, 1995). This emphasizes the importance of paying attention to the specific context the process under study takes place.

A relevant debate on the importance of context is the so-called best practice versus best fit discussion in Strategic Human Resource Management (SHRM) literature (e.g. Delery & Doty, 1996). On the one hand, the universalistic perspective, also labeled as the best practice approach, entails that certain HRM practices will improve organizational performance regardless of the context (e.g. Pfeffer, 1998). On the other hand, the contingency perspective, or the best fit approach, assumes that the effects of certain HRM practices are dependent on the internal and external context of the organization. Increasingly, scholars in the field of Human Resource Management (HRM) research are making a plea for more contextually based research. For example, in 2004 Paauwe introduced the Contextually Based Human Resource Theory (CBHRT), which accentuates the importance of both the internal and external context when studying Human Resource Management. The organizational culture and history are examples of internal context and market and institutional mechanisms are constituents of the external context (Paauwe, 2004). In 2011, Boselie also stressed the importance of considering the internal and external context when studying and designing Human Resource Management. He claims that the analytical approach enables scholars to improve the contextualization of HRM research.

The analytical approach was introduced in 2007 by Boxall, Purcell and Wright. They propose analytical Human Resource Management (HRM) in order to enable both researchers and practitioners to understand real-life organizational phenomenon better. Three principles of this approach can be identified. First of all, research is based on empirical data and is evidence-based. Secondly, methodological quality and rigor is important in order to achieve valid and reliable research findings. As Wright and Boswell (2002) state, the HRM discipline could learn from the Organizational Behavior (OB) discipline when it comes to methodological rigor. On the other hand, OB research could learn from the embeddedness of HRM research in contexts. This brings us to the third principle of the analytical approach; embedding the research in organizational contexts. Such a contextually based approach focuses on "understanding what management tries to do with work in different contexts and with explaining why" (Boxall et al., 2007, p. 7). This is related to contextual awareness. Instead of taking on a best practice or universalistic approach, the analytical approach favors a best fit or contingency approach.

When considering these appeals to take into account context in research, it is important to observe that most studies that investigate innovation processes focus on product innovations in private sector organizations (Damanpour & Aravind, 2011). Recently, managerial innovations in other sectors such as the healthcare sector are studied more intensely (e.g. Barringer & Milkovich, 1998; Birkinshaw, Hamel, & Mol, 2008; Bondarouk, Looise, & Lempsink, 2009; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Länsisalmi, Kivimäki, Allto, & Ruoranen, 2006). However, it is questionable whether it is possible to apply theories and methods designed to analyze product innovation processes in private sectors to the analysis of managerial innovations in public sector organizations. Therefore, a novel methodology, inspired by the analytical approach, is introduced an applied in this dissertation. This contextualized process methodology allows us to take into account contextual characteristics of the organization and innovation process under study and therefore be able to unravel this process more accurately.

CONTEXTUALIZED PROCESS METHODOLOGY

Although many scholars emphasize the importance of contextually based research, relatively limited effort is devoted to developing a research methodology enabling truly contextually based research. In this research, the aim is to fill this lacuna by introducing a new way to study innovation processes by applying principles of iterative qualitative research methods and the analytical approach.

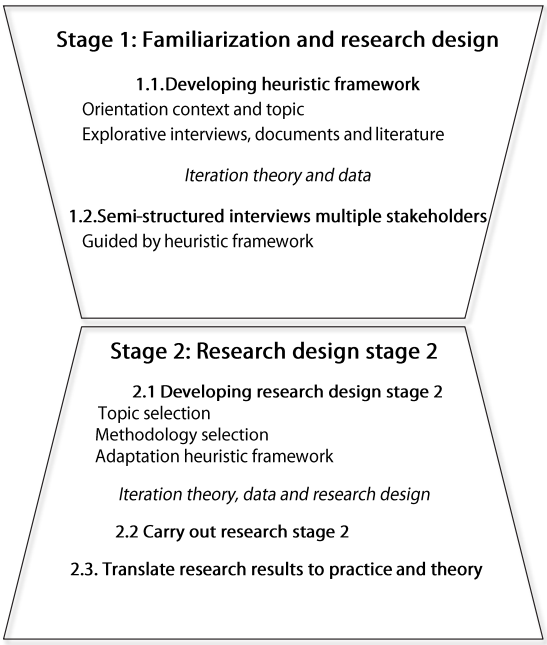


Figure 2.1: Characteristics of the contextualized process methodology

Due to the importance of contextually based research, the first stage of the contextualized process methodology focuses on familiarization with specific characteristics of and developments in the context under study and with selecting topics for further investigation in the second stage. Explorative interviews with relevant stakeholders in the context under study and scientific literature on innovation processes can inform researchers on elements of the process that are suitable for further investigation. However, these theoretical ideas are not used to guide the data collection. On the contrary, they only act as starting points for the data collection stage by forming a heuristic framework, as qualitative data collection and analysis are the core aspects of this methodology. Iteration between data and theory and iteration between data and research design are of great importance in this stage. The research design of the study is not completely developed on beforehand, but the data gathered in this first research stage guides the design of the second stage in that the collected data will help to determine the research design and topics in the second stage. Therefore, theory will not primarily guide what topics to investigate in the second stage, but the collected data will. In this way, a contextually focused basis is formed in order to be able to investigate these context specific topics.

The second part of the two-stage model focuses on the investigation of the topics from the data collected in the first stage. Adopting this approach enables researchers to conduct contextually based research. In addition, data collected in this second stage might also lead to adaptation of the heuristic framework and the research design. Iteration between existing theories and the collected data is also important, because the findings could elaborate or nuance existing theories for the specific context under study. Finally, research findings will be translated into information that is useful for practitioners to improve organizational processes. The two stages of the contextualized process methodology are represented in figure 2.1.

The distinctiveness of this research methodology is that principles of iterative qualitative research approaches are used in combination with principles of the analytical approach. Instead of starting with a theoretical framework and fitting the data within this framework, this approach uses theoretical models and ideas as a heuristic framework, allowing for much flexibility during the data collection stage for interviewees to discuss themes and phases that characterize the innovation process in their context. While this approach is similar to that of inductive qualitative research methods, the contextualized process methodology takes it a step further. The context also strongly influences the topic and design of the rest of the study. For example, in this study on HRM innovation process in hospitals, the first round interviews determined which innovations and which innovation process themes were studied more in-depth in the second stage of the research. This reflects one of the elements of the analytical approach; the research is contextually embedded due to this approach that takes context exploration as a starting point for the design of follow-up studies. Furthermore, methodological quality and rigor are taken into account by carefully selecting and executing methodologies that fit the research questions and issues derived from stage one. In addition, the research findings are translated to useful information for the organizations that participated in the study. This reflects the evidence based element of the analytical approach, which allows practitioners to use the research findings in practice. The research findings are also related back to theory, in order to contribute to the development and improvement of theory in this research area.

APPLYING THE CONTEXTUALIZED PROCESS METHODOLOGY: HUMAN RESOURCE MANAGEMENT INNOVATIONS IN DUTCH HEALTHCARE ORGANIZATIONS

The focus of this research is on unraveling the HRM innovation process in the healthcare sector. Many studies on HRM and innovation focus on other sectors (e.g. Damanpour & Aravind,

2011). Hence, there is a need to investigate which specific processes take place in this sector. For example, the healthcare sector is highly institutionalized, as governmental agencies and healthcare insurers strongly affect not-for-profit healthcare organizations. Therefore, one could expect significant involvement of institutional pressures from for example laws, norms and regulations in these innovation processes.

In effect, the contextualized process methodology applied in this research is aimed at unraveling the HRM innovation processes in healthcare organizations. First of all, several orientating interviews are conducted with practitioners from different disciplines (e.g. HR, general managers, and nurses) and scientists and other experts in this field (e.g. consultants) in order to understand the research context better. In addition, a literature review is conducted on HRM innovations and (management) innovation processes. Furthermore, a heuristic framework is developed based on scientific literature and these interviews. After the development of this heuristic framework, semi-structured interviews are conducted with HR practitioners, line managers, directors and professionals (nurses) of several healthcare provider organizations in order to identify recent HRM innovations and dominant topics in the diffusion, adoption and implementation of these innovations. In this way, a basis is formed in order to be able to investigate these context specific topics in stage two. The current chapter focuses on the first stage of the contextualized process methodology. First of all, the heuristic framework that guides the research will be introduced.

Stage 1.1 Developing the heuristic framework

As described above, the interviews and literature review result in the development of a heuristic framework.

Employment and work innovations

Both the interviews and the scientific literature show that little consensus exists regarding the definition of innovations. For example, based on their systematic review of the organizational innovation literature, Crossan and Apaydin (2010) conclude that there are numerous definitions of innovation. One of the core elements of many innovation definitions is the accentuation of the newness aspect of innovation. Newness of an innovation can be conceptualized on different levels. Some scholars state that an innovation can be defined as innovation only when it is new to the world. According to others, an innovation is an element that is new to the individual, organization or sector (e.g. Rogers, 2003). In this research the view is followed that a new element is defined as an innovation when it is new to the focal organization.

Another difficulty that rises from both the interviews and the scientific literature is the conceptualization of HRM. Several HRM scholars acknowledge that HRM could be viewed in a narrow or in a broader sense. This differentiation is reflected in the discussion on employment practices versus work practices. In the Human Resource Management literature, considerable effort is devoted to distinguishing practices that are focused either on the design of work (work practices) or on the management of human resources (employment or HR practices) (Boxall & Macky, 2009; Boxall & Purcell, 2008; Godard, 2001, 2004, 2009; McCartney & Teague, 2004; Osterman, 1994; Whitfield & Poole, 1997; Wood & Bryson, 2009). Employment practices are more related to a narrow conceptualization of HRM, including more traditional employment activities such as recruitment and selection and training and development. Work practices could be perceived as a broader interpretation of HRM, in that work design issues such as task reallocation and new work arrangements are also included in HRM.

Diffusion, adoption and implementation

Innovations have been studied both as an outcome and as a process. An important stream of innovation research focuses on unraveling the innovation process (Wolfe, 1994). In this current research, the focus will be on this innovation process. Many scholars introduced different models of innovation processes, incorporating different stages or phases (e.g. Schumpeter, 1934; Tidd, Bessant, & Pavitt, 1997; Zaltman, Duncan, & Holbek, 1973). An example is the innovation-decision process model of Rogers (2003). He distinguishes five phases in the innovation process. In the knowledge phase, the potential adopter becomes aware of the innovation and gathers information about it. In the persuasion phase, the potential adopter develops a positive or negative attitude towards the innovation. This leads to the decision phase, in which the potential adopter decides to adopt or reject the innovation. If the adopter decides to adopt the innovation, the phase in which the adopter puts the innovation into practice is called the implementation phase. Finally, in the conformation phase the adopter seeks reassurance that his adoption decision was sound. While Rogers' model is primarily based on his research on product innovations in private organizations, the model Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou (2004) propose is based on their literature review of innovation research in the healthcare sector. Firstly, they identify the diffusion phase, which is the 'passive spread' of an innovation. Secondly, the dissemination phase entails the active and planned effort to persuade others to adopt an innovation. The third phase they identify is implementation, which they define as "active and planned efforts to mainstream an innovation within an organization" (p. 582). The final phase is sustainability, which are efforts to make an innovation routine within an organization. In addition, Damanpour and Avarind (2011) focus on managerial innovations and conclude that all the phases proposed in the literature can be broadly categorized in generation and adoption. According to these authors, the generation phase is about "all efforts and activities aimed at

creating new ideas, getting them to work, and supplying them for transfer to, and use by, other organizations" (p. 425). The second phase, adoption, is being defined by these authors as "how an organization becomes aware of new ideas, acquires, adapts, and uses them. The phases of innovation adoption include initiation, decision adoption, and implementation" (p. 436).

In order to develop a heuristic framework for (human resource) managerial innovation in the healthcare sector, the phases identified by general innovation process studies are used (e.g. Rogers, 2003), as well as innovation process studies in the healthcare sector (e.g. Greenhalgh et al., 2004) and process studies of managerial innovations (e.g. Damanpour & Avarind, 2011). A literature review on these phases will help to constitute the heuristic framework. This framework will be used to guide the semi-structured interviews and together contribute to the development of a contextualized research design.

The first phase is the diffusion of innovations, which is concerned with the spread of innovations. In the knowledge stage of Roger´s (2003) Innovation-Decision process the decision making unit "is exposed to an innovations existence and gains understanding of how it functions" (Rogers, 2003, p. 171). Two important concepts here are selective exposure and selective perception. These concepts relate to "the tendency to interpret communication messages in terms of the individual´s existing attitudes and beliefs" (Rogers, 2003, p. 171). According to Rogers (2003), selective exposure and selective perception make clear that before this knowledge stage, the decision making unit should have a felt need for an innovation or experience a problem that could be solved by an innovation. A need can be defined as "a state of dissatisfaction or frustration that occurs when an individual's desires outweigh the individual's actualities" (Rogers, 2003, p. 172). Due to the highly institutionalized context healthcare organizations operate in in The Netherlands, institutional factors are expected to play an important role in creating the need for innovations. It could also be the other way around: by becoming aware of the existence of an innovation, the decision making unit may create a need for this innovation. Based on several studies, Cohen and Levinthal (1990) conclude that "most innovation results from borrowing rather than invention" (p. 128). For example, other hospitals, organizations from other sectors and consultancy organizations could be the source of diffusion of the innovation to the focal hospital.

After the need for an innovation is established and potentially suitable innovations are detected in the environment of the organization, organizational decision making processes become important. This element is represented in the second phase; the adoption. The adoption of innovation can be defined as "the decision to make full use of an innovation as the best course of action available" (Rogers, 2003, p. 177). The motives for adoption may vary.

Rational-economic and institutional perspectives propose several reasons for organizations to adopt innovations. New institutionalism is focused on why organizations within a population exhibit similar characteristics (DiMaggio & Powell, 1991). Institutional isomorphism emphasizes normative rationality – in contrast to economic rationality – behind decision making processes. Normative rationality reflects processes of cognitive and normative institutionalism, whereby people and organizations conform 'without thinking' to social and cultural influences. DiMaggio and Powell (1991) propose three institutional mechanisms in this respect: coercive, mimetic and normative mechanisms. Paauwe and Boselie (2003) and Paauwe (2004) argue that these institutional mechanisms affect the shaping of HRM in organizations. Related to HRM, coercive mechanisms include, among others, the influence of the trade unions, labor legislation and the government. Mimetic mechanisms refer to imitations of strategies and practices of competitors as a result of uncertainty or fashionable fads in the field of management. Normative mechanisms refer to the relation between management policies and the background of employees in terms of educational level, job experience and networks of professional identification (for example universities and professional training institutes). These types of networks are important centres for the development of, very often taken for granted, organizational norms among professional managers and their staff specialists. Scott (2008) proposes three pillars of institutions, which are similar to the institutional mechanisms DiMaggio and Powell (1991) discuss. He identifies the regulative, normative and cultural cognitive pillars which are closely related to respectively coercive mechanisms, normative mechanisms and mimetic mechanisms. In contrast to institutional theory, the rational-economic perspective assumes organizations will adopt HRM related innovations based on information about the contribution of these innovations to the performance of the organization. This perspective explicitly takes into account the role of human agency and strategic choice in the innovation adoption decisions organizations made. Several scholars (e.g. Child, 1972; Huang, Gattiker, & Schröder, 2010; Oliver, 1991) consider the role of organizational strategy in decisions to adopt innovations. An illustration of the assumption that organizations can strategically choose how to respond to pressures from the external environment is strategic balance theory. Strategic balance theory (Deephouse, 1999) acknowledges the fact that an organization needs to adhere to institutional pressures that force them to become similar to other organizations. On the other hand, organizations are also confronted with market pressures that force them to differentiate from other organizations. This stands in contrast with competitive isomorphism, which proposes that market issues will force organizations to imitate each other and thus become more similar instead of becoming more differentiated. Strategic balance theory proposes that a firm should find a balance between differentiation and conformity; moderately differentiated firms that are able to balance the institutional and the market focus have higher performance than either highly conforming (emphasis on the institutional dimension) or highly differentiated firms

(emphasis on the market dimension). Strategic balance theory highlights the importance of investigation of institutional and market pressures that could affect the adoption decision.

Once the adoption decision is made, the innovation needs to be implemented in the organization. This brings us to the third phase: the implementation phase. Several scholars suggest that the motive underlying the adoption decision could influence the implementation process. For example, Westphal, Gulati and Shortell (1997) conclude based on their research on Total Quality Management (TQM) adoption in hospitals that early adopters are more likely to customize practices and adapt them to the specific organization than late adopters. According to the authors, early adopters adopt because of the potential benefits the innovation has for their performance. These early adopters will customize, or adapt, the innovation to the organizations, while later adopters will conform more to the normative pattern of practices as they were introduced by other hospitals. Furthermore, Kostova and Roth (2002) distinguish between implementation and internalization. "Implementation is expressed in the external and objective behaviors and the actions required, or implied, by the practice. Internalization is that state in which the employees at the recipient unit view the practice as valuable for the unit and become committed to the practice" (Kostova & Roth, 2002, p. 217). According to these authors, internalization is an important predictor of the persistence of an innovation over time. In their review on innovation processes in healthcare organizations, Greenhalgh et al. (2004) identify several factors predicting implementation success. Examples are leadership, human resource issues such as training and communication. However, one of the major gaps in the literature on innovation in healthcare they discovered was by which processes specific innovations in healthcare are implemented in specific contexts and whether these processes can be improved.

Based on the above described literature review and information derived from the orientating interviews, a heuristic framework is developed. This framework is depicted in figure 2.2 and will guide the semi-structured interviews that will be discussed in the next section.

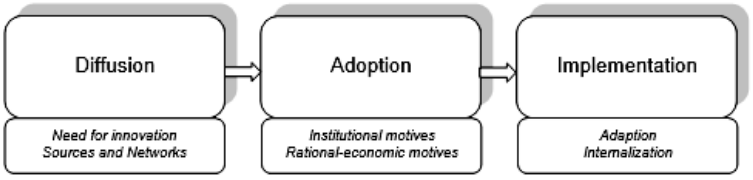


Figure 2.2: Heuristic framework

Stage 1.2 Semi-structured interviews

Semi-structured interviews are conducted to inventory which HRM related innovations are recently adopted or implemented in the hospitals under study. In additions, the interviews are conducted in order to find out which themes in the diffusion, adoption and implementation of HRM related innovations are dominant in the healthcare sector.

Ten Dutch hospitals are included in this study. All hospitals are top-clinical teaching hospitals located in different areas of the Netherlands. In total, 104 semi-structured interviews were conducted in 2010 and 2011. Respondents included in this study are hospital directors, general managers, HR directors, HR advisors, managers of other staff departments (e.g. communication, quality), and employees such as nurses, works council members and nursing advisory board members. A multi-actor approach is adopted to generate a complete picture of the process. Interviews lasted approximately 1 to 1.5 hours. Interview topics covered the diffusion, adoption and implementation process of the innovation under study. In addition, respondents were asked to list examples of recent HRM related innovations in their organization. All interviews were fully transcribed. In addition, several documents that could inform us on the organizations and the innovations were studied. For example, strategic plans, policy documents and news articles were analyzed. The collected interview and document data was analyzed using Atlas.ti, following thematic analysis (Braun & Clarke, 2008; Grbich, 1999; Rapley, 2011). First of all, the interview material was transcribed and reread. Secondly, initial codes were generated, which were used to search for themes. These initial codes formed an initial list of ideas about what information was in the data. Codes were primarily data-driven, as an inductive approach was adopted to let themes emerge from the data. These initial codes where then organized in broader categories based on repeated patterns across the data set: the themes. In this phase, the analysis was refocused at a broader level and codes where sorted into subthemes and themes. After that, the (sub)themes were reviewed in the light of the coded data extracts the initial codes refer to and the entire data set. Finally, the themes were defined and renamed. Some of the initial codes that were identified were 'money is barrier', 'financial constraints', 'economizing' and 'lack of financial resources'. These initial codes were grouped into a broader theme, which was labeled 'financial barrier'. 'Financial barrier' was grouped as a subtheme under the theme 'barriers'. After the coding process was completed, member checks were conducted through presentation of the research results to respondents in all participating organizations. Both the inventory of innovations and the resulting themes will be discussed next.

Different categories of innovations

Many different innovations are reported by the interviewees. These innovations can be categorized in employment innovations, work innovations and organizational innovations.

Employment innovations are innovations related to more traditional employment issues such as training and development and recruitment and selection. Work innovations are new practices that are related to the design of work, such as task reallocation. In addition to these two categories that are derived from the HRM literature, respondents also refer to innovations that would fit a broader category than employment or work innovations. These innovations are organizational innovations with a strong HRM component, such as restructuring programs, and are labeled organizational innovations in this study. In table 2.1, an overview of these innovations is depicted.

Table 2.1: HRM related innovations resulting from interview data

Employment innovations	Work innovations	Organizational innovations
Blended learning / e-learning	Introduction of Nurse Practitioner	Organizational restructuring (e.g. management structure)
Talent Management Pool	Introduction of Physician Assistant	Restructuring HR department
Management Development (MD) program	Introduction of lower level nurses	Cultural change programs
Labor market communication program	Dual management	Family centered care
Employer branding	Manager participating in nursing work	Process improvement techniques: Theory of Constraints, Business Process Redesign, Lean management for healthcare (Productive Ward: Releasing Time to Care)
Education and performance program	Changing teams	Capacity management program
Performance management cycle	Job rotation	Centralized scheduling
Development plan employees	Job crafting	Digitalization (paperless office, digital portals, electronic patient files)
Generic job descriptions	Internal mobility paths	Operating room checklist (SURPASS)
Competence management		Safety rounds
Sickness absence management		Networks with other healthcare providers
Introduction of recruitment department		Networks with regional business organizations (e.g. Health2Business)
Flexible labor office		
Monitoring employee satisfaction		
Workability plans		

Extended heuristic framework

When discussing these HRM innovations with the interviewees, several relevant issues with regard to the innovation process in healthcare organizations appeared to be relevant. In this section, an overview of important topics for this context will be presented. This will result in the development of a more extended heuristic framework.

Time, process and dynamics

The research findings show that innovating in healthcare organizations is a dynamic process and the time element is important here. For example, findings show that a long period is needed in order to involve and commit stakeholders to innovations.

> *We are slow. These things [innovations] don't happen from one day to another…you have to dare and want to take time for these change processes.* (Staff manager, hospital C)

> *The speed of innovation processes in such large institutes of over 3000 employees, it always takes longer than a year.* (HR manager, hospital D)

In addition, findings show that within the phases of the heuristic model several changes can be observed. For example, at the start of implementation, nurses first want to resist change and innovation, while during this process their opinion changes and they become committed to the innovation.

> *The advantage of the fact that these processes take a long time is that some problems disappear on its own…people that don't want to commit to change process will find their way. Sometimes they will quit or they will adjust themselves and participate.* (Line manager, hospital I)

This calls for studying of innovation processes for longer periods of time, in order for these changes to be observed and explained. This fits well with more recent observations of process theorists, stressing the importance of seeing innovation processes as dynamic instead of static, emphasizing the importance of the time element in innovation studies and recommendations to study these processes longitudinally (e.g. Greenhalgh et al., 2004; Langley, 2007; Länsisalmi et al., 2006; Pettigrew, 1997; Van de Ven & Poole, 2005). Therefore, the first building block for the second phase of this study is to follow the innovation process for a longer period of time.

Barriers and enablers

Secondly, several barriers and enablers are at play in the innovation process in healthcare organizations. Several factors enabling the innovation process are mentioned by the respondents. One of the most prominent one is to use the external pressures hospitals experience to increase the acceptance of the innovations. The changes in the external context are used as reason to adopt certain innovations and thereby stimulate the adoption process.

In my opinion you should be able to innovate without external pressure, for example to do everything more efficiently. However, these pressures force you to think about innovation…It is often the big stick. (Nursing representative, hospital B)

I think 30% of the hospitals innovate and change because of their internal motivation, 40% needs external pressure and 30% needs to be forced. (Line manager, hospital E)

In addition, involving the relevant stakeholders in an early stage is often mentioned as an enabler of successful innovation processes.

Politics often have a negative connotation, but what I want to accomplish is that I take input from all different parties seriously. (HR director, hospital C)

You need to gain trust. You can accomplish this by communicating with and listening to different stakeholders from the beginning of the process. It takes time, but it works. (HR manager, hospital E)

On the other hand, several barriers for successful innovation processes are mentioned. First of all, miscommunication and misunderstanding among different internal stakeholder groups are barriers for effective HRM implementation. For example, differences in opinion and priority among HR and line managers and line managers and nurses appear to be hindrances for successful innovation processes. In addition, money is reported as a major barrier for innovation projects.

Believe me, when we talk about hindrances, then we talk about money. Money is an enormous barrier when it comes to innovation in healthcare. (Director, hospital A)

We can talk about thousands of barriers, but money is the most important one. (Line manager, hospital D)

Furthermore, many hospitals seem to suffer from wanting to implement too many changes in too little time, which appears to have negative consequences for the successfulness of innovations.

In hospitals you have so many projects, you need to be careful that people don't get tired of projects and therefore projects do not launch. (Line manager, hospital C)

Because we have so many projects and many of them bleed to death. It is difficult to create support for your idea because of that. (HR manager, hospital B)

In sum, several factors hindering and facilitating the innovation process are identified. Investigating these factors is important for enhancing our understanding of innovation processes in healthcare, as for example Fleuren, Wiefferink and Paulussen (2004) show.

Actors

The third element is represented by the actors involved in or affecting the innovation process. First of all, the healthcare sector, and specifically the hospital sector, is facing many changes and challenges caused by external actors. As a consequence, respondents report that institutional actors such as the government and healthcare insurance companies heavily affect management and decision making in their organizations. For example, quality standards for healthcare initiated by the federal health inspection and healthcare federations further increase the need to make changes in order to live up to these standards.

A few years ago the health inspection came here and almost closed us down. From that point on, many changes are made in the management and organization of this department. (Line manager, hospital F)

The pressure from outside to increase patient safety was increased for example by the health inspection. (HR, hospital D)

Another group of external actors that is often mentioned in the context of the HRM innovation process are networks with other hospitals. The hospitals participating in this research are all top-clinical teaching hospitals that are member of a teaching hospital association. Respondents often refer to this association when discussing sources for innovations and exemplars of good practice when it comes to HRM innovation implementation. However, other respondents are convinced that this network could be used much more effectively when it comes to sharing ideas and exchanging experiences. Besides the teaching hospital association, relationships with other hospitals and healthcare providers are also mentioned as important sources for innovations.

Every two months, meetings are organized where HR employees come together and share best practices. (HR advisor, hospital A)

We also visit each other to learn. Recently, we had another hospital visiting us to see how we handled the implementation. (HR advisor, hospital G)

Organizations from outside the healthcare sector are mentioned considerably less as sources for innovation, while several respondents refer to the benefits of learning from other organizations outside the sector.

> *In my opinion, people working in healthcare are reluctant to look over the boarders of the sector. Maybe they don't trust the market; the market is often viewed as money-driven, while we see ourselves as people-driven.* (Line manager, hospital B)

Besides the external stakeholders, such as the government and healthcare insurance companies, internal stakeholders appear to be of great importance during the innovation process. Healthcare professionals such as nurses and physicians play an important role in the innovation process. In Dutch hospitals, physicians are often not employed by the hospital, but still obtain powerful positions within these organizations due to the fact that they are crucial in the healthcare delivery process. Interviewees indicate that HRM innovations often don't strongly affect the work of physicians, which results in less involvement of physicians in the innovation process. Nurses on the other hand are affected by many HRM innovations. Especially in the implementation phase resistance of nurses is being observed, which can be explained by a lack of involvement in the adoption process.

> *Nurses are very much concerned with day-to-day care delivery instead of organizational developments. They often show resistance when changes are implemented.* (Line manager hospital J)

Furthermore, initiators of innovations are often HR professionals, but also line managers, staff employees and nursing professionals take up the initiative to innovate in the area of HRM. When it comes to adoption of innovations, the relationship between HR and line management appears to be important. It is crucial for the initiator of the innovation, often the HR professional, to commit other actors, often line managers, to their idea in order to be able to implement the innovation effectively. However, these two actors often have different perceptions and priorities.

> *The difficulty is that managers focus on things that are relevant today or tomorrow or maybe this year. Something that is relevant in 3, 4, 5 or 10 years is no issue at all for managers…This is a real bottleneck in innovation processes.* (HR director, hospital B)

> *Real innovations need to come from staff departments. They have a broader view and are less hindered by limitations from being responsible for day-to-day operational results. (HR manager, hospital E)*

In addition, large differences among the hospitals are found regarding the role of HR in the adoption process. This can be related to the power and position of the HR department. In some hospitals, the HR director has an official seat at the management table and is therefore able to influence the adoption decision. Yet, in other organizations HR is not involved in strategic decision making and therefore has to invest a lot of time and energy to convince organizational stakeholders to adopt these innovations. This leads to very long adoption processes, which sometimes results in HR giving up.

> *Power and position, how HR is positioned in a hospital, that makes a big difference…Are you mandated by the board to make decisions?* (HR director, hospital B)

> *In some respects initiating changes when HR has a better position is easier.* (HR director, hospital D)

Thus, it can be concluded that internal and external actors appear to play an important role in the innovation adoption process in healthcare organization. First of all, the findings indicate that the role, power and position of the HR department differ for the hospitals under study. In addition, the power and position of the HR department appears to play an important role in successfully diffusing, adopting and implementing innovations in the area of HRM. Several developments in the healthcare sector, such as labor shortages, economizing and healthcare reforms lead to organizational changes related to HRM and the organization of work in healthcare organizations. This is the expertise area of the HR professionals in the organization. The assumption that HRM as a policy issue is on the table in most organizations, which means that issues related to people management are considered important is widely established (Ulrich & Brockbank, 2005). Whether HR is at the table, i.e. that the Human Resource function is involved in strategic decision making, is a more debated assumption. Several studies focus on categorizing the array of roles HR can have in organizations and the determinants of these roles (e.g. Legge, 1978; Paauwe & Farndale, 2008; Ulrich, 1997). However, the power, position and role of HR in healthcare organizations remains less clear (Townsend & Wilkinson, 2010). The findings show that this is of great importance for the HRM innovation process. Therefore, engaging in the research stream on the role of the HR function in healthcare organizations is crucial.

Tensions

Furthermore, several tensions in the innovation process are revealed by the interview data.

Cooperation and competition

First of all, the tension between the simultaneous pressures to enhance both competition and cooperation among healthcare organizations is identified. In 2006, the Dutch government introduced a new healthcare act, aiming to stimulate competition among healthcare organizations. This development appears to be affecting the innovation process, for example by urging hospitals to innovate in order to differentiate themselves from other hospitals.

> *Now you're in a competitive position. You want to position your products well on the market to make sure that patients will choose for our hospital instead of another hospital or a private clinic.* (Line management, hospital A)

> *Before, the hospital focused on providing care and clients would come to us spontaneously. We didn't have to do anything for that. Now the world has changed and we have to raise our profile and be innovative.* (Staff, hospital B)

Furthermore, demographic changes such as the ageing population resulting in a higher demand for care and labor shortages are developments urging hospitals to innovate in the area of HRM, for example to differentiate oneself from other employers.

> *And the labor market with the ageing workforce and higher demand for care in this region. We are going to fish in a pond where many organizations fish for personnel. How can you distinguish yourself?* (Staff, Hospital I)

Conversely, these challenges could also create the need to cooperate with other hospitals in order to be able to cope with them.

> *I think all hospitals are confronted with similar problems. Hospitals might want to emphasize different things, but eventually all hospitals are in the middle of the same developments stimulated by external forces…So similar problems, but we are not avoiding duplication enough by cooperation and sharing ideas.* (HR manager, hospital D)

The findings indicate that the development of increasing competition among organizations in the sector creates barriers for sharing information and innovations, but that the need for cooperation is also increasing. This duality of cooperation on the one hand and competition on the other hand is reflected in the theoretical debate on coopetition (Brandenburger &

Nalebuff, 1996; Peng & Bourne, 2009). Coopetition is often studied in private sector where competition is a longstanding concept. However, for not-for-profit hospitals competition is a relative new phenomenon. As cooperation is often seen as an important driver for innovation (Blomqvist & Levy, 2006; Goes & Ho Park, 1997; Miles, Snow, & Miles, 2000; Ribeiro-Soriano & Urbano, 2009, Tomlinson, 2010), it is interesting to see how coopetition affects innovation processes in healthcare organization. The paradox of collaborative innovation, which heavily draws on cooperation between hospitals, in times of increased competition for human and financial resources, is highly relevant for today's healthcare sector and is in need for further examination.

Business-like and professional logics

The second tension that can be identified is related to the observation that hospitals are increasingly being confronted with pressures to enhance their productivity and efficiency. For example, economizing measures from the government are affecting Dutch hospitals. Respondents report on the one hand that this hinders innovation processes, because there is less money to invest in innovation projects. On the other hand, respondents state that these measures legitimize innovation in the area of HRM, because this enables hospitals to work more efficiently.

> *Then there are periods you have to economize even more, because the government wants that. Then people's attention is not focused on innovation.* (Staff, hospital B)

> *Healthcare organizations need to economize a lot. That conflicts with innovations, because that requires money needs to be invested…That remains to be a challenge.* (Line management, hospital F)

> *The hospital needs to downsize. Therefore you need to make sure that you can do the work with less people…That's only possible if you make changes to work more efficiently.* (HR, hospital D).

However, the introduction and growing importance of these business-like aims creates friction with professional standards such as delivering a high quality of care.

> *On the one hand there are the economizing measures from the government that put pressure on the organization. On the other, healthcare insurers influence us because they demand a higher quality of care.* (Nursing representative, hospital C)

In sum, the findings show that healthcare employees experience a shift towards a more business orientation in the organization and sector. This is supported by policy reforms and economizing measures introduced by the Dutch government. In the scientific literature, the introduction of these business-like goals into the public sector is referred to as New Public Management (Bekkers, Edelenbos, & Steijn, 2011). Several researchers in the institutional logics research stream indicate shifts in institutional logics in the healthcare field from a professional logic to a business-like logic (Kitchener, 2002; Reay & Hinings, 2009; Ruef & Scott, 1998). Literature on institutional logics acknowledges that multiple logics are often present in healthcare fields; business-like logics emphasizing efficiency and professional logics emphasizing quality of care might be there simultaneously and tension between these logics could affect the innovation process. Since institutional logics affect organizational decision making (Ocasio, 1997), it is important to gain insights in the way these multiple logics affect HRM innovation adoption and implementation.

Leaders and laggards: rational and economic motives

Finally, when discussing the HRM related innovations adopted by the hospitals under study, large differences can be observed in the timing of adoption. This also reflects the first element of the extended heuristic framework, the time, process and dynamics element. Some organizations seem to be ahead of the sector with implementing certain innovations, while others are lagging behind.

> *We are the frontrunners. Other hospitals come to visit us to see how we approached and do this. I think it is a sign of courage to do this.* (Line manager, hospital A)

> *I think we're are among the first to adopt innovations because we're a hospital that is always open to innovation and were employees enjoy to see beyond the end of one's nose.* (HR manager, hospital E)

In addition, when discussing the motives for adoption, different types of reasons are mentioned by the respondents, ranging from following organizational strategy to adopting because most other hospitals adopt the innovation.

> *Are we doing this because it is a hype, or because we have a problem?* (Staff employee, hospital B)

> *If you make an adoption decision, you are being driven by ambition, patient interests and business interests.* (Line manager, hospital F)

These findings are related to the multiple theoretical perspectives offering different and sometimes conflicting explanations for the adoption of innovations. In the scientific literature, a debate is going on about the relationship between adoption motives and timing of adoption (Kennedy & Fiss, 2009). Therefore, studying the motives for and timing of HRM innovations is a relevant topic.

Visual representation: extended heuristic framework

Figure 2.3 represents an extension of the heuristic framework presented before, including an overview of perspectives and topics derived from the empirical data collected in stage one of the contextualized process methodology. This extended heuristic framework will guide design the second stage of this study.

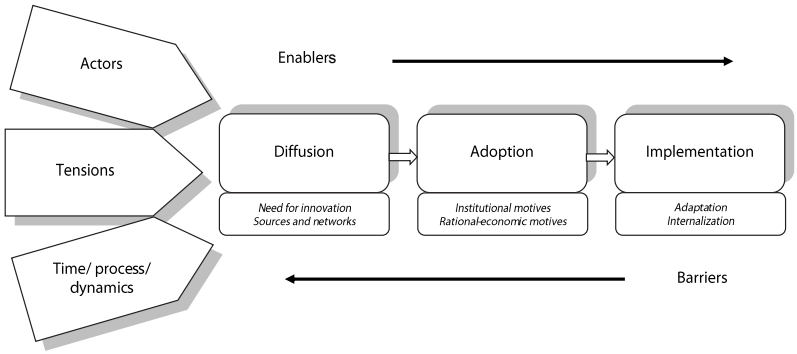


Figure 2.3: Extended heuristic framework based on empirical data

Stage 2.1 Developing research design stage two

Based on the findings of stage one presented in the previous section, the aim of this section is to design studies to investigate the relevant topics of HRM innovation process in healthcare organizations. This represents the second stage of the contextualized process methodology.

Research design

Qualitative research

One of the choices to be made when designing these studies is whether qualitative or quantitative methods will be applied. In this case, qualitative case studies are chosen to further investigate the topics resulting from the first stage. First of all, the perspectives presented in the previous section are all related to the underlying mechanisms of the innovation process under study. Qualitative research is appropriate to enhance our understanding of these

mechanisms and allows for in-depth investigation of these mechanisms. Furthermore, qualitative research is very suitable to investigate the how and why of organizational processes, which is useful for unraveling this innovation process (Welch, Plakoyiannaki, Piekkari, & Paavilainen-Mäntymäki, 2013). In addition, results of the first stage show that these processes are very complex and qualitative research enables research to reveal this complexity (Miles & Huberman, 1994). For example, researchers have investigated the relationship between adoption motives and timing quantitatively before (e.g. Walston, Kimberly, & Burns, 2001). However, the aim of our study is to unravel the underlying motives for adoption that appear to be quite complex. For example, seemingly rational motives might actually have an institutional nature. Therefore, the perspectives and topics in the extended heuristic framework will be qualitatively investigated.

Longitudinal and comparative case studies

Secondly, both comparative case studies and a longitudinal qualitative study will be conducted. One of the advantages of focusing on specific cases is that "the influences of local context are not stripped away, but are taken into account" (Miles & Huberman, 1994, p. 10). Comparative case studies are adopted, because many topics derived from stage one entail many contrasts. For example, contrast between collaboration and competition, leaders and laggards, and business and professional logics and HR and non-HR professionals. Fitzgerald and Dopson (2009) make a plea for comparative case study research in organizational studies to study such contrasts by stating "the questions to be addressed within the arena of organization studies include many that are comparative in nature" (p. 472). Comparative case studies are suitable for these studying these contrasts, because they can provide depth and allow for analysis incorporating multiple stakeholders (Fitzgerald & Dopson, 2009). Furthermore, Langley (2007) claims that comparative case study designs allow for pattern generation and theory development in process studies. In addition, the findings from phase one show that the time and dynamic element in the innovation process is important. Therefore, a longitudinal case study is conducted in order to investigate this process over time instead of only providing snapshots of the process. This also represents one of the strengths of qualitative research (Miles & Huberman, 1994).

Innovation case selection

The distinction between employment and work practices is present in both the literature review and the interview findings. In addition, the interview findings show that organizational innovations with HRM components are also reported frequently. Therefore, the selection of innovations for in-depth investigation during the second stage of the research consists of employment, work and organizations innovations. In order to select suitable innovations for further investigation, the list of innovations created during the first interview stage was

used. Based on the following arguments, four innovations were selected. First of all, an employment and a work innovation that were present in multiple hospitals were selected for in-depth investigation, in order to allow for comparative case studies on the innovation process. These innovations are respectively e-learning and task differentiation among nurses. In addition, two innovations with a clear HRM component were selected because of their distinctiveness. The first one was the ward improvement program 'Productive Ward: Releasing Time to Care'. The innovation process of this organizational innovation was studied in one of the first hospitals in the Netherlands that adopted this innovation and I had the unique opportunity to longitudinally follow the implementation of this program. In addition, this program is very relevant for the changing healthcare context, as it represents a more business-like perspective on healthcare management. Productive Ward fits well with this development due to the lean management principles underpinning the program. The second distinctive innovation is the Talent Management Pool, which is a cooperative project among regional hospitals in order to be able to cope with labor shortages and to increase mobility. This also represents a unique innovation case, because the regional hospitals under study were the first in the Netherlands to develop such a cooperative pool. In addition, the tension between on the one hand cooperating with other hospitals in order to be able to cope with challenges and on the other hand competing with these hospitals for scarce (human) recourses was reflected in this case and fits the healthcare context well.

Four qualitative studies

In sum, four in-depth studies on the empirically derived topics presented in the extended heuristic framework coupled with current debates in the scientific literature will enhance our understanding of the innovation process of Human Resource Management (HRM) related innovations in the specific context of the healthcare sector. Therefore, these topics, together with the four selected innovations, will be investigated more in-depth in the second stage of this research. These four themes will therefore guide the following four empirical chapters of this dissertation. In subsequent table 2.2, these four empirical chapters are presented. Chapter 3 will investigate the *role of the HR function* in several Dutch healthcare organizations. In-depth semi-structured interviews will inform us on the determinants of the power and position of the HR department and HR director in these organizations. Chapter 4 generates knowledge on the barriers and enablers of *cooperative innovation in times of increasing competition*. In-depth case studies in four hospitals that together initiated the Talent Management Pool are conducted to empirically investigate these issues. Chapter 5 will focus on the interplay of *multiple institutional logics* and the effect on the adoption and implementation of a specific innovation in a Dutch hospital. A longitudinal in-depth case study of the innovation 'Productive Ward: Releasing Time to Care' is conducted in order to enhance our understanding of institutional logics and the innovation process. Chapter 6

focuses on the role of the *institutional context* in the innovation adoption decision making process. Comparative case studies in ten hospitals on the motives for adoption of e-learning and task differentiation are used to study whether these motives differ for early and late adopters. In table 2.2 an overview of the next chapters in this dissertation is provided and in table 2.3 an overview of the interviews conducted for this study is provided.

Table 2.2: Overview studies stage two

	Topics/ perspectives	*Case*	*Design*	*Chapter*
HRM in healthcare: Living the dream	Actors: internal Enablers and Barriers	HR function	Comparative case studies	3
Collaborative innovation in times of increasing competition	Tensions: cooperation and competition Actors: internal Enablers and barriers	Talent Management Pool	Comparative case studies	4
Multiple institutional logics in healthcare: 'Productive Ward: Releasing Time To Care'	Tensions: business-like and professional logics Actors: internal and external Enablers and barriers	Productive Ward: Releasing Time to Care	Longitudinal case study	5
Leaders, Laggards and institutional pressures in healthcare: e-learning and task differentiation	Tensions: leaders and laggards, adoption motives Actors: internal and external	E-learning Task differentiation	Comparative case studies	6

Table 2.3: Overview interviews contextualized process methodology

Interviews	**Number of interviews**	**Number of organizations**	**Type of respondents**
Stage 1			
Studying the Human Resource Management innovation process: Introducting the contextualized process methodology (chapter 2)	104 interviews	10 teaching hospitals	Hospital directors Line managers HR professionals Managers of other staff departments (e.g. communication, quality) Employees (nurses, works council members and nursing council members)

Table 2.3 *Continued*

Interviews	Number of interviews	Number of organizations	Type of respondents
Stage 2			
HRM in healthcare: Living the dream (chapter 3)	59 interviews	15 healthcare organizations (care and cure sector)	HR professionals Line managers Managers of other staff departments Employees (works council members)
Collaborative innovation through Talent Management Pool: Coopetition in Dutch hospitals (chapter 4)	38 interviews	4 teaching hospitals	HR directors Project team (e.g. pool developer, project leader) Higher-level managers Line managers Employees (nurses, works council members)
Multiple institutional logics in healthcare: 'Productive Ward: Releasing Time To Care' (chapter 5)	15 interviews (8 at start of project, 7 at middle of project) 2 focus groups (at end of the project), 7 respondents per focus group	1 teaching hospital	Interviews: Hospital director Communication advisor External consultant Project leaders (internal advisors) Project team members Workgroup members (including nurses) Focus groups: Nurses Internal advisors Managers
Leaders, Laggards and institutional pressures in healthcare: e-learning and task differentiation (chapter 6)	83 (43 interviews task differentiation, 40 interviews e-learning)	6 teaching hospitals	Hospital director HR director HR advisors Line managers Employees (nurses, works council members and nursing council members)

CONCLUSION AND DISCUSSION

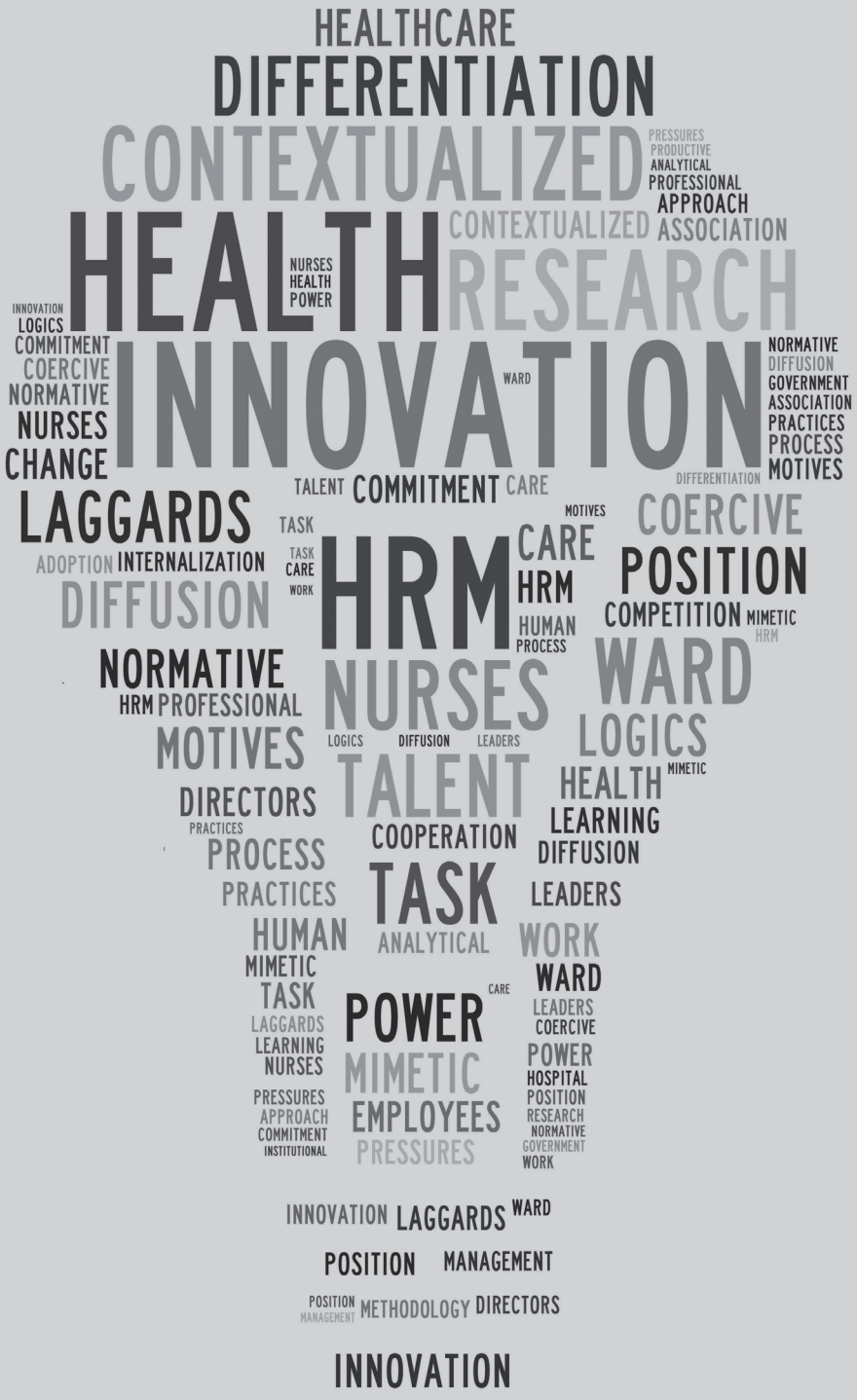
The aim of this chapter was to introduce the contextualized process methodology, in order to enable researchers to enhance the understanding of innovation processes and conduct research that takes into account the specific context. After the introduction of this methodology, an application of this methodology on the investigation of the HRM innovation process was presented.

This study introduces a new approach to the study of innovation processes that explicitly takes into account the research context. This study illustrates that qualitative research is valuable for enhancing our understanding of managerial themes. The stream of qualitative management research aiming to "gain in-depth understanding of an issue or viewpoint and use empirical data to illustrate this empirical point" (Welch et al., 2013) is followed. The research approach introduced in this study, incorporating principles from the analytical approach and iteration, is used to enhance our understanding of HRM innovation processes in healthcare organizations and the results of the first stage provide yardsticks for more in-depth studies on themes in the innovation process that are of specific importance to healthcare organizations.

This research approach yields several advantages. First of all, the contextualized process methodology allows for the research design to become adapted to empirical findings and theoretical considerations. Going back and forth between these elements results in a dynamic research design that allows us the capture interesting themes that otherwise might not have been studied. Secondly, this methodology answers the call of many scholars for contextually based research, in order to enhance our understanding of contextual influences on innovation processes in specific settings (e.g. Boselie, 2011; Boxall et al., 2007; Paauwe, 2004). In addition, truly taking into account the context and adapting the research design to specific contextual issues enables us to conduct contextualized innovation process studies, which provides a clear picture of the issues at play in HRM innovation processes in Dutch healthcare organizations. This approach is relevant for both scientists as well as practitioners. This benefits the scientific public through the adaptation and refinements of generic innovation process theories and by enhancing our understanding of innovation processes in certain contexts that are not explained well by generic models. Moreover, one of the risks associated with larger qualitative studies is that there is a lack of guidance. This approach provides guidance for further investigation by combining a heuristic framework based on theory, contextual elements and empirical results. The distinction between two stages is an element that differentiates this approach from other research approaches and this allows for methodological rigor. In addition, this approach benefits practitioners as well, through pointing out specific barriers and enablers, tensions and dynamics for innovation processes they are confronted with. This allows them to manage innovation processes more effectively. Moreover, this research approach allows us to balance rigor and relevance. This study shows that rigor in conducting research and relevance for organizations are not each other's counterparts, as often presumed, but that combining rigor and relevance is possible and results in useful research.

Critique on contextualizing research is that generalization of the findings to other contexts is difficult. However, the aim of these types of studies is not to generalize the findings to other contexts, but to enhance our understanding of HRM innovation processes in a specific context, such as healthcare. Output of this type of context specific research can be used as theoretical vehicles for the examination of other cases. Furthermore, the contextualized process methodology that was developed is usable for contextualized research in other contexts. Therefore, this research is very relevant for researchers studying organizational processes in other contexts.

Qualitative research in management studies are increasingly more adopted (e.g. Bluhm, Harman, Lee, & Mitchell, 2011; Lee, Mitchell, & Sablynski, 1999) and progress in qualitative methodologies are being observed (Bluhm et al., 2011). With this study the call from Bluhm et al. (2011) to add to a further development of qualitative research in management studies by introducing a new approach to study innovation processes is answered.


HEALTHCARE
DIFFERENTIATION
CONTEXTUALIZED
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PRODUCTIVE
ANALYTICAL
PROFESSIONAL
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POWER
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INSTITUTIONAL
PRESSURES
WORK
INNOVATION
LAGGARDS
WARD
POSITION
MANAGEMENT
POSITION
MANAGEMENT
METHODOLOGY
DIRECTORS
INNOVATION

CHAPTER **3**

HRM in healthcare: Living the dream?

This chapter is based on: Van den Broek, J., Veld, M., Boselie, P., Paauwe J. HRM in healthcare: Living the dream? Paper presented at Improving People Performance in Health Care conference, London, United Kingdom, September 9, 2011.

Manuscript is under review for publication.

INTRODUCTION

Human Resource Management (HRM) issues including increased work pressure, retention of nurses and medical specialists in times of an ageing population, and governmental cuts limiting recruitment and development are extremely relevant for healthcare organizations. The literature, however, is mainly focused on what happens in large private multinational companies (MNCs). And although highly relevant and interesting, these MNCs only represent one segment of all organizations in the world. The healthcare sector in western countries is a dynamic and vibrant context (Toth, 2010). Both the external and the internal context of healthcare organizations are affected by major challenges for rigorous organizational change. External challenges include first of all increasing demands for care arising from an ageing population (Kuhlmann, Batenburg, Groenewegen, & Larsen, 2013). This demographic development represents a double challenge for healthcare organizations. The ageing population not only causes increasing demands for healthcare, it also results in an ageing healthcare workforce, leading to retirement of highly qualified and motivated personnel. In other words, healthcare organizations are confronted with increased 'market' demands in combination with labor market shortages. Secondly, healthcare organizations are put under pressure by cost containment issues introduced by national governments and health insurance companies (Barros, 2010). The current healthcare management reforms are triggered by politics and national reforms. Healthcare organizations are subject to these major reforms and the impact is substantial, in particular the impact of the reforms on healthcare workers. Managing employees in times of major organizational change is therefore highly relevant for the healthcare organizations and its workforce. Medical innovations and new ways of working characterize the internal organization of many healthcare organizations nowadays, often caused by both cost containment considerations and higher public demands and expectations (Dubois, Nolte, & McKee, 2006).

As a result of these developments, healthcare organizations have introduced a number of organizational changes and innovations. Examples are restructuring nursing and medical functions (for example the introduction of nurse practitioners and physician assistants in hospitals), integral management as a new way of systematically working fully in line with optimizing customer care and cure, innovative forms of learning (for example e-learning and blended learning), new performance measurement and management systems, Crew Resource Management (CRM) for minimizing medical mistakes, and talent management to attract and retain highly qualified and motivated employees (e.g. Conway & Monks, 2010; Hyde, McBride, Young, & Walshe, 2005). There is a growing body of empirical evidence that these HRM themes are not just on the table as points of attention and input for new policies, but that these themes are being implemented as concrete work practices (for example work

restructuring initiatives) and HR practices (for example talent recruitment) in healthcare organizations as well (MacFarlane et al., 2011).

HRM and organizing work is the typical expertise domain of the Human Resource (HR) function and its HR professionals. Surprisingly, HRM and the HR professionals themselves do not seem to be significantly involved in many of the organizational healthcare changes. At least, that is the impression based on the interviews conducted in the first stage of this study. One can wonder why on the one hand HRM issues are highly relevant in healthcare organizations (and therefore clearly visible on the table), while at the same time, the Human Resource function and the Human Resource Management professionals are apparently not the innovators of organizational changes and in many cases do not seem to be significantly involved in any of these change processes. Therefore, systematic research into the realm of HRM and the involvement of HR professionals in healthcare settings is badly needed to investigate whether and why this is indeed the case. In this respect HRM is defined as involving all management decisions related to policies and practices that together shape the employment relationship and are aimed at achieving individual, organizational and / or societal goals (Boselie, 2010, p. 5). The aim of this study is to investigate which hindering and favouring factors affect the role of HR professionals in organizational changes and innovations in healthcare organizations. The central research question of the study is: What kind of hindering and favouring factors are related to the (non) involvement of the HR professional in healthcare organizations?

This paper can be positioned within the HR professionalization debate (e.g. Guest & King, 2004). More specifically, it can be positioned within the ongoing debate with regard to HRM being 'on the table' referring to HRM issues being taken seriously at all levels of the organization (in particular at the top management level) and HRM being 'at the table' when decisions are being made and actions being taken (Ulrich & Brockbank, 2005).

In this study, the focus is on the HR is 'at the table' debate and which hindering and helping factors affect the role of HR professionals using qualitative research methods. This study is inspired by the research by Guest and King (2004) who conducted multi-sector research in the UK. They investigated whether senior managers accept and act upon the arguments about the central role of human resources and whether HR managers are included in strategic planning and decision making (i.e. act as strategic partners). The focus will be on investigating whether the HR function is able and allowed to act upon these themes, and which factors help or hinder the HR function. First, the power and position of the HR function and different theoretical models are discussed. The HR function represents the Human Resource responsibilities and tasks that are bundled in a Human Resource department and performed by Human Resource professionals (Boselie, 2010, p. 255). Second, based on previous studies,

hindering and favouring factors affecting the HR function are described. Finally, the research design is described and the findings are presented and discussed.

The scientific relevance of this paper therefore lies in revealing the HRM discipline's influence (or non-influence) on management decisions in the specific healthcare sector given the nature of the contemporary organizational challenges (e.g. ageing population) and given the nature of HRM today. The focus of this study is on the hindering and favouring factors for HR professionals in the shaping of HRM in the complex and turbulent healthcare context. Secondly, mainstream HRM research has been focused on large private companies and only recently HRM researchers have started to focus on other organizations including public organizations (Bach, 2009).

The societal relevance of this research lies in understanding why HR professionals and their HR function are at the table with respect to actual involvement in strategic decision making with regard to HRM themes. In addition, the relevance of the study lies in the identification of hindering and favouring factors for HR professionals for influence on HRM decision making and HRM implementation. These insights can provide concrete yardsticks for HR professionals in healthcare practice to make strategic contributions to the achievement of organizational goals.

THEORETICAL FRAMEWORK

Focusing on healthcare, one can see an increasing interest in the relevance of HRM policies and practices for creating added value (Townsend & Wilkinson, 2010). This is reflected in the growing number of empirical studies on the relationship between HRM and performance in healthcare (e.g. Lee, Lee, & Kang, 2012). These studies provide a first indication that the management of employees (HRM) plays an important role in achieving organizational goals in healthcare. Important to note, however, is that in practice it is more difficult to determine the HR responsibilities, and therefore the position of the HR department in an organization (Legge, 1978, Guest & King, 2004). The HR department and its professionals are often 'the victim' of strategic decision making in organizations, implicating that HR is only involved after the initial strategic decision making and in some cases not or only partly involved in the implementation of the HR practices and work practices. Therefore, the HR department and the HR professionals are limited to interventions that require little or no influence on the strategic decision making right from the start (Buyens & De Vos, 2001; Hope-Hailey, Gratton, McGovern, Stiles, & Truss, 1997). Ulrich and Brockbank (2005) refer to this issue as HRM is

not 'at the table'. In the next section, the roles the HR function can adopt in order to acquire power in organizations are described in more detail.

In the literature, much is written about different roles HR can adopt in order to acquire power and influence. Legge (1978) for example identifies three strategies by which personnel managers could gain power and influence within organizations, i.e. the conformist innovator, the deviant innovator and problem-solver role. The conformist innovator speaks the (business) language of the CEO, CFO and other disciplines such as marketing. Overall, the conformist innovator accepts the dominant managerial values and bureaucratic relationships within the organization and is aimed at simply satisfying the requirements of senior management. A role which has much in common with this conformist innovator role is the strategic business partner role (Ulrich, 1997). According to Ulrich and Brockbank (2005), business partners should focus on the execution of the organizational strategy by aligning HRM systems in order to accomplish the organization's vision and mission. In other words, the business partner aims at satisfying the needs of senior management, just as the conformist innovator. An alternative way for HR to acquire power and influence is by adopting a deviant innovator role. A deviant innovator puts forward long term issues related to HRM and highlights the continuous search for balancing economic interests and human aspects (Legge, 1978), for example embedded in employee well-being and corporate reputation. The deviant innovator identifies with different but not necessarily conflicting sets of values and takes a powerful independent professional stance vis-à-vis managerial clients. He or she is much more critical towards decision making and recognizes the tension between economic and moral values in the case of managing employees.

Though the theoretical distinction between the two roles is interesting for discussing the role and position of HR managers, these roles might be difficult to put into practice. Guest and Bryson (2009) for example, conclude that they can't present evidence of the emergence of either of these roles. Legge's problem-solver role is less ambitious than the conformist innovator and deviant innovator role, but perhaps more realistic. The HR manager as problem solver is capable of delivering the basic HRM practices (for example staffing) to HR customers, such as employees and line managers. The idea behind the relevance of this role is that solving problems of customers such as line managers and employees will gain credibility and strengthen the reputation of HR managers. Credibility and a good reputation are most likely to positively affect the position and the power of the HR function within an organization. Much emphasis, both in research and practice is put on the role of business partner (or conformist innovator). Especially the work by Ulrich attracts a lot of publicity and research, and many profit organizations have adopted the business partner role or some variant of it (Reilly, Tamkin, & Broughton, 2007). Despite the attractiveness to practitioners, the business

partner / conformist innovator role, as well as the deviant innovator role, might be difficult to realize in practice, as administrative tasks and providing support to line managers are still time-consuming tasks (Reilly et al., 2007). On the contrary, the problem solver role seems more promising in this perspective. More specifically, HR professionals that adopt this role are much more focused on day-to-day problem solving, thereby creating more opportunities to get actively involved in HR implementation and organizational change processes. Hence, one can expect that this indeed will result in more credibility and a better reputation, thereby increasing their power and position.

So far, there is hardly any empirical evidence about the power and position of HR in healthcare. An exception can be found in the work by Townsend, Wilkinson and Allen (2011). Based on a case study in a large Australian hospital, they conclude that the HR department was aimed at a transition from a traditional hospital style of personnel administration towards more strategic HRM. More specifically, they present some indications that the HR department is more and more involved in influencing strategic goals and planning, and as such there role is now seen as more strategic. However, important to note is that the findings show that the implementation of a more strategic HR policy was hindered by pressures on budgets. Although this is just one example of a hindering factor the HR professionals are confronted with, one can expect that the actual influence of the HR department is dependent on hindering and favouring factors in the organizational context. Hence, in the next section a short overview of factors that could hinder or favour the position of HRM is provided.

Hindering and favouring factors

As suggested in the previous section, organizational factors might hinder or favour the adoption of strategic HR policies and practices as well as the power and position of HR professionals in an organization. Different studies indeed show that a lack of resources (e.g. time, money) hinder the adoption and implementation of HR (e.g. Garman, McAlearney, Harrison, Song, & McHugh, 2011; Townsend et al., 2011). Given the fact that more and more HR responsibilities are devolved to line managers in healthcare nowadays, the lack of resources not only hinders the HR professionals, but line managers as well. McConville (2006), for example, shows that a lack of time and money are major obstacles for line managers in public organizations in being able to manage their staff properly. Besides a lack of resources, HR adoption and implementation might be hindered by the fact that there is no sense of urgency, as shown in a case study by Björkman and Søderberg (2006). It can be expected that these factors could also be directly linked to the HR professionals and departments themselves. Several studies identify hindering factors directly related to the HR function. Truss and Gill (2009) identify for example lack of stability in the HR department, lack of skills (e.g. negotiation, communication skills) among HR professionals and a lack of connected-

ness in the organization as factors that result in lower credibility of the HR department. In line with this, Björkman and Søderberg (2006) also identify a lack of competencies among HR managers as constraining factor. Moreover, their results suggest that top management and line managers do not have any expectations about the strategic involvement of HRM. These expectations about the role of HR appear to be deeply rooted in the historical and administrative heritage of the organization, and therefore difficult to change. This factor appears to be of direct relevance to healthcare as well, as HR departments in this sector used to be focused on personnel administration, rather than strategic decision making. Changing the expectations by line managers and top executives therefore seems to be a relevant task in order to become involved in strategic decision making.

This overview of mainly hindering factors is just exemplifying. Nevertheless, it shows that getting at the table and gaining power and position is a challenging task for HR professionals in healthcare.

Summarized, the impression, based on frequent interaction with healthcare managers and professionals and based on previous studies described above, is that HR issues are on the table in healthcare. The question remains, however, how the (lack of) involvement of HR in strategic decision making can be explained. In the remainder of this chapter, it will be explored whether the HR function and HR professionals in different healthcare settings are involved in strategic decision making, and which hindering or favouring factors they are confronted with.

METHODS

The research design was inspired by the design used by Guest and King (2004). Nevertheless, some modifications were made. Their framework was used as a guiding principle for the research design and data collection in this study. In order to answer the research question, qualitative data was collected. A qualitative research design was chosen, as qualitative data enables taking into account influences of the local context and this type of data has the "strong potential for revealing complexity" (Miles & Huberman, 1994). Therefore, semi-structured interviews in fifteen Dutch healthcare organizations were conducted. Six hospitals (cure) and nine care organizations were included in this research. These latter organizations deliver a wide variety of care, including mental-, nursing-, home- and social care.

A multi-actor approach was adopted in this study, which was set up to as a form of triangulation to increase the validity of the findings. In this way, the results were not just based on the input from HR professionals, who tend to be more positive about HRM in general than non-HR professionals such as line managers and executives from other disciplines (Wright, McMahan, Snell, & Gerhart, 2001). The multi-actor and multi-rater design in HR research is also recommended by Gerhart, Wright, & McMahan (2000). An employee representative was included in this study to broaden the picture, as they are very relevant for the Dutch healthcare sector, which is characterized by a relatively high degree of unionization. The employee representative was either a member of the works council of the healthcare organization or the chair of the works council. In this design, every organization (n=15) was represented by on average four different respondents. In total 59 interviews were conducted within these fifteen organizations, which includes one interview where two respondents participated. This design enabled us to make comparisons across the 15 healthcare organizations, as well as between views of HR directors and non-HR executives.

A semi-structured open-ended interview list, inspired by the list of Guest and King (2004), was applied to collect the empirical data among the respondents. The questions focused on identifying whether the HR function is at the table and what hindering and favouring factors can be identified. An example question is 'Why aren't HR professionals involved in strategic decision making?' The advantage of this type of interview questions is that the researcher is informed about a wide range of issues which all together create the bigger picture of the subject. The data were collected in 2010. All the interviews were recorded on tape and fully transcribed.

Framework analysis as described by Ritchie and Spencer (1994) was applied to analyze the data. Following this method, the thematic framework was used for classifying and organizing the data. The first stage in framework analysis, familiarization, was aimed at making the researcher become acquainted with the obtained data through listening to the taped interviews, reading the notes and typing out the full transcripts. The second stage in framework analysis was aimed at identifying a thematic framework and a list of categories. This was a first step towards categorization of the empirical data. Two main themes were identified; hindering and favouring factors affecting the role of HR professionals. Data was sorted by these themes in the coding scheme that was developed. The third stage in framework analysis, indexing, entailed the further sifting of the empirical data (Ritchie & Spencer, 1994). The original data was labelled to identify the theme or concept to which it belongs using Altas.ti software. During this process, the coding scheme was continuously adjusted. A second researcher was also involved in the coding process, in order to check whether the texts were similarly coded by both researchers. Minor differences in coding between the two research-

ers were identified. In addition, during the charting process the original data was rearranged and transferred in the framework. Excel tables were used to be able to compare the data of the different respondent categories and different healthcare sectors (care and cure) in the sample. The final stage in the analysis was the mapping process in which the interpretation of the findings took place through analyzing the relationships between the quotes and the underlying themes in the dataset.

FINDINGS

The analysis of the interview data reveals several issues with regard to the power and position of HRM in Dutch healthcare organizations, which will be discussed below. The results are reported in two parts. First, the findings with regard to whether the HR function and HR professionals are involved in strategic decision making will be presented. Subsequently, the hindering and favouring factors affecting this process will be presented.

Power and position of the HR function

The results show that in many healthcare organizations, the HR function is not or only marginally involved in strategic decision making.

> *HR should be involved at the highest level and in strategic decision making, but in practice this doesn't happen.* (HR director, hospital A)

However, in some other organizations the HR function is involved in strategic decision making.

> *I enjoy being able to pull the strings and influence the internal HR process and the external process. I'm talking about my role in the management team, the bilateral with the Board of Directors.* (HR director, hospital B)

In subsequent sections, on the one hand the factors hindering the HR function to gain strategic influence and on the other hand the factors facilitating strategic involvement of the HR function are identified.

Hindering factors

While the importance of HRM themes is widely acknowledged, actually acting upon this awareness is not that self-evident. The majority of the respondents explain that investment in employees and HRM is limited, mainly due to financial constraints. Multiple organizations

in the sample are recently (before or during the interviews) confronted with downsizing, mergers and budget cuts. One of the reasons for these developments is the cutback on healthcare budgets by the Dutch government, which affects healthcare organizations and further enhances their need to economize. In quite a few organizations financial barriers towards investments in HRM are present. Subsequent quote illustrates this.

> *We have had major cutbacks, they economized heavily on training budgets. That is a shame, because previously they invested heavily in employees.*
> (HR professional, care organization E)

Besides financial concerns, time constraints are also seen as a barrier towards investing in HRM. This issue is becoming increasingly more pressing due to the shift of operational HRM tasks from the HR department to line managers.

> *My employees would be very willing to follow training and courses, but our organization does not have the resources to enable them. Financially, but also in terms of time. Our organizations want to deliver 5 star care, but we only have 2 star financing...What you see is that employees are eager to develop themselves, but that the organizations focuses on things like fire prevention... Higher management decides that those affairs are prioritized.*
> (Line manager, care organization B)

> *Facilitating employees to follow courses, which is also a problem in healthcare, because if people are attending courses, no one stands next to the bed.*
> (Policy advisor quality, care organization I)

As these quotations illustrate, staffing issues could also hinder investing in the development of employees. It becomes more and more difficult to free employees from their tasks in order for them to be able to attend training or education programs. This could indicate that a short-term HRM focus is dominant in these organizations. It seems that here the focus is not on long-term HRM issues such as employee development and retention, even though these are important topics in handling challenges such as labor shortages. On the contrary, short-term issues like day-to-day staffing of the wards seem to be prioritized.

> *I wrote a nice proposal for a new task structure..., but it was cancelled by my boss due to time constraints...There was support for the proposal, because everyone wanted it, but they shied away because of the time investment.* (HR manager, hospital A)

The next quotation shows that also within the HR departments, time constraints limit the investments in HRM. In a few organizations, the HR department itself is affected by financial cutbacks, resulting in downsizing of the HR department. As the next quotation shows, this affects the amount of time and energy that can be devoted towards personnel management.

> *...If you translate that to the current amount of HR employees, this is a small group compared to the amount of employees working in the organization. Nationwide there is a standard which shows how many HR advisors are needed for a certain amount of employees. We are far below that. In other words, our HR advisors need to work extremely hard...the HR department is too small relative to the enormous amount of employees in this organization.* (Line manager, hospital E)

Several factors explaining the lack of strategic involvement of the HR function can be identified. In this respect, one of the issues is that in some organizations the basic HRM processes are not delivered well enough. In most organizations, HR primarily advises line managers, but these line managers are not always satisfied with the quality of advice. Next to that, HR managers themselves also recognize that there is room for improvement in their delivery of basic processes.

> *Sometimes, HR practitioners say: "Well, I don't know either" or "We don't have that, I can't help it". I think it is a shame that they don't say: "I will follow up on that" or "I will arrange that".* (Sector manager, hospital F)

> *I have the impression that people aren't always helped well or that they don't get the right answer or don't receive an answer at all. And sometimes the advice is not straightforward; one HR consultant advises differently than the other.* (HR manager, care organization B)

In addition, the fact that HR professions lack sufficient orientation towards efficiency and results appears to be an important hindering factor. Respondents indicate that, primarily due to governmental and financial pressures, healthcare organizations are becoming more result oriented. Especially for hospitals, this is necessary in order to survive in the increasingly competitive environment. Several respondents indicate that HR also needs to make this transition; they clearly need to show their added value for organizational performance if they want to be taken seriously by the board.

> *The HR employee that listens carefully and reasons from the primary process and thinks about what he or she can contribute to accomplish the goals will be at the table, you can*

see that change. Thus I see traditional HR employees that linger and HR employees that take on a business-like approach, with organizational sensitivity, that develop themselves. Throughout the country you can see a differentiated picture: you can see a hospital with a really old-fashioned form of personnel management and 100 kilometres further a hospital where HR is incredibly business-like. This will have to be initiated by HR. (HR director hospital D)

Finally, an important finding related to the positioning of the HR function is related to the connection of HR with the core business processes of their organization. Respondents indicate that it is very important that HR really understands the complexity of healthcare organizations in order to be perceived as credible and to be able to satisfy the needs of managers. First of all, political processes are complex in healthcare organizations. For example, the power structure in Dutch hospitals is complicated by the fact that most medical specialists are not employed by the hospital, but are self-employed. This often results in conflicts of interests between the organization and the physicians. Also within the healthcare sector differences exist. For example, employment related problems in a hospital laboratory could be different compared to problems in a nursing ward. Sector specific issues like these complicate effective management of human recourses and stress the need for the HR function to be aware and to act upon them.

Core business involvement is very important. Someone from the profit sector can't imagine what healthcare is actually about. Really understanding it is difficult. Assembly lines are straightforward, but that isn't how it works in healthcare. (HR manager, hospital A).

Despite the acknowledgement that core business involvement is very important for the positioning of the HR function and the adequate delivery of HR-services, many respondents indicate that the involvement and knowledge of the core business is not always sufficiently present in the HR departments

I doubt to what extent they [HR] are aware of what is going on in the organization. (Staff manager, care organization A)

I think they [HR] have no idea what they are doing. For example, they come up with things of which I think; well, you can see you don't know anything about the core business. (Line manager, care organization, D)

Favouring factors

In some of the organizations, the HR function is actively involved in strategic decision making. Some factors facilitating this process can be identified.

The extent to which the HR director is involved in strategic decision making may depend on the degree of leeway the top management grants the HR manager. In some organizations, the advice HR gives to the board is taken very seriously and affects the decisions that are made, while in others this is not the case.

> *Yes, I have a voice…I'm part of the management team….the Management Team is an advisory source for the Board of Directors. The Board of Directors eventually makes the decisions. However, if it is about things within my field, they expect me to make a proposal or give an advice, and that is taken very seriously. I think that that is something special in a hospital culture; people tend to reason in specialisms. So the physician knows a lot about a knee, an HR manager knows a lot about HR, so the position comes to you naturally. I think that is very special.* (HR manager, hospital F)

> *HR is not present when the strategic decisions are made, because we primarily have a supportive role. This really has to do with the leaders of our organization. If there would be another director, this could be very different…. I don't feel valued by the top of the organization.* (HR director, care organization F)

These quotations illustrate how important it is that the Board of Directors endorses the value of HR and HRM issues in their organizations. Support from executives at the highest level enables the HR function to influence strategic decision making.

In addition, the expertise of the HR function is an important facilitating factor. When HR is perceived by other organizational actors as being an expert and providing excellent advice, the chance they will be involved in strategic decision making is much larger according to the interviewees.

> *Expertise justifies the existence of HR, creating added value for managers and employees.* (Staff manager, hospital B)

This is related to another favouring factor; the image and visibility of the HR department and the visibility of their results. Often, internal clients are satisfied with the quality of the HR department, but they find it difficult to indicate whether HR really has added value for the

organization. If HR is able to improve its visibility and is better able to show its added value, board members may be more inclined to involve HR in strategic decision making.

> *I think that HR is visible at the highest management level. But I doubt whether HR is that visible towards employees. Therefore, they are taken less seriously at that level.* (Line manager, care organization A)

> *Most people only know HR when something is going wrong and needs to be changed. They are not very visible.* (Works council member, hospital B)

> *They are involved in the Management Team, involved in team meetings. They are present, they are visible and therefore the HR policy is also visible.* (Line manager, hospital F).

Finally, the extent to which HR is acting pro-actively is also an important determinant of strategic involvement. In most organizations pro-active behaviour is lacking, but in the organizations where HR is involved in strategic decision making, HR shows pro-active behaviour. For example, by anticipating on future developments by advising line managers unasked. In general, the respondents claim that the HR professionals do not display enough pro-active behaviour, which may account for the poor strategic positioning of HR. Respondents from all respondent groups indicate that a more forward-looking and anticipating attitude of HR would significantly improve their strategic influence

> *They [HR] need to work on that. Especially when you talk about the work at the policy level, there has been too little development there. You expect a certain degree of pro-activity; not just waiting for a signal and then come up with proposals. In addition, the quality of those proposals is poor.* (Line manager, care organization I)

> *I think HR would be much more effective when they would behave a bit more pro-active.* (Line manager, hospital D)

> *I think an HR department should make proposals at the organizational level. They do that in our organization.* (Line manager, cure organization C)

The results described show that HRM issues are highly relevant in the organizations under study. Furthermore, the importance of these issues is widely recognized and they are high on the agenda. However, the data do reveal limitations and barriers to really act upon these challenges.

To sum up the findings with respect to the power and positioning of the HR function in the organizations under study, the results show that the importance of HRM issues is widely recognized. Nevertheless, many HR managers are not involved in the actual decision making process. Several hindering and favouring factors were identified to explain the extent of strategic involvement of the HR function in healthcare organizations. These factors are displayed in table 3.1.

Table 3.1: Hindering and favouring factors

Hindering Factors	Favouring Factors
Financial constraints	Sense of urgency General awareness of relevant HRM issues in healthcare (for example labor shortages)
Time constraints -Day-to-day staffing prioritized over long term investments in personnel, such as training -Time constraints within the HR department, caused by downsizing of the HR department	Top management support for HR function/department and HR professionals
Lack of long term strategy / short term orientation	Growing recognition that HR professionals are experts in recruitment & selection, training & development, compensation and appraisal / performance management
Administrative support not satisfactory	Image / reputation of the HR department through: - Visibility (not in the ivory tower) - HR delivery
HR professionals insufficiently oriented towards efficiency improvements and results	Pro-active behaviour HR professionals -Forward-looking -Anticipating
Limited business knowledge HR professionals -Nature of business -Politics and processes (how the land lies)	

CONCLUSION AND DISCUSSION

The analysis of the interview data reveals several issues with regard to the position and power of HRM and the HR function in Dutch healthcare organizations. The results show that HR is often not involved in organizational change processes and strategic decision making. The findings reveal hindering and favouring factors affecting this process that could be useful in enhancing this role of HR.

Hindering factors

The findings reveal several factors hindering the involvement of HR in organizational change processes. The critiques on the HR function and the HR professionals by non-HR respondents focus on both the problem-solving role and the strategic partner role of HR professionals. In many cases the HR professionals are not able to deliver the HRM basics (such as staffing and solving employee problems), but also the strategic partner role of HR professionals in Dutch healthcare organizations is not fully grown. Overall, the conclusion is that HRM issues are on the (top) management table, but HR is not always fully at the table, meaning the influence of the HR function and its professionals in healthcare organizations is often still limited. This is remarkable given the nature of the major organizational reforms within healthcare organizations. On the one hand HRM as a policy area is perceived as essential for healthcare organizations, but on the other hand the HR function itself is not connected to most actual implementations and organizational changes with people (and thus HRM) related issues (e.g. integral management and Crew Resource Management). If HR professionals in healthcare want to enhance their involvement in these implementation and change processes, more insight is needed in constraining factors and circumstances that impede this involvement. In the next sections, an overview of these constraining issues is provided.

The relevance of HRM issues is strongly related to external and internal organizational challenges including the ageing population and cost containment pressures put on healthcare organizations by the Dutch national government. In practice, however, the focus in most healthcare organizations is not (yet) on searching for Long-term solutions for solving these issues through for example HRM. HRM is still mainly involved in the more traditional activities like recruitment and selection, socialization, training and development, appraisal and pay. Yet, even these practices are perceived by the respondents as being limited due to:

- a lack of financial resources for HRM investments (financial constraints);
- a lack of time or people available to implement HRM (time constraints; for example no time available for sending healthcare workers to training sessions because of regular work planning problems);

- the quality of the HR professionals or HR managers in terms of HRM delivery (the actual delivery of HRM practices) and personal credibility (quality and credibility constraint);
- limited business knowledge of the HR professionals regarding the nature and politics of healthcare organizations.

Quality of the HR function: subject to improvement

The first explanation for the phenomenon that the HR function in healthcare organizations is not really involved in strategic decision making and in organizational change processes is a lack in the knowledge, skills and abilities to be a problem-solver and a strategic partner. Research reveals some indications that HR professionals lack personal credibility from line managers potentially caused by a lack of a good relationship with management, lack of talking the language of (healthcare) business and lack of other personal skills, such as verbal communication skills (Boselie & Paauwe, 2005).

Need to shift focus (from employment to work practices)

A second explanation linked to the first one is the focus of HR professionals mainly on the typical HRM practices or basic personnel instruments such as recruitment, selection, appraisal, training and pay. Boxall and Macky (2009), for example, make a strong plea for more emphasis on practices beyond the traditional personnel instruments. The work practices in the terminology of MacDuffie (1995) and Appelbaum, Bailey, Berg, & Kallenberg (2000) cover the area of work design and are represented by for example employee autonomy, employee involvement in decision making, job rotation, job enlargement, job enrichment, teamwork and decentralization. Interestingly enough, this is the area in which most organizational changes have emerged in healthcare organizations in the last couple of years. In other words, the HR function and its HR professionals focus too much on HRM or employment practices, while the real HRM issues in healthcare organizations focus on work (re)design and related work practices. In fact, in most cases the HR professionals are not involved in any of these organizational changes in healthcare organizations such as integral management and Crew Resource Management. These initiatives and implementations apparently have other initiators and implementers. This is a missed opportunity for the HR function and its HR professionals within the healthcare organizations. They are not connected. This notion will be developed further in the discussion on possible ways for HR professionals to improve their position in healthcare organizations.

Other priorities

So far, the focus was on the HR function and its professionals as explanation for the lack of influence of HR on decision making and organizational changes in healthcare organizations. However, it is not only the HR function and its professionals that can be blamed for this. First,

the results in this study show that top managers are still not fully convinced of the relevance and importance of good HRM for achieving organizational goals. They have too many other priorities on their mind: priorities related to healthcare reforms at macro level, construction building (new building and facilities), internal conflicts (for example with or between medical specialists), public benchmarking (outcomes of rankings in national newspapers) etc. In other words, they have a lot of issues on their plate and HRM issues are not always fully clear and on the spot. Another explanation linked to top managers is that they are actually far from being in control of the initiatives and organizational renewals within healthcare organizations. In this respect, one should take into account that in particular in healthcare, organizations are open systems with continuous interactions within the organization at all levels and interactions with the outside world. Medical specialists and nurses, for example, have their own professional networks and together with middle managers and / or project managers they can come up with all new kind of work practices including the introduction of physician assistants and Crew Resource Management. In the end, top management may be involved for the final approval, but most of these initiatives are bottom-up with a diversity of origins and actors involved. It is likely that the HR professionals are often not the ones that are involved and again it may be concluded that the HR function and its professionals are not connected. This might have to do with the fact that HR professionals have not only been too much focused on employment practices (instead of work practices), that do not connect to new work design initiatives at a more tactical and implementation level within healthcare organizations, that really link to the key business (healthcare delivery) processes (Becker & Huselid, 2006).

Is there a way out?

Several factors favouring the role of HR in shaping HRM in healthcare organizations can be identified. First of all, the awareness of a sense of urgency when it comes to HR issues, such as labor shortages, is an important facilitating factor. In addition, the support of top management is crucial for HR in acquiring a bigger role in organizational process. In addition, establishing a reputation as well-delivering expert on HR issues, being visible throughout the organization and behaving pro-actively are favouring factors derived from the data. These factors indicate that there is a need for change in the HR function as it is in most organizations. In order to overcome the hindering factors and enhance the availability of favouring factors, there is a need for a new role for HR. There might be a solution for these professionals in healthcare organizations. HR professionals in healthcare organizations have to improve their knowledge, skills and abilities in order to gain more credibility and to increase their level of influence throughout the organization. Previous HRM research has shown what kind of knowledge, skills and abilities are required for HRM delivery, personal credibility and strategic contribution (Boselie & Paauwe, 2005). Getting involved in strategic decision

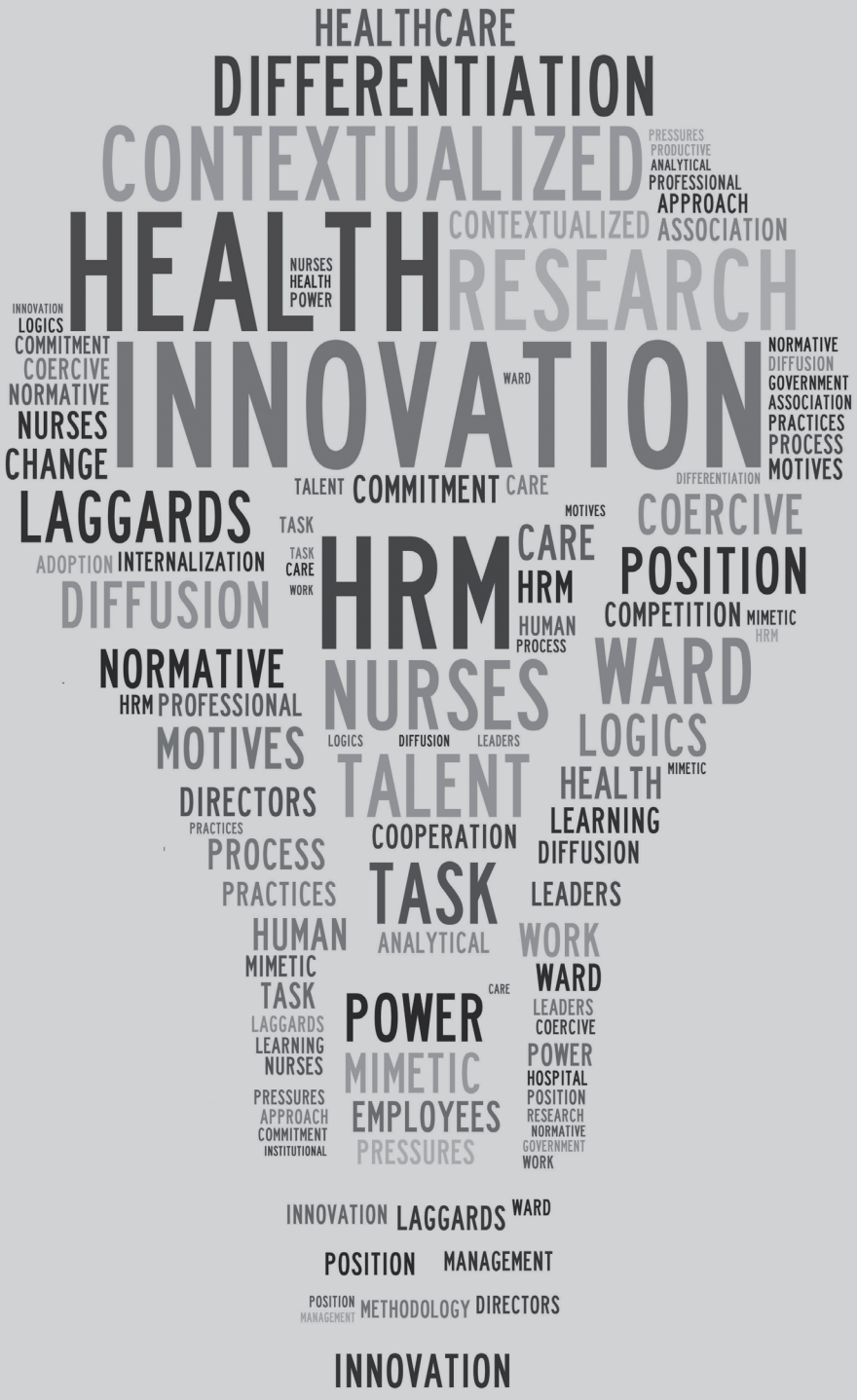
making at the top level of the organization is not good enough given the nature of most organizational renewals within healthcare organizations. The HR professional in healthcare of tomorrow needs to be connected to all levels of the organization to facilitate, integrate and coordinate innovations in work design within the organizations. Healthcare organizations are characterized by multiple innovations and concrete organizational changes and it is therefore crucial that the actual HR interventions and implementations are connected to other organizational developments and the overall organization's strategy. The 'connected human resource manager' is a sort of project manager and coordinator that brings together different actors within the organization, facilitates the design and implementation with knowledge and skills with regard to organizational change, and creates linkages between different organizational initiatives to avoid an overkill of 'stand-alone' initiatives within one healthcare organization. The idea of 'connectedness' is strongly linked to recent notions on the relevance of implementation in HRM (Becker & Huselid, 2006; Regnér, 2008). Suggested can be that strategies for good implementation in combination with increased levels of 'connectedness' can contribute to increasing the dynamic capabilities of healthcare organizations operating in a turbulent environment.

Final remarks

The central question of this research was:

What kind of hindering and favouring factors are related to the (non) involvement of the HR professional in healthcare organizations?

The answer to this question is threefold. First, the HR function and its HR professionals are hardly connected to major organizational changes in healthcare organizations, which is partly due to the fact that a majority of the HR professionals lack the necessary knowledge, skills and abilities to contribute to these changes. Second, there is too much focus on HR practices instead of work practices. Finally, the focus of HR professionals in healthcare is not on trying to take on the role of 'the connected human resource manager' in new initiatives and implementations. If Human Resource professionals really want to be perceived as credible and to be taken seriously in healthcare organizations, in other words if they want to be living their dream, it is necessary that they are connected with organizational developments.


HEALTHCARE
DIFFERENTIATION
CONTEXTUALIZED
PRESSURES
PRODUCTIVE
ANALYTICAL
PROFESSIONAL
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METHODOLOGY
DIRECTORS
INNOVATION

CHAPTER 4

Collaborative innovation through Talent Management Pool: Coopetition in Dutch hospitals

This chapter is based on: Van den Broek, J. Paauwe J., & Boselie, P. Collaborative innovation through Talent Management Pool: Coopetition in Dutch hospitals. Paper presented at British Academy of Management conference, Cardiff, United Kingdom, September 11-13, 2012.

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INTRODUCTION

Recently, there has been a significant increase in competition between Dutch hospitals. Market-oriented reforms introduced by the Dutch government increase competition for financial resources. Simultaneously, demographic developments create labor shortages, which increase the competition among hospitals for human resources. Therefore, the fight for scarce resources is highly relevant for the Dutch healthcare sector. One might expect that Dutch hospitals might be less likely to cooperate with each other because of the increased amount of competition. However, four Dutch teaching hospitals started to cooperate to find innovative solutions for these challenges. This is in line with the increasing role of cooperation in innovation processes (De Faria, Lima, & Santos, 2010). To be able to cope with labor shortages, the Human Resource (HR) managers of these hospitals formally agreed to educate nurses in order to increase the regional labor pool. In addition, they developed the Talent Management Pool, a virtual labor market where employees can be exchanged among participating hospitals. The hospitals aim to become better able to attract and retain talent for the participating hospitals. They also expect to benefit from reducing costs on hiring external personnel. This development fits well with Beechler and Woodward's (2009) argument that innovative approaches are needed in order to attract and retain employees. They suggest that developing partnerships and creating local talent pools are innovative strategies that could help organizations to achieve these goals.

In contrast to the competitive perspective usually taken to address labor shortages, this approach emphasizes cooperation. However, the competitive aspect of relationships between hospitals might complicate such cooperative initiatives. This combination of competition on the one hand and cooperation on the other is reflected in the concept of coopetition (Brandenburger & Nalebuff, 1995).

This study focuses on cooperative innovation with competitors. The Talent Management Pool is studied, as a striking example of collaborative innovation in times of increased competition that could enhance our understanding of the complications in the innovation process that might be created by coopetition. One can wonder how stakeholders perceive the fact that these four hospitals that compete for scarce human resources cooperate and how this affects the innovation process. Managers, HR professionals and managers of the talent pool of all the four hospitals involved are the focus of this research, because their perceptions are expected to affect the success of the innovation. Therefore, the central research question of the study is: *How do organizational actors perceive cooperative innovation with competitors and how does this affect the innovation process?* Many coopetition scholars refer to cooperation literature when discussing rationales for coopetition (Padulo & Dagnino, 2007; Ritala,

2012). As the competition aspect that is added in coopetitive relationships might complicate innovation processes, the aim of this research are to explore whether these theories are applicable to coopetitive relationships.

The scientific relevance lies in the observation that cooperation with other organizations is increasingly important to develop and implement innovations (De Faria et al., 2010) and cooperative innovations are increasingly developed. While the body of literature in this area is growing, the number of studies focusing on cooperative innovation in the public sector is lagging behind. There is a need to examine the process of cooperative innovation with competitors in the public sector more in-depth in order to understand the role of the interpretations of different actors (Sørensen & Torfing, 2011). Bengtsson, Eriksson and Wincent (2010) call for research that enhances our understanding of the perceptions and response of different actors on the tensions associated with coopetition because these perceptions potentially affect the success of coopetitive innovation with competitors.

It can be expected that these processes in public sector organizations such as hospitals differ from cooperative innovation in the private sector, because the former organizations are often characterised by bureaucracy and inertia, which hamper the innovation process (Bommert, 2010). However, the recent introduction of competition in the healthcare sector might drive innovation by forcing hospitals to change their routines and norms (Sørensen & Torfing, 2011). While innovation might be stimulated by the introduction of competition, the effects on cooperative innovation with competitors remain unclear. This is related to coopetition, which is still relatively underdeveloped (Dagnino, 2007) and under-researched in the hospital sector (Peng & Bourne, 2009). The paradox of cooperative innovation in times of increased competition for resources is in need of in-depth examination. Therefore, this study adds to the literature on cooperative innovation in the public sector and coopetition by empirically examining the perceptions of organizational stakeholders on coopetition and their consequences in Dutch hospitals. In addition, these insights are relevant for practitioners facing innovation challenges related to coopetition.

THEORETICAL FRAMEWORK

Interorganizational cooperation for innovation

Due to the challenges healthcare organizations are confronted with, they are in need for innovative managerial practices (Rye & Kimberly, 2007; Walston, Kimberly, & Burns, 2001). In particular, Human Resource Management (HRM) innovations seem to be of increasing importance, due to the fact that many healthcare sector developments are related to

employment issues. For instance, the ageing population results in a greater demand for healthcare employees to deliver care. However, in many countries major issues regarding the recruitment and retention of nurses are present, resulting in increasing labor shortages (Länsisalmi, Kivimäki, Allto, & Ruoranen, 2006). In their review on innovation in healthcare, Länsisalmi et al. (2006) define innovation as "the intentional introduction and application within a role, group, or organization, of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, or wider society" (p. 67). Many authors connect interorganizational cooperation with innovation (Ribeiro-Soriano & Urbano, 2009; Blomqvist & Levy, 2006; Miles, Snow & Miles, 2000; Goes & Ho Park, 1997). For example, Tomlinson (2010) concludes that theory and empirical results point towards the conclusion that cooperative ties between organizations positively affect innovation. Knowledge transfer among the cooperating organizations is expected to enhance innovation (Tsai, 2001). While there are a vast number of studies investigating cooperative innovation in private sector organizations, the amount of research on cooperative innovation processes in public sector organizations, such as hospitals, is lagging behind (Sørensen & Torfing, 2011). Goes and Ho Park's (1997) study does focus on interorganizational links and service innovation in hospitals, and show that there are many barriers for organizations to be innovative. For example, institutional pressures and organizational barriers towards change hinder a single organization to innovate. Therefore, they conclude that cooperation with other hospitals is of increased importance for innovation.

Coopetition: competition and cooperation

In response to this more traditional view on interorganizational cooperation, the relatively recent research stream on coopetition takes a different point of view. Padula and Dagnino (2007) observe that research on cooperation between organizations suffers from a so-called "collaboration bias" (p. 32), assuming that cooperation is based on common goals and interests. However, research results indicate that in many interorganizational relationships competitive aspects are at play. Brandenburger and Nalebuff (1995) were one of the first to introduce the concept of coopetition to converge these two aspects. Coopetition refers to "a relationship between two firms that simultaneously involves both competition and cooperation" (Walley, 2007, p. 11). According to Padula and Dagnino (2007), the participants in these relationships have "partially convergent interests" (p. 36). In the literature, there is agreement about the fact that coopetition refers to a combination of cooperation and competition (Padula & Dagnino, 2007; Rebeiro-Soriano & Urbano, 2009). An underlying assumption of cooperation is that organizations want to fulfill their own interests (Padula & Dagnino, 2007). When their interests resemble the interests of another organization, cooperative links may develop. However, a competitive element can be introduced in this cooperative relationship, for example when the environment changes or becomes uncertain. Therefore, the notion of

coopetition indicates that "cooperation does not exclude competitive pressures" (Padula & Dagnino, 2007, p. 47). As a result of combining competition and cooperation in one relationship, organizations need to adopt conflicting roles (Walley, 2007).

Coopetition can take different forms. For example, organizations may cooperate in upstream activities, such as Research & Development and purchasing, while they compete in downstream activities, such as service delivery and distribution (Walley, 2007). Although recently more attention is being paid to the concept of coopetition, the literature is fragmented when it comes to defining exactly what coopetition relationships entail and what the consequences are (Peng & Bourne, 2009; Padula & Dagnino, 2007). As Dagnino (2007) states: "the study of coopetition is at the beginning of its life cycle, we have not reached a stage at which a thorough body of research on the topic has been gathered" (p. 4).

Coopetition in healthcare

Coopetition stems from the private sector, but several researchers indicate that coopetition also takes place in the healthcare sector (Barretta, 2008; Gee, 2000; Goddard & Mannion, 1998; Mascia, Di Vincenzo, & Ciccetti, 2012; Peng & Bourne, 2009). For example, with regard to HRM, teaching hospitals could cooperate to educate a sufficient amount of nurses for the regional labor market, but compete with each other to hire the most talented ones. According to Barretta (2008), "several studies have pointed out the possible co-presence of stimuli to compete and cooperate within the health-care sector" (p. 210), which is likely to be caused by healthcare reforms. The introduction of competitive pressures is a relatively new development in the healthcare sector (Sørensen & Torfing, 2011). Therefore, the potential for coopetiton in innovation processes, where competition and cooperation both play a role, is increasing in the healthcare sector. However, as Mascia et al. (2012) point out, "few empirical studies have analyzed simultaneous collaboration and competition in universalistic healthcare systems" (p. 274). While coopetition is an emergent trend for hospitals across the world, empirical research on this matter is lagging behind (Peng & Bourne, 2009).

The role of perception on competition

Bengtsson et al. (2010) stress the importance of perceptions of organizational actors in the process of coopetition. According to these authors, there are diverse forms of coopetitive relationships among organizations, depending on the degree of competition and cooperation in these relationships that range from weak to strong. Bengstsson et al. (2010) state that strong competition is characterized by actors perceiving each other as competitors. A strong degree of competition is expected to result in tensions that could stimulate organizations to innovate, but also complicate the cooperative innovation process (Bengtsson et al., 2010). When organizations are competing and cooperating at the same time, this could result in role

conflict and tension among organizations (Dowling, Roering, Carlin, & Wisnieski, 1996; Walley, 2007). According to Walley (2007), "the tension arises in many areas, but one particularly important area is interorganizational knowledge sharing and learning, for which the tension can actually affect the dynamics of the learning alliance" (p.16). As knowledge sharing and learning are important elements of cooperative innovation (Tsai, 2001), an increase in the (perceived) degree of competition might actually harm the innovation process. Competition is relatively new for the hospitals under study. It was introduced by the Dutch government by a new healthcare reform act and generated much attention in healthcare organizations. More specifically, the labor shortages also create competitive tensions among hospitals. Hospitals are now competing for scarce human resources in their region. Therefore, the expectation is that organizational actors in healthcare will perceive their situation as a situation with a strong degree of competition. Furthermore, it can be expected this perception of competition harms the cooperative innovation process, due to the tensions arising from coopetition, as described above. This results in the following proposition:

Proposition 1: *An increase in the perceived degree of competition will negatively affect cooperative innovation.*

Rationales for coopetition

Many scholars refer to the benefits of coopetition for all organizations participating in the coopetitive relationship. Tether (2002) identifies three reasons for this type of cooperation that are not necessarily anti-competitive. First of all, competitors might cooperate on setting common standards because creating standards is expensive, while copying is easy. Secondly, because a lot of organizations are only competitors in some markets, so-called partial competitors, they might cooperate in other areas to make use of each other's strengths. Finally, addressing shared problems might be a reason to cooperate with competitors. As Tether (2002) states: "Competitors collaborate when they face common problems, and especially when these problems are seen as being outside the realms of competition and/or when by collaborating they can influence the nature of the regulatory environment" (p. 952). This third rationale for coopetition might be particularly relevant for healthcare organizations operating in the same region and facing labor shortages; they all face similar problems. Related to this observation is the argument of HuxHam and Vangen (2005) that organizations engage in coopetition because they are not able to achieve their objectives with their own resources. For example, hospitals might not be capable to set up an innovative Talent Management Pool on their own, because they do not have enough resources for it but want it because they believe this innovation will bring them benefits. This is in line with the observation of Ritala (2012) that organizations "collaborate with their competitors in the quest for improved performance and innovation results" (p. 307). In this respect, Resource Dependency Theory

(Pfeffer & Salanick, 1978) could be used to explain the rationale for coopetition. According to this theory, organizations are dependent on their environment to gain the resources they need to survive. Madhavan, Gnyawali and He (2004) state that organizations operating in the same region are more likely to cooperate due to the fact that they face similar resource constraints. This is expected to stimulate coopetition.

Furthermore, Peng, Pike, Yang and Roos (2012) conclude that market commonality and resource similarity are the most dominant antecedents of coopetition. They define market commonality as "the degree to which the presence that a competitor manifests in the market overlaps with the focal firm" (p. 535). In addition, resource similarity is defined as "the extent to which a given competitor possesses strategic endowments comparable with those of the focal firm" (p. 535). They conclude that competing organizations will cooperate with each other "because they face similar market constraints and market situation" (p. 381). This is expected to result in common interests and enhance cooperation between competitors (Peng & Bourne, 2009).

One could expect that hospitals operating in the same region face similar market conditions. The fact that hospitals face similar problems attracting and retaining talent might stimulate coopetition. Thus, applying ideas from Resource Dependency theory to coopetition implicates that an organization needs resources from other, competing organizations operating in the same market in order to be able to be innovative and therefore need to cooperate with competing organizations. This effect is expected to be stronger when organizations are operating in the same region and their resource constraints are similar. In the healthcare sector, teaching hospitals operating in the same region are dependent on each other for the supply of talented employees, but also compete for these human resources when there is labor scarcity. In that sense, they might need to cooperate with these competitors to ensure that enough nurses are trained and a Talent Management Pool can be developed.

Therefore, the following proposition is developed:

Proposition 2: *Perceived shared problems and resource constraints will stimulate competing hospitals to cooperate with each other, which will result in coopetition.*

Furthermore, value creation and value utilisation are often used to explain coopetition (Bengtsson et al., 2010). Value creation represents the cooperation part of coopetition, in that organizations cooperate by sharing resources and knowledge in order to create value. Value utilization represents the competition part of coopetition because competition forces them to utilize this value. The metaphor that is used by Brandenburger and Nalebuff (1996) is that

organizations cooperate in order to "increase the size of the business pie, and then compete to divide it up" (p. 36). These dynamics seem to be relevant for the innovation under study; hospitals cooperate to create the Talent Management Pool, but might then compete to utilize the talent included in this pool for their own gain in order to remain competitive. This could pose a serious threat for the talent pool because managers might become reluctant to allow their employees to participate in the pool.

However, little is known about whether these theories from cooperation and collaborative innovation theory are applicable to collaborative innovation in times of competition. Based on the discussion above, it can be expected that the dynamics of value creation versus value use will be perceived by organizational stakeholders. Therefore, the following proposition is presented.

Proposition 3: *Hospitals will cooperate in the development of an innovation, but will compete in the distribution of the benefits resulting from that innovation.*

In conclusion, the theoretical framework is developed in order to enhance our understanding of coopetition in healthcare innovation processes and consists of three main elements. First of all, the role of perception of the amount of competition in the sector is expected to affect the innovation process. Secondly, the existence of perceived shared problems and resource constraints is expected to affect this process. Finally, it can be expected that while competitors will cooperate in the development of an innovation, they will compete for the advantages resulting from this innovation.

METHODS

Case study context

In this study, the focus is on the Talent Management Pool, an interorganizational innovation initiated by four Dutch hospitals. The relationship between these hospitals might be conceptualized as coopetitive because these hospitals are in essence competitors when it comes to financial and human resources and patients. However, they cooperate with each other by exchanging employees through the Talent Management Pool. Due to the relative newness of the coopetition notion, many questions related to this type of interorganizational linkage need to be answered. When discussing the coopetition research agenda, Walley (2007) stresses the importance of qualitative research and case studies to investigate to coopetition for exploration purposes. The current study aims to address this gap in the current coopetition literature.

The hospitals under study were among the group of Dutch hospitals that initiated an educational agreement in which they agreed on educating a certain amount of nurses per hospital. In that way, they aimed to enhance the amount of qualified employees available for the hospital in their region. In this sense, they cooperated with respect to educating nurses, but competed for them when these nurses would have finished their education programs. After the development of this labor education agreement, four hospitals initiated the Talent Management Pool, which offers employees of the participating hospitals the opportunity to develop themselves by working in other hospitals, and thereby retaining them for the participating organizations. The pool is a virtual organization that consists of three levels. The first level is the individual participating hospital, where personnel within the organization can be exchanged. The second level is a virtual market where labor demand and supply from the participating organizations will come together, because the internal labor markets are being connected here. The organizations expect that more than half of their demand for external personnel will be solved here, which leads to substantial savings for the participating hospitals. This second level is the focus of this study because the combination of competitive and cooperative elements is most relevant here. Finally, the third level of the pool. When it is impossible to fill in a vacancy with personnel from the pool, external suppliers will be used. Self-contracted employees and external suppliers will be able to join the pool, and participating hospitals will be able to benefit from economies of scale. The pool provides participating hospitals with nursing and medical staff, as well as managerial and other support staff. The hospitals decided that all employees above a specific salary level could enroll to participate in the pool. However, permission for enrollment by the manager of the employee is needed.

Research design

All four of the hospitals that are involved in the Talent Management Pool are included in this study. Our study focuses on the perceptions of different organizational actors of the amount of competition in the sector and the existence of perceived shared problems and resource constraints. In addition, the focus will be on whether organizational actors perceive that the hospitals cooperate in the development of an innovation, but compete for the advantages resulting from this innovation. Finally, the focus will be on how these perceptions affect their opinion on and commitment to the Talent Management Pool. These elements will be systematically compared across actors (HR professionals, project team members, managers and employees) within the four organizations under study and across these organizations in order to investigate whether systematic differences exist across stakeholders and across organizations. In sum, all four of the hospitals participating in the Talent Management Pool are under study so that these organizations can be compared. However, the primary focus of this study is to investigate the perceptions of coopetition of different organizational stake-

holders, to compare the differences in perceptions, to explain these and to gain insights in their effects on the success of the pool.

Data collection and analysis

An in-depth case study focusing on the Talent Management Pool (Yin, 2008) was performed, because this enabled a detailed exploration of a real-life phenomenon and its context, which suits the research question under study. Therefore, semi-structured interviews with several stakeholders from the four participating hospitals were conducted. The initiators of the innovations, the four HR directors, and the project team were included, as well as high-level managers, line managers and employees from all of the hospitals participating in the Talent Management Pool. At the start of the research project, in spring 2011, respondents in the four organizations were asked to list HRM-related innovations in their hospitals. Many respondents referred to regional collaboration, primarily in terms of the labor education agreement. This is an agreement made among a group of hospitals to educate a certain amount of nurses. In addition, some respondents referred to the Talent Management Pool, which was not yet fully developed by that time. The development of this innovative practice was followed by conducting 38 semi-structured interviews in the following 1.5 years. A multi-actor approach was adopted to generate a complete picture of the process. Interviews lasted approximately 1 to 1.5 hours. Questions covered the diffusion, adoption and implementation process of the innovation under study. For the purpose of this study, the focus was on the perceptions of different stakeholders on competition, rationales for cooperation and resulting coopetition dynamics. All interviews were fully transcribed. In addition, several documents that could inform us on the organizations and the innovations were studied. For example, the project plan, business case, communication plan and several presentations related to the project were analyzed.

The collected interview and document data was analyzed using Atlas.ti, following thematic analysis (Braun & Clarke, 2008; Grbich, 1999; Rapley, 2011). Inductive and deductive research approaches were combined. The propositions on coopetition were used as a priori framework, but an open mind was kept for other factors and themes that emerged from the data. The first step was about familiarization with the data by transcribing all of the interview material and rereading the transcribed material. Secondly, initial codes were generated, which were used to search for themes. These initial codes formed an initial list of ideas about what information is in the data. Literature on coopetition and the propositions inspired the coding framework, but an open mind was kept for aspects that would not fit this theoretical framework. These initial codes where then organised in broader categories based on repeated patterns across the data set: the themes. In this phase, the analysis was refocused at a broader level and codes were sorted into subthemes and themes. After that, the (sub) themes were

reviewed in the light of the coded data extracts that the initial codes referred to and the entire data set. Finally, the themes were defined and renamed. Examples of initial codes were cooperation with other hospitals and need for collaboration with competitors, which resulted in the theme coopetition. These themes, and the quotations underlying the themes, were used to compare the perceptions of different actors within and across organizations. For example, the theme competition as barrier was more prominent in the transcripts of line managers that that of HR professionals, across organizations.

FINDINGS

The propositions that were developed in the theoretical section of the paper are used to order the findings of the study.

Coopetition: competition and collaboration

In this section, the focus will be on the first proposition: An increase in the perceived degree of competition will negatively affect cooperative innovation.
The fact that the participating hospitals simultaneously compete and cooperate is acknowledged by several respondents from different respondent categories: both general managers and HR professionals recognize that hospitals are both competing and cooperating.

> *I recognize that there is a field of tension between competition and cooperation.* (Line manager, hospital A)

> *If two hospitals are competing in the same area when it comes down to employees, than the talking becomes more difficult. But that doesn't mean that it will become difficult in all areas. There are areas enough where you can have collaboration.* (HR manager, hospital B)

> *Competing hospitals. I say it with a smile because I know that the hospital world is like that. While the key for solving the challenges they are being confronted with, from my point of view, is in cooperation.* (Pool manager)

Most line managers, and one of the hospital directors, stress the competition aspect of the coopetitive relationship. The fact that line managers perceive the relationship with the other hospitals as highly competitive appears to affect the innovation process of the Talent Management Pool. Line managers are reluctant to share their talented employees because of the

competitive pressures they experience. They are afraid that sharing talented employees with competing hospitals threatens their competitive position.

> *The introduction of the market mechanism invites us very much to take a competitor position. From that position it is very illogical that you're going to cooperate and share your best employees with your competitor.* (Line manager, hospital C)

> *Cooperation between hospitals is difficult because they compete each other to death out of necessity.* (Hospital director, hospital C)

> *The field of tension between competition and cooperation could withhold the pool from becoming a success.* (Line manager, hospital A)

However, HR professionals, Talent Management Pool managers and the other directors seem to focus on the cooperative aspect of coopetition and even downplay the competitive aspect of the Talent Management Pool.

> *When it comes to HR, sharing knowledge. When we need some expertise we don't have ourselves we can easily use the expertise of another hospital. This type of cooperation is present in many aspects of the hospital…For example, when we can't help a patient, we are able to consult another hospital.* (HR advisor, hospital A)

> *Retaining talent is the basis of the Talent Management Pool. That is where we cooperate because we think that we will be better in that together.* (HR business partner 1, hospital A)

The difference between HR and line managers might be explained by the fact that competition with other hospitals on scarce human resources affects line managers more directly than HR professionals; line managers will experience staffing and potential performance problems in their departments. In addition, HR professionals are more occupied with policy making and long-term planning than line managers, who are responsible for the daily operations of their business. Therefore, the consequences of exchanging talent with competitors are more severe for line managers. This has consequences for the Talent Management Pool because line managers are reluctant to share their talented employees.

> *Most managers don't get it…they are still focused on the short-term, looking at their own processes operationally instead of thinking about talent management, strategic personnel*

planning, where do I want to go, what kind of employees do I need for that and how will I attract and retain them? (HR business partner 1, hospital A)

And you see that it's about employees that are really scarce. When I would go along with it [participation in Talent Management Pool] I would get problems in my daily business. So that's why I concluded that I can't send them to another hospital. (Line manager, hospital A)

As operational manager, I could put someone in the Talent Management Pool, but when he is gone, I have a gap. (Line manager, hospital C)

The participants of the steering group are strategic managers who are being judged on their strategy, while the operational managers are being judged on how do you realize your one-year goals and then allowing talented employees to leave for half a year would be detrimental for your end result. (Pool developer)

On the other hand, HR is more focused on the cooperative aspect of a coopetitive relationship. This might be related to the cooperative relationship that exists between the HR professionals of the different hospitals. All four of the hospitals participate in an HR network and have experience cooperating together on several projects. The cooperative effort to develop an education agreement is an example of this.

Precisely because of the existing education covenants, there was a bond of trust. (HR advisor, hospital A)

The fact that the covenant story was there definitely contributed to the fact that these hospitals were prone to take this step to do it together again. (Pool developer)

The hospitals in this region are known for arranging things together...I think they are more inclined to cooperate because they did it before. (Pool developer)

In conclusion, the findings show that actors across different actor groups and across organizations perceive that there is coopetition: both competitive and cooperative elements are at play in the relationships between these hospitals. However, the findings show that HR professionals stress the cooperative aspects of the relationship, while line managers emphasize the competitive elements of the relationship. As a result, line managers are reluctant to engage in the Talent Management Pool, which hinders the implementation of this pool. Related to the proposition, it can therefore be concluded that the willingness of organiza-

tional actors to engage in coopetition will be limited when the competitive elements of the interorganizational relationship are perceived as strong by these actors.

Rationale for coopetition: lack of resources

In this section, the second proposition will be discussed: Perceived shared problems and resource constraints will stimulate competing hospitals to cooperate with each other, which will result in coopetition.

The lack of talented human resources is often mentioned as rationale for engaging in coopetition by managers, HR professionals, and Talent Management Pool managers. Related to this are the comments of several stakeholders that all hospitals have the same interest in the Talent Management Pool; they all need to attract and retain talented employees, for their own hospital but also for the region and sector. In addition, they claim that they need other hospitals to attract and retain these resources. These elements are in line with the proposition.

> *When the labor shortage will have the impact that we think it will, you have to dare to think in new models. That is the way to do it. You can't handle it on your own and you need each other to succeed.* (Pool manager)

Also, the fact that all hospitals have the same goal, deliver high quality care and help patients in the best way possible was put forward as a driver of coopetition that is typical for the healthcare sector.

> *I'm from the energy sector and I can't imagine Essent and Nuon [Dutch energy companies] developing such a concept. That is unthinkable. We [hospitals] are competitors, right? Of course we are competitors, but there are already covenants on several aspects. We already made agreements when it comes to crucial human resources, such as ER personnel. The difference with energy companies is that every hospital wants the patients to be treated as well as possible. If you don't cooperate, this could harm patients. You just don't want a patient to suffer from a labor shortage.* (HR advisor, hospital A)

Furthermore, the data reveals an additional driver of the development of the Talent Management Pool. Primarily higher-level managers, i.e. hospital directors, refer to the financial benefits that the Talent Management Pool is expected to bring. This could be explained by the fact that many hospitals are forced to economize because of the budget cut measures of the government. Therefore, saving costs is placed high on the agenda of directors.

I think the vision on mobility and for some hospitals the economic benefits, we can do it cheaper, are important. (Director, hospital C)

I looked at the potential savings. Because of course now we are in a period of downsizing. So, a hospital director will only be triggered when an innovation generates money. And fortunately, there are also leaders, people with vision that see the other side. (Pool developer)

All in all, the findings show that the perception that all organizations face a shortage of human resources and strive to achieve similar goals stimulates the development of a coopetitive relationship. This observation that perceived shared problems and resource constraints will stimulation coopetition is also reflected in the second proposition. In addition, the findings show that expected financial benefits of the pool engage (higher-level) managers.

Cooperation versus competition

In this section, the third proposition will be discussed: Hospitals will cooperate in the development of an innovation, but will compete in the distribution of the benefits resulting from that innovation.

In accordance with this proposition, most line managers refer to the fact that they expect competition between hospitals to attract talent from the Talent Management Pool. They fear that they will lose valuable personnel because of this. This causes them to be reluctant to allow their employees to participate in the pool.

I'm a bit reluctant to share knowledge and employees because it is something that we have invested a lot of time and energy in. In certain areas you want to get a regional role and if you then feed competing hospitals with that, I don't think that is smart. (Line manager, hospital A)

Other line managers do not expect this will happen very soon. In addition, even if hospitals will compete for talented employees in the Pool, they do not fear this as much as other managers. While other line managers see this as a threat for the competitive advantage of their hospitals, this group of line managers aren't convinced this will happen; one of them claims that you can't copy success by taking on another hospital's talented employees.

I don't believe in seeing each other as competitors. I think you should be able to learn from each other; that will benefit the country and the tax payer. And you can see something really good in another hospital today, but you won't be able to copy that

tomorrow because you will need to activate your people for that. In that sense, I don't believe in competition. (Line manager, hospital A)

However, this manager did acknowledge that other managers might have a different view on this. This can be explained by the fact that competition is relatively new.

I think others will look at this differently because competition is of course a new phenomenon in the hospital world. And if you're working here for years I can imagine that you'll be a bit more anxious for that. (Line manager, hospital A)

An explanation for this difference in perception between these groups of line managers is that managers in the second group all previously worked in private sector organizations. The fact that they are more familiar with competition and that competition is a common element for them might explain the fact that they fear cooperation with competitors less and ascribe fewer consequences to competition than their colleagues that have worked in healthcare for a long time.

As discussed in the section on proposition one, HR professionals and directors focus more on the cooperation aspect of the Talent Management Pool. They don't refer as often as line managers to the possibility of competition after the pool is developed. On the contrary, they stress the importance of retaining employees for the health care sector and region instead of only for their own organization. Therefore, they don't seem to see competition with other hospitals in the region as a threat.

We know that there will be a labor shortage…We will have to keep the knowledge and skills for our own hospital, but also for the sector. In the future, it will no longer be about if we can compete with other hospitals, but about whether we can compete with the banking sector or other sectors our professionals could be working. (HR manager, hospital B)

Because you know what the labor turnover is and how the labor market develops, we already have a shortage in the really specialized functions…Then it is about retaining employees, not only in your own organization, but also about how you can make the sector more attractive. (Director, hospital C)

In sum, the findings show that line managers are reluctant to allow employees to participate in the Talent Management Pool. One of the reasons for this is discussed in the previous sections: the emphasis of line management on the competitive aspect of the coopetitive

relationship. With regard to proposition three, line managers focus on the competition in the distribution of the benefits resulting from the innovations, while HR professionals and directors focus on the cooperation needed to develop the innovation. This has consequences for the development of the Talent Management Pool, because the success of this pool largely depends on whether or not employees are participating.

In addition, the findings show several differences between line managers on the one hand and HR professionals and directors on the other. First of all, HR professionals and directors emphasize cooperation, while line managers emphasize competition. Secondly, line managers are focused on short-term staffing problems, while HR professionals and directors are more occupied with long-term benefits of the Talent Management Pool. Explanations for these discrepancies are also present in the findings. For example, line managers are responsible for daily operations, while one of the tasks of the HR department is to monitor labor market developments and develop tools to anticipate on that. Furthermore, HR professionals seem to have little fear of competition once the Talent Management Pool was established, while this appears to be an important barrier for participation by line managers. This could be explained by the amount of trust that was built previously among the HR professionals of the participating hospitals. They already have positive experiences with cooperation in different projects together, while line managers lack this.

CONCLUSION AND DISCUSSION

The aim of this study is to enhance our understanding of perceptions of different organizational stakeholders on collaborative innovation in times and contexts of competition. The coopetition and cooperation literature were used in order to develop propositions to reach this aim.

The findings show that all of the organizational stakeholders acknowledge the cooperative and competitive elements in the development and implementation of the Talent Management Pool. However, there are differences in the focus of these different stakeholders. Line managers appear to stress the competition aspect, while HR professionals and directors are more focused on the cooperation aspect of this coopetitive relationship and its benefits. Explanations for this difference can be found in their roles (respectively a focus on short-term goals versus a focus on long-term goals) and their position within the organization. HR professionals and directors operate on organization level often mainly focused on strategy and policies (intended practices), while line managers are mainly implementing actual practices (Wright & Nishii, 2013). This is supported by HRM studies in other sectors that acknowledge

that tensions can arise among HR professionals and line managers during the implementation of HR practices, such as talent pools, and that their framing of these processes differ (e.g. Bondarouk, Looise, & Lempsink, 2009; Renwick, 2003). In addition, previous (positive) experiences with coopetitive relationships also appear to diminish the perceived potential threat of competition in the relationship.

Bengtsson et al. (2010) theorize that there can be varying degrees of competition and cooperation in coopetitive relationships. They propose that competition should be perceived as strong because this will urge organizational actors to develop and innovate, but that cooperative relationships should also be perceived as strong because this enhances the sustainability of the relationship. The findings stress the importance of these perceptions. First of all, different organizational stakeholders appear to potentially have very different perceptions of the degree of competition and cooperation in the relationship. Secondly, perceptions focusing on the competitive aspect appear to negatively affect the success of the coopetitive innovation, in this case the Talent Management Pool in the healthcare sector. Line managers are reluctant to allow their employees to participate in the pool, and one of the main reasons for that is the competitive aspect in the relationship with the other participating hospitals. Therefore, as Bengtsson et al. (2010) propose in their conceptual study, this empirical study shows that balancing competition and collaboration is crucial for the success of coopetitive innovation. In addition, potentially different views of stakeholders need to be taken into account here, because it remains unclear whether this affects coopetition processes. Involvement of all relevant stakeholders in the design and implementation of coopetitive innovation potentially creates agency and perceived ownership. Agency and perceived ownership in turn has positive effects on motivation and commitment of all the relevant stakeholders towards the innovation.

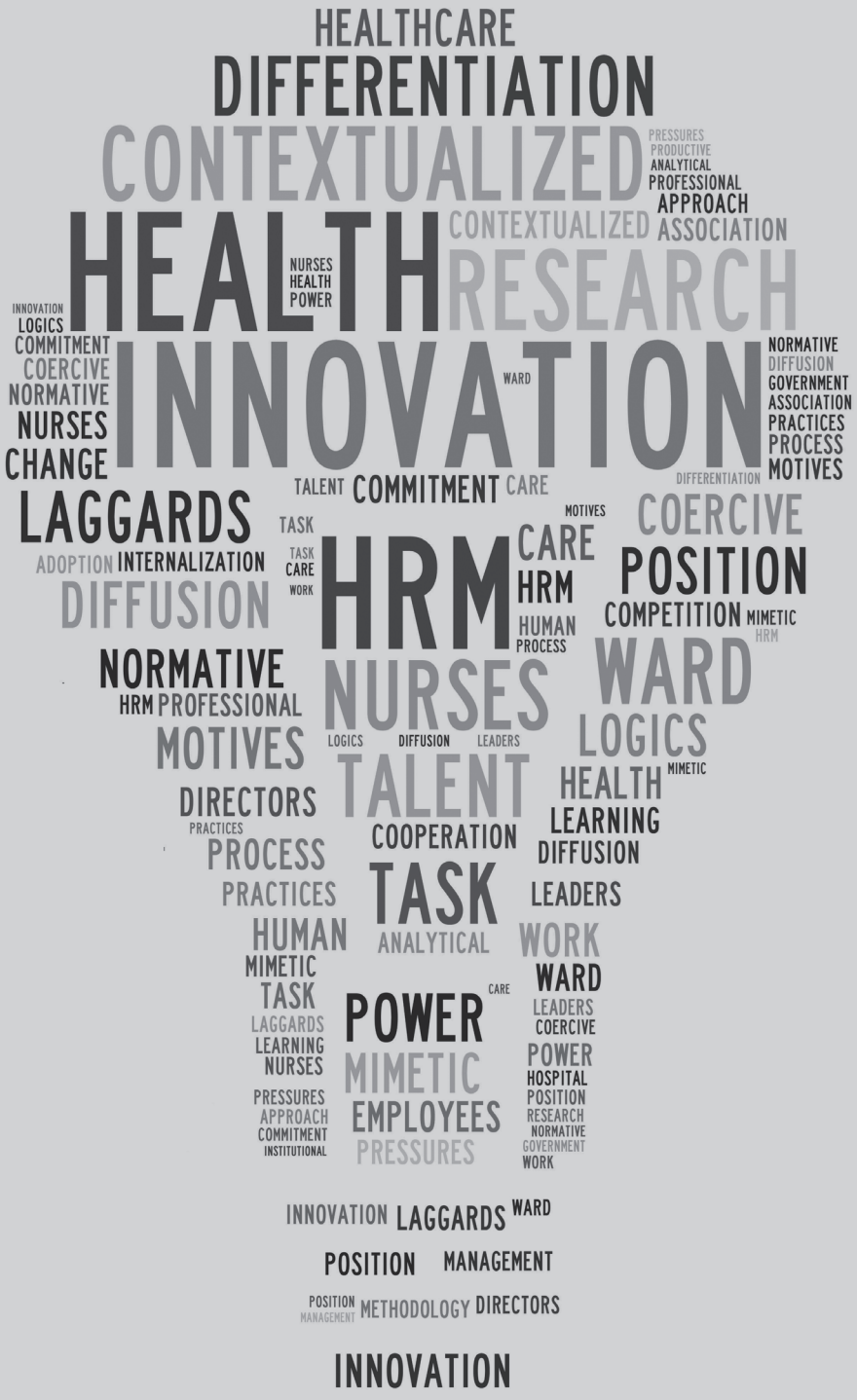
As discussed in the theoretical section of this research paper, many aspects of coopetition theory are derived from theories on cooperative relationships. One could wonder whether these theories are also applicable to cooperative relations where competition plays an important role. The findings show that, at least to a certain extent, this is the case. For example, the Resource Dependency Theory, which proposes that when organizations lack resources they cooperate with other organizations in order to obtain these resources, appears to be a relevant rationale for Talent Management Pool participators. However, this study also shows that the competitive element complicates the innovation process. In effect, the competition aspect hampers the innovation process because it makes line managers reluctant to participate. They are afraid that when they share talent with competitors their talent will end up leaving. Or, to refer to the pie metaphor discussed in the theoretical section of this paper, they are afraid that they will lose their piece of the business pie that they created together

with their competitors. It appears not to be the case that hospitals compete in one area and collaborate in the other according to line managers, as often suggested in the coopetition literature. Line managers perceive that they collaborate and compete in the same area, scarce labor resources. That might have partially caused their resistance because collaborating and competing in the same area might pose an extra barrier for coopetition. However, HR professionals view the pool as a means to increase the pie, i.e. to enhance the amount of talent available for hospitals in the region, and focus on this aspect of cooperation instead of focusing on the possible competition that could take place afterwards. The fact that line managers are more focused on the competitive aspect and the costs that coopetition might have, may be related to the fact that competition is a relatively new development in the Dutch healthcare sector. As suggested by the findings, line managers might be afraid of the unknown. This is supported by the fact that line managers that have previously worked in private sector organizations and are familiar with competition and even cooperation with competitors, are not focused on the competition aspect and are more willing to stimulate participation in the Talent Management Pool. It is therefore important to pay specific attention to perceived uncertainty of stakeholders, for example through communication, information sharing and active stakeholder involvement as suggested above (agency and ownership). The other important notion here is to share the benefits for all stakeholders involved, not just at the level of the organization as a whole, the organization level (what is good for the hospital), but for groups of stakeholders as well (for example what is in it for line managers at the level of their own ward or department).

Financial benefit is an additional rationale that this study reveals. This rationale can be explained by current developments in the Dutch healthcare sector. The government is cutting down on budgets, which also affects the healthcare sector. Hospitals are urged to economize to remain viable. Therefore, it is reasonable that especially higher-level managers and hospital directors refer to this issue. This is important to realize, because it reveals the importance of context in coopetition processes. As Bengtsson et al. (2010) state, it is important to consider the context because this might affect the coopetiton dynamics. In addition to the budgetary constraints, the labor market situation also plays an important role in the development of the Talent Management Pool. Several respondents refer to labor market shortage as rationale for engaging in the coopetitive project. Especially HR professionals refer to this as challenges they couldn't cope with alone and therefore cooperated with other hospitals 'fishing in the same pool' of human resources. In line with coopetition theory, the findings show that, for hospitals, addressing shared problems is part of the rationale for engaging in coopetition. In this case, the shared problems are caused by the labor market shortage in the regions where participating hospitals operate. Therefore, external pressures, for example from economizing measures or labor market shortages, appear to be important drivers for coopetition. Further

examination of these issues could be an interesting avenue for future research. Tapping into these contextual pressures for economizing and labor market shortage might be an effective strategy for initiators of innovations in order to convince other stakeholder to adopt the innovation. In this case, the expected financial benefits of the Talent Management Pool convinced hospital directors to participate in times of economizing. As institutional theory is occupied with external pressures on organizational dynamics, applying an institutional perspective on the study of coopetition dynamics seems to be very useful. More specifically, theory on institutional logics appears to be applicable in this respect. The emergence of business-like logics in healthcare, which reflects the emergence of a focus on financial and efficiency concerns in this sector, could be relevant here (Reay and Hinings 2009; Scott, Ruef, Mendel, & Caronna, 2000). The findings indicate that business-like logics might stimulate coopetitive dynamics. However, more research is needed in this respect.

This study aimed to add to the literature in several ways. First, the fact that several theoretical arguments developed in the coopetition literature are based on theories that are often used in literature on cooperation was addressed. While these arguments appear to be relevant for coopetition studies, one should be careful not to downplay the competition aspect of coopetition. This study reveals that this aspect could seriously hamper coopetitive innovation processes. Therefore, researchers studying interorganizational relationships and cooperative innovation should be aware of the potential negative effects of competition on innovation processes. In addition, based on the findings, it can be suggested that contextual factors should be taken into account by researchers and practitioners confronted with coopetiton. For example, the degree of resource scarcity in a specific context and the degree of common goals and interests of competing organizations might be favorable for cooperative innovation with competitors. Specifically for healthcare sector and public sector managers and researchers, the effect of the relatively new phenomenon of competition in these sectors should not be underestimated. Furthermore, a new approach to study coopetition is adopted in this study by focusing on perceptions of relevant actors, which reveals that large differences exist in their views of the level of competition and cooperation. In particular, line managers and HR professionals appeared to have quite different views on the amount of competition their existed among the hospitals. Similar differences in perceptions and framing of HR and line management are also acknowledged by scholars studying these groups in other sectors, such as construction sites (Bondarouk et al., 2009). Therefore, this problem might be relevant across organizational sectors. This implies that a multi-actor approach, as adopted in this research, is very useful in gaining a full understanding of cooperative relationships in future research. By neglecting important stakeholders, researchers run the risk to miss out on important coopetition dynamics.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POSITION
MANAGEMENT
METHODOLOGY
DIRECTORS
INNOVATION

CHAPTER 5

Multiple institutional logics in healthcare: 'Productive Ward: Releasing Time to Care'

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INTRODUCTION

As a result of developments in their sector, public organizations are being confronted with competing values (Van der Wal, de Graaf, & Lawton, 2011). The healthcare sector is a striking example of a public organizational field where multiple values and demands are at play. Hospitals in many countries are confronted with the challenge to simultaneously enhance the quality and reduce the costs of care. One of the drivers of this development in the Netherlands is the 2006 healthcare act, forcing Dutch hospitals to consider the cost aspects of care. These developments are also taking place in other countries, such as New Zealand and the UK. In these countries, New Public Management inspired reforms are restructuring healthcare (Doolin, 2001). Bekkers, Edelenbos and Steijn (2011) illustrate this by referring to the healthcare sector when discussing the "introduction of a stronger market orientation" (p. 9). In addition, Noordegraaf (2007, p. 773) notices that 'business-like managerialism' and 'traditional professional values' are being combined in public organizations. From a theoretical point of view, the institutional logics perspective can be used to analyze these developments in public sector organizations such as hospitals (Thornton, Ocasio, & Lounsbury, 2012). Institutional logics can be defined as "the belief systems and associated practices that predominate in an organizational field" (Scott, Ruef, Mendel, & Caronna, 2000, p. 170). Scott et al. (2000) observed a shift from dominance of a professional logic to dominance of a managerial logic through market mechanisms in healthcare. Furthermore, several authors suggest that healthcare is an organizational field were multiple institutional logics exist (e.g. Raey & Hinings, 2005, 2009), i.e. an institutional complex field. Reay and Hinings (2009) for example show that both professional and business-like logics co-exist in a Canadian healthcare system. It is expected that hospitals, physicians and nurses will be acting in accordance with a professional logic that emphasizes the quality of care, while managers and directors take on a more business-like logic, which is mainly occupied with efficiency (Ruef & Scott, 1998).

Several researchers conclude that research is needed to increase our knowledge about the ways in which organizations respond to multiple institutional logics (e.g. Greenwood, Raynard, Micelotta, & Lounsbury, 2011; Lounsbury, 2007). While research has been undertaken to explore the adoption and implementation processes of innovations in the healthcare sector (e.g. Jespersen, Nielsen, & Sognstrup, 2002; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004), the adoption and implementation of innovative practices from a multiple institutional logics perspective is still relatively unexplored. Therefore, this study aims to contribute to the existing knowledge by studying the adoption and implementation of an apparently hybrid practice in a context where multiple institutional logics are at play.

In the literature, several clues are provided that make it likely that institutional complexity affects innovation adoption and implementation. First of all, the linkage between logics and practices is well established; organizational practices are seen as manifestations of institutional logics (Greenwood, Diaz, Li, & Lorente, 2010; Lounsbury, 2007). In addition, logics are expected to determine the appropriateness of practices (Greenwood et al., 2011). Moreover, it is expected that institutional logics affect organizational decision making by steering the attention of decision makers (e.g. Ocasio 1997; Thornton, 2002). For example, Thornton (2002) expects that when one logic is dominant, the attention of decision makers is directed towards issues and practices consistent with this logic. This makes us wonder what would happen when an organization experiences multiple logics. Adoption and implementation could result in possible tensions, contradictions and ambiguities, because different organizational stakeholders will be influenced by different logics. This study combines the innovation and the institutional logics perspective to study the adoption and implementation of an innovative practice in an institutional complex context where both business-like and professional logics are expected to be present, namely the healthcare sector. More specifically, the focus is on the innovative practice 'Productive ward: Releasing Time to Care', which in its appearance is a hybrid practice combining the business like (productive ward) and professional (releasing time to care) logic. The institutional logics perspective is used as the prime theoretical focus, because the aim of this study is to address public sector developments from a different perspective and thereby add to the debate on healthcare management and governance.

The research question of this study is: *How does the presence of multiple logics affect the adoption decision making and implementation process of an innovative practice in healthcare?* By focusing on multiple institutional logics, this study extends public management, innovation and institutional logics research.

To explore these issues, a longitudinal case study of 'Productive Ward: Releasing Time to Care' in a Dutch hospital was performed. First of all, this paper will proceed with theoretically embedding this study in the literature and introducing the context. After describing the methods, the results of the study will be presented. This will be followed with a discussion of the results and concluding remarks.

THEORETICAL FRAMEWORK

Institutional logics

The institutional logics perspective represents a research stream within new institutionalism (Friedland & Alford, 1991). While new institutionalism is being criticized for the limited atten-

tion for agency in studying organizations, the institutional logics perspective emphasizes the role of actors (e.g. Thornton et al., 2012). As Scott et al. (2000) state: "Institutional logics refer to the belief systems and associated practices that predominate in an organizational field" (p. 170). Greenwood et al. (2010) explain that "logics underpin the appropriateness of organizational practices in given settings and at particular historical moments" (p. 2). Research on this topic has for example focused on the ways institutional logics can guide the attention of organizational decision makers (Ocasio, 1997) and paid attention to shifts in dominant logics in organizational fields (e.g. Scott et al., 2000; Thornton & Ocasio, 1999).

Thornton et al. (2012) state that "individuals and organizations, if only subliminally, are aware of the differences in cultural norms, symbols, and practices of different institutional orders and incorporate this diversity into their thoughts, beliefs and decision making. That is, agency, and the knowledge that makes agency possible, will vary by institutional order" (p. 4). Markets and professions are examples of institutional orders (Thornton et al., 2012). Often organizations experience multiple and sometimes conflicting institutional logics (Pache & Santos, 2010; Thornton & Ocasio, 2008). Research on this topic shows how organizations respond to and manage competing institutional logics (e.g. Saz-Carranza & Longo, 2012; Pache & Santos, 2010). Pache and Santos (2010) explain that organizations in organizational fields that are moderately centralized and highly fragmented are most likely to experience multiple institutional logics. Research (e.g. Reay & Hinings, 2009; Scott et al., 2000) shows that healthcare is highly fragmented, i.e. that healthcare organizations are dependent on a high number of actors with possibly different logics (Pache & Santos, 2010). Also, this field appears to be moderately centralized because there is a dual authority structure, with public authorities and healthcare professionals as central actors (Pache & Santos, 2010). Therefore, it is expected that healthcare organizations are confronted with multiple institutional logics. In addition, Greenwood et al. (2011) state that in hospitals many different occupations are present that are likely to be influenced by different logics and that hospitals should be able to balance professional and business goals in order to be perceived as legitimate. Several authors indicate shifts in institutional logics in the healthcare field from a professional logic to a business-like logic. In addition, it is acknowledged that multiple institutional logics can co-exist (e.g. Kitchener, 2002; Reay & Hinings, 2009; Ruef & Scott, 1998; Scott et al., 2000). According to Kitchener (2002), the professional logic entails that "legitimacy was judged against criteria of prestige and the technical quality of the services provided" (p. 391). Goodrick and Reay (2011) emphasize that autonomy is an important aspect of a professional logic. The core aspects of the professional logic are high quality of care, sufficient time to spent directly on patients and autonomy (e.g. Goodrick & Reay, 2011; Kitchener, 2002). Alternatively, the business-like logic ascribes importance to practices that could lead to cost reduction (Raey & Hinings 2009).

Competing or compatible institutional logics

Based on their review of empirical studies on institutional complexity, Greenwood et al (2011) conclude that most studies implicitly assume that logics are "inherently incompatible" (p. 332). This is illustrated by their own definition of institutional complexity as situations where organizations are confronted with "incompatible prescriptions from multiple institutional logics" (p. 318).

However, there are indications that multiple logics can co-exist and maybe even be combined within an organization or an organizational practice: so-called hybrids (e.g. Battilana & Dorado, 2010; Dunn & Jones, 2010; Goodrick & Reay, 2011). A hybrid organization is an organization that combines different institutional logics (Battilana & Dorado, 2010). Next to the hybridization of an organization, it is also possible that organizational practices become hybridized, i.e. that multiple logics will be combined within one practice. An example of a hybrid innovative practice in the healthcare context is the clinical management role implemented in healthcare organizations (e.g. Kirkpatrick, Jespersen, Dent, & Neogy, 2009). 'Productive Ward: Releasing Time to Care' also appears to be such a hybrid practice.

Innovation

Scholars define innovation in several ways (Crossan & Apaydin, 2010). These definitions all emphasize a newness aspect, primarily in terms of new to the organization that adopts it. For example, Damanpour (1991) defines innovation as "adoption of an internally generated or purchased device, system, policy, program, process, product, or service that is new to the adopting organization" (p. 556). In their review on innovation in healthcare, Länsisalmi, Kivimäki, Aalto and Ruoranen (2006) define innovation as "the intentional introduction and application within a role, group, or organization, of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, or wider society" (p. 67). Very early on, Schumpeter (1934) distinguished product innovation (a new good), process innovation (a new production method), market innovation (opening of a new market), input innovation (new source of input) and organizational innovation (new organization or industry). Another well-known distinction is that between technological and administrative innovations. Technological innovations refer to product, process and service innovations, whereas new procedures, policies and organizational forms can be regarded as administrative innovations (Damanpour, 1991; Damanpour & Evan, 1984). In this paper, the definition of Damanpour (1991) is adopted. Therefore 'Productive Ward: Releasing Time to Care' is viewed as an innovation, because it is a new practice for the adopting hospital. This innovation can be characterized as an administrative innovation, because it represents a new way for hospitals to enable nurses to make changes in their wards. Because little is known about the role of multiple logics in innovation processes of these types of

innovations, the focus of this paper will be on the role of multiple institutional logics in the adoption and implementation phases of this innovative practice. These phases are used as a heuristic framework to guide the research.

Institutional logics and the innovation adoption decision process

Adoption of an innovative practice can be defined as "the decision to make full use of an innovation as the best course of action available" (Rogers, 2003, p. 177). According to the rational-economic perspective, organizations will adopt innovations based on information about their contribution to performance. This perspective explicitly takes into account the role of human agency and strategic choice in adoption decision processes (Child, 1972). Alternatively, research indicates that institutional logics could also influence adoption decisions. As Ocasio (1997) explains, institutional logics are capable of guiding the attention of organizational decision makers to specific issues and affect decisions. This means that organizational actors convert the logics into action. Thornton (2002) and Goodrick and Reay (2011) support this view by explaining that logics play an important role in steering the attention of organizational actors. Goodrick and Reay (2011) state that "logics shape individual and organizational practices because they represent sets of expectations for social relations and behavior" (p. 375). A core assumption is that the interests, identities and values of individuals and organizations are embedded in logics and provide the context for decisions and outcomes'. Therefore, institutional logics could play an important role in the adoption process by steering the attention of actors towards innovations that fit with their logic.

In public management literature, the distinction is made between logic of consequence and logic of appropriateness. The logic of consequence emphasizes the efficiency and effectiveness of innovations (Bekkers et al., 2011; Bekkers & Korteland, 2008). In this view, adoption decisions are rational decisions based on balancing the cost and benefits of the innovation (Korteland, 2011). This logic shows many similarities to the rational-economic perspective explained above. The logic of appropriateness emphasizes legitimacy and trustworthiness (Bekkers et al. 2011; Bekkers & Korteland, 2008). Taking on this perspective, it is believed that the context of the organizations has a tremendous influence on the adoption decisions (Korteland, 2011), which is related to the institutional logics perspective. In this study, the institutional logics perspective will be used to study innovation adoption and implementation, because little research uses this perspective to focus on these processes. The adoption decision making process might be complicated through the potential conflict between the different logics.

Institutional logics and the innovation implementation process

After the adoption decision has been made, the implementation process follows. The implementation of an innovation can be defined as "the early usage activities that often follow the adoption decision" (Meyers, Sivakumar & Nakata, 1999, p. 295). Kostova and Roth (2002) distinguish two elements in this response to the adoption decision. First of all, the behavioral element, which is reflected by what they label implementation: "Implementation is expressed in the external and objective behaviors and the actions required, or implied, by the practice" (p. 217). Secondly the attitudinal element, internalization, is the "internalized belief in the value of the practice" (p. 216) and represents an important predictor of the persistence of an innovation. According to these authors, "Internalization is that state in which the employees at the recipient unit view the practice as valuable for the unit and become committed to the practice" (Kostova & Roth, 2002, p. 217). Different combinations of internalization and implementation are proposed. For example, ceremonial adoption is the "formal adoption of a practice on the part of the recipient unit's employees for legitimacy reasons, without their believing in its real value for the organization" (p. 220). Ceremonial adoption combines a high level of implementation with a low level of internalization. A related concept is decoupling, which can be defined as "a situation where compliance with external expectations is merely symbolic rather than substantive, leaving the original relations or practices within an organization largely intact and unchanged" (Han & Koo, 2010, p. 31). Both decoupling and ceremonial adoption refer to the superficial implementation of a new practice, possibly affected by institutional pressures to adopt the practice (Kostova & Roth, 2002). The presence of multiple institutional logics, both in the institutional context and in the innovative practice, might play an important role in determining the extent to which a new practice becomes implemented in the organization. This adopted practice could be only superficially implemented on the one hand or become actually internalized by organizational actors on the other hand. As Dearing (2009) states, "often in complex organizations, the users are not the choosers of the innovations. Implementers often subvert or contradict the intentions of the adopters" (p. 504). This is especially relevant when the organization is confronted with multiple logics, because then it is more probable that the decision makers will adhere to a different logic than the users of the new practice. For example, in healthcare organizations decision makers are often the board members and directors, adhering to a business-like logic, while the users are primarily nurses, adhering to a nursing professional logic. These multiple logics might complicate the implementation process and affect the extent of implementation of innovative practices.

'Productive Ward: Releasing Time to Care'

In order to unravel the adoption and implementation processes of an innovative practice in a institutional complex context, a hospital that was among the first to adopt 'Productive

Ward: Releasing Time to Care' in The Netherlands is studied. This program was developed in 2006 by the NHS Institute for Innovation and Improvement in the UK (NHS, 2010). The core assumption of the program is that nursing staff organizes their own ward and improve processes themselves. This could increase the amount of time for direct patient care, which would result in a higher quality of care, more satisfied patients and nurses and a decreasing amount of waist. One of the core components of the program was to enhance the empowerment and autonomy of nurses. Evaluations of the program in the UK show that empowerment of ward staff has increased due to the program (Lipley, 2009). Empowerment can be defined as "the psychological state of a subordinate perceiving four dimensions of meaningfulness, competence self-determination and impact, which is affected by empowering behaviors of the supervisor" (Lee & Koh 2001, p. 686). Research shows that empowerment is important for positive nursing outcomes, such as retention (e.g. Erenstein & McCaffrey, 2007).

This practice represents an innovative way for Dutch hospitals to initiate changes, by empowering nurses. It is especially interesting to investigate the adoption and implementation of this program using an institutional logic perspective, because at first glance the program seems to combine the multiple logics healthcare organizations are confronted with. Research shows that communication plays an important role in the implementation of innovations in healthcare organizations (e.g. Damschroder et al., 2009; Rogers, 2003). In this specific case, the way the program is communicated throughout the organization refers to multiple institutional logics. That is, the labeling of the program, 'Productive Ward: Releasing Time to Care', suggests that this could be an example of a hybrid practice that incorporates both the nursing professional logic (Releasing Time to Care) and the business-like logic (Productive Ward).

METHODS

Case study context

The pilot project 'Productive Ward: Releasing Time to Care' in the focal hospital is about implementing the first three modules (of a total of eight) within approximately nine months in two wards. The focus of this research is on this pilot phase, because it was expected that the role of institutional logics in the adoption and implementation of the practice manifested itself especially in the early phases of implementation when the innovation is introduced. The first module is called 'Knowing how we are doing', where ward based measures are developed to make better informed decisions. The second module is called 'Well organized ward', which is about reorganizing and rearranging the ward. The third module, 'Patient status at a glance',

aims to improve patient communication and flow. A project organization was set up to facilitate the implementation process, supported by an external consultancy agency.

This study was performed in a Dutch hospital. Dutch hospitals are not-for-profit organizations. Different types of hospitals (academic, top-clinical and general) exist, each with their own characteristics. The hospital under study is a top-clinical hospital, which performs highly specialized medical care. A two-tier governance model is adopted in these organizations, consisting of a board of directors and an independent board of supervisors. Traditionally, Dutch hospitals have a functional organization structure. However, more and more hospitals are changing their design towards a more process oriented structure (Veld, 2012).

Data collection and analysis

Two in-depth longitudinal case studies were carried out (Yin, 2008), because this enables the in depth study of a real-life phenomenon and its context, which suits the research question. Both pilot wards are under study to be able to compare these wards.

Several data collection methods were used; semi-structured interviews, focus groups, document studies and observations. First of all, semi-structured interviews were conducted with project leaders, project team members and workgroup members (including ward nurses) from both wards, as well as the hospital director, communication advisor and an external consultant that facilitated the implementation process. In total, fifteen interviews were conducted, of which eight were conducted at the start and seven in the middle of the pilot program. The key actors in the process were selected and from each key actor group one or more respondents were interviewed in order to provide a complete overview of the process from all perspectives. The interview questions primarily focused on the adoption decision process and the implementation process of the program. Interviews lasted approximately 1.5 hours. Secondly, at the end of the pilot program, two focus groups were conducted, in order to collect information on the implementation process with focus group members interacting with each other. One focus group of approximately 2.5 hours was organized for each pilot ward, with seven nurses, internal advisors and managers participating. In addition, relevant documents were analyzed, such as the project plan, communication plan, presentations and brochures. Finally, the researcher was able to attend workgroup meetings during the implementation period and the evaluation meeting of the steering group at the end of this period. Observational notes from these meetings were made.

In sum, a multi-actor approach was adopted to generate a complete picture of the process. Multiple data collection methods were used to triangulate the data. Furthermore, a longitudinal research design was used to be able to detect potential changes throughout the

process. Three data collection rounds were performed; at the start, the middle and the end of the pilot project.

The collected interview, focus group and document data were analyzed using Atlas.ti, following thematic analysis (Braun & Clarke, 2008; Grbich, 1999; Rapley, 2011). First, the researchers familiarized themselves with the data, by transcribing all the interview material and rereading the transcribed material. Secondly, initial codes were generated, which were used to search for themes. These initial codes formed an initial list of ideas about what information is in the data. As Braun and Clarke (2008) state, these codes "identify a feature of the data…that appears to be interesting to the analyst" (p. 88). When searching for initial codes, the research question was kept in mind, but codes were primarily data-driven. These initial codes where then organized in broader categories based on repeated patterns across the data set: the themes. In this phase, the analysis was refocused at a broader level and codes where sorted into subthemes and themes. After that, the (sub)themes were reviewed in the light of the coded data extracts the initial codes refer to and the entire data set. Finally, the themes were defined and renamed. Examples of initial codes were business, economizing, budget, efficiency, productivity and time pressure. These codes resulted in the subtheme business-like logic. The resulting theme this subtheme belongs to is multiple institutional logics. In addition, this process of identifying codes, subthemes and themes resulted in the themes communication, labeling, empowerment and internalization. These resulting themes are used to structure the findings section of this paper.

FINDINGS

In order to answer the research question, *How does the presence of multiple logics affect the adoption decision making and implementation process of an innovative practice in healthcare?*, the main themes derived from the data analysis are used in this section.

Multiple institutional logics

Several respondents refer to the two-sided nature of the program, including both efficiency and quality of care, when discussing motives for adoption. Respondents from the nursing population as well as managers refer to the multiple logics reflected in the program.

> *Well, one of the reasons to introduce it is finding a way to improve the quality of care. But not only quality of care, also how you can realize efficiency in the ward.* (Internal guide, ward A)

> *Increasing direct patient care, but also working more efficiently...I think how can you use rooms in the best and most efficient way will benefit us. Less walking, and less searching.* (Senior nurse, ward B)

However, some differentiation in adoption motives that are mentioned by respondents stemming from different disciplines can be observed. First of all, nurses reported to the Nursing Advisory Board that they increasingly experience more work pressure. They feel that many additional administrative tasks are being forced upon them and they don't understand why these tasks, that withhold them from direct patient care, are necessary. The fact that they are unable to spend enough time on direct patient care, is perceived as a problem and results in lower job satisfaction.

> *Nurses felt that they were almost communicating with the patient via checklists. That is not what nurses want, it is not nice.* (Nursing Advisory Board chair)

Due to the fact that administrative tasks are being imposed on nurses, they experience a lack of empowerment. They feel that other people determine how they have to do their job. This results in a lot of resistance from the nurses when management tries to implement something new. Therefore, the chair of the Nursing Board searched for a program that would give the control over work to nurses. Exactly the fact that the 'Productive Ward: Releasing Time to Care' is not a top-down change program, but that nurses are being empowered to reorganize and restructure their ward themselves in order to improve patient care is what appeals to them.

> *They [nurses] feel that a lot of work is improper and forced upon them. This causes dissatisfaction and resistance about every innovation and change.* (Project plan, page 3)

> *If you talk about innovation in healthcare, it is often top-down or a management tool.... employees say nice for you, but we can't work with that.* (Nursing Advisory Board chair)

> *They [Nursing Advisory Board] were enthusiastic about involving the team in thinking along instead of letting everything come from the top...I think that will eventually result in a better running hospital.* (Senior nurse, ward B)

Quality of care, another indicator of the nursing professional logic, is also reflected in reactions from the nursing perspective on the program.

That is why the Nursing Advisory Board went looking for possibilities to improve the quality of care, but then for and by nurses. (Project plan, page 3)

There is nothing worse for a nurse than being unable to do your work right, resulting in lower quality of care. (Nurse, ward A)

Besides these indicators that were closely linked to the nursing professional logic, the project plan also reflects a motive that could be linked to the business-like logic.

The Nursing Advisory Board also wanted to contribute to the strategy of the hospital by looking for more efficient ways of working. (Project plan)

The hospital director, who was involved in making the adoption decision, primarily refers to rational-economic motives for adoption and shows a more business-like logic. He mentions motives such as working more efficiently.

More from a business perspective, of course hospitals are confronted with economizing... We will have to work with the people we have, there will be no additional staff. That means that you will have to work more efficiently. (Hospital director)

Next to that, he also refers to problems within the organization that could be improved by the project, such as the high perceived work pressure and agitation within the wards. Similar to the Nursing Advisory Board chair, he also refers to fact that the program is a bottom-up implementation that empowers nurses is one of the main reasons for adopting 'Productive Ward: Releasing Time to Care', because this addresses the needs of nurses.

What I as director find important is that this is a bottom-up innovation. Thus, I only facilitate and steer. They [nurses] are the directors and have to do the project....they embraced the project. (Hospital director)

When evaluating the project at the end of the pilot period, the two logics are also represented. The healthcare manager refers to both logics when expressing his opinion at the end of the pilot.

It [Productive Ward: Releasing Time to Care] results in better patient care and I believe in the business case of the program. (Healthcare manager)

The hospital director primary refers to the business-like logic, by stressing the importance of the Return On Investment to project could generate. In evaluating the pilot, the director emphasizes the importance of whether the investment brings benefits towards the organization in terms of money.

> *We started this project with the idea that it is an economic instrument; that you can skip a dayshift because of the project.* (Hospital director)

On the other hand, a physician and nursing representative evaluating the program are more drawn towards the implications the program has for the work and care processes in the ward.

> *I think it is special that the project gives something back to people that deliver care, which can't be expressed in financial value.* (Physician, ward A)

> *I consider what the project brings, empowerment of nurses to be of much more importance than that it results in mayor efficiency gains.* (Nursing representative)

In summary, these findings suggest that 'Productive Ward: Releasing Time to Care' is indeed being perceived by the respondents as a practice that combines nursing professional logics and business-like logics.

Communication and labeling

The labeling and communication of the program also reflects these multiple logics. The communication of the program was adjusted to the different audiences within the hospital. The communication plan reveals that different messages were composed to explain the program, according to the logics of the audiences. The message to the directors and managers is *'Productive Ward is a good way for nurses to structure and organize their work themselves, fitting with the mission and vision of the hospital'.* The message to the healthcare professionals, nurses and physicians, emphasizes the effects of the program in terms of increased time for patient care, safety and quality of care, which fits well with the professional logic. To illustrate this, the message for nurses of the pilot wards is: '*Productive Ward is the way you, together with your colleagues, can organize your ward in order to eventually again, within the mission and vision of the hospital, have more time for the patient. By organizing the wards well, patient safety and quality of care will improve. The project is not used to economize, it is not the intention to cut back on personnel.'*

In addition, the labeling of the project appears to be important. The fact that not only the logics of efficiency and productivity side of the project are being emphasized, but also the aspect of 'Releasing time to care' is important to engage nurses. The director even prefers not to call it 'Productive Ward', but 'Releasing Time to Care'.

> *I thought 'Productive Ward' was a difficult label. 'Releasing Time to Care' is more friendly and points out the direct customer interest....I prefer that latter name instead of productive ward or enhancing efficiency, because the latter are terms that do not ground easily with that kind of professionals.* (Hospital director)

The double label of the program used in the organization, 'Releasing Time to Care: Productive Ward', seems to create some suspicion among nurses. Before the start of the project, when hearing the double label of the program, nurses were afraid that the time they would save because of the more efficiently organized ward they would create during the project would result in cutbacks on personnel. They thought the program would be a disguised economizing method. To prevent this perception from becoming an obstacle for implementation, the director guaranteed that any time that would be saved, could be invested in direct patient care, at least in the first year of the project. This reassured nurses and enhanced their commitment to the project.

> *It is not only focused on efficiency, also not in its appearance. And it works well that all the time it brings in extra will not be used for economizing. That really creates support among nurses; that they know that if they gain time they don't have to hand it in terms of shifts of hours, but that they can really put it back in patient care. That is very important for them.* (Internal guide, ward A)

Nevertheless, during the focus groups at the end of the pilot program, it appeared that the labeling of the program had some drawbacks. Several respondents, primarily from the nursing discipline, indicate that the label 'Releasing Time to Care' was misleading in the sense that because of this label they expected to see an increase in direct patient time, while in fact there were no large changes observed at the end of the pilot. In the beginning, the project title motivated them, because they presumed direct patient time would be increased. However, the title backfired when nurses didn't experience an increasing amount of time they could spend on direct patient time. Moreover, they often were more occupied with rearranging closets and measuring the efficiency of their ward for the project, than actually providing care.

The name of the project should be different next time. With the current name, wrong expectations are being created. (Nurse, ward B)

However, more time for direct patient care is not visible.... The title suggests something else. That is still a struggle for our team. The title suggests that you will have more time for the patients, but you're actually working on organizing your ward well. (Senior nurse, ward A)

Empowerment and internalization

While empowerment of nurses is one of the core components of the program, some ambiguities are revealed. First of all, the implementation process is top-down. While one of the core principles of the project is that nurses are empowered to make their own decisions, the decision to participate in the pilot program was made by their supervisors.

If you're going to say that the ward team has influence in such a project, so they can decide for themselves what the ward is going to look like and have control over it, than they should also have that in the choice to participate. (Internal guide, ward A)

This might have caused nurses to perceive this project as yet another top-down intervention that they didn't choose for, while 'Productive Ward: Releasing Time to Care' was introduced into the organization to empower nurses. The top-down implementation of this project contradicts with this aim and with the autonomy component of the nursing professional logic.

Nurses seem to appreciate the fact that they were finally able to determine themselves how to organize and change their ward, instead of listening to managers. Nevertheless, internal guides and project leaders notice that it is very difficult for nurses to propose solutions themselves.

They all say, finally we can decide for ourselves. But you notice that if they just get a plan how to do something that they also find that very convenient. (Project leader 2)

This was supported by findings that show that nurses need a lot of support and need to be motivated by the work group members to be actively involved in the implementation process. An illustration of this can be found when analyzing the events during the summer holiday break. This was a difficult period for both wards to remain working on the project, because a lot of the project members were on holiday. In ward B, the motivation of nurses was extremely low during this period. Nurses were very busy with patient care because of a staffing shortage and didn't feel like working on the project. Not many concrete results

were visible yet, and they questioned the merits of investing so much time and effort in the project. Without many project ambassadors on site, it was difficult for them to find the motivation to keep working on the project. This is a clear signal the project was not completely internalized in that ward. Also in other periods during the implementation, nurses did not seem to be very pro-active in addressing issues they wanted to improve and much of the project results depended on the work group.

> *If we [workgroup] ask nurses to volunteer to participate we get very little response…I hope that nurses will feel more committed and will come up with topics themselves. And also for example go to a workgroup member and say I see you are working on this topic and I would like to contribute.* (Internal guide, ward B)

When evaluating the implementation process, committed and enthusiastic ambassadors of the project appear to be crucial. Many respondents express their satisfaction with the project team and workgroup members and the important role they play in successfully implementing the project. They stimulate others by showing a lot of energy and enthusiasm.

> *Your workgroup needs to be enthusiastic and needs to be able to make the team enthusiastic.* (Care coordinator, ward A)

During the evaluation of the program this observation was confirmed by responses of workgroup members. When discussing whether nurses make use of the opportunity to be involved in decision making, the reactions of work group members point in the direction that this was rarely done.

> *When you sit and wait, not much is coming from the ward.* (Nurse, ward B)

In sum, the findings indicate that institutional logics play an important role during the adoption and implementation of the program. In the next section, these findings will be discussed.

CONCLUSION AND DISCUSSION

The goal of this study is to unravel the adoption and implementation processes of a new practice when multiple logics are present in both the organizational field and the practice itself.

First of all, the findings verified that the healthcare organization is indeed being confronted with multiple logics; both the nursing professional logic and the business-like logic are reported by respondents when discussing the 'Productive Ward: Releasing Time to Care' program.

With respect to the adoption process, some respondents, managers and project leaders as well as nurses, refer to both logics simultaneously when discussing the motives of adoption of the program. However, motives related to the nursing professional logic are dominant in the responses of nursing staff, while managers and directors primarily referred to motives related to the business-like logic. Nurses referred to aspects related to improvement in the quality of care and enhancing their own autonomy, while managers primarily mentioned arguments related to the enhancement of efficiency. Similar results were found in the evaluation of the program. These findings are consistent with the conclusions from other researchers (e.g. Reay & Hinings, 2009).

The labeling and communication of the program throughout the organization seems to play an important role in addressing these multiple logics. More specifically, the project is called 'Productive Ward: Releasing Time to Care' in the hospital, which reflects both logics. Besides that, the communication of the program was adjusted towards the target audience. This resulted in a description of the program stressing aspects related to the nursing professional logics, such as quality of care, empowerment and more direct patient care time, when communicating towards nurses. These elements were not explicitly mentioned in communication towards managers. These labeling and communication strategies might explain the appearance of multiple logics in the findings mentioned above. In addition, these results indicate that the program is a hybridized practice, incorporating multiple logics. The double labeling of the practice seemed to motivate nurses on the one hand, because 'Releasing Time to Care' appealed to their professional logic. However, this backfired when only very limited increases in direct patient time were observed. In addition, nurses struggled to make use of the room for maneuver they were supposed to get due to the program. Moreover, the results show that double label also appeared to create suspicion among nurses whether it was not just another tool to enhance the productivity and efficiency which would eventually result in downsizing.

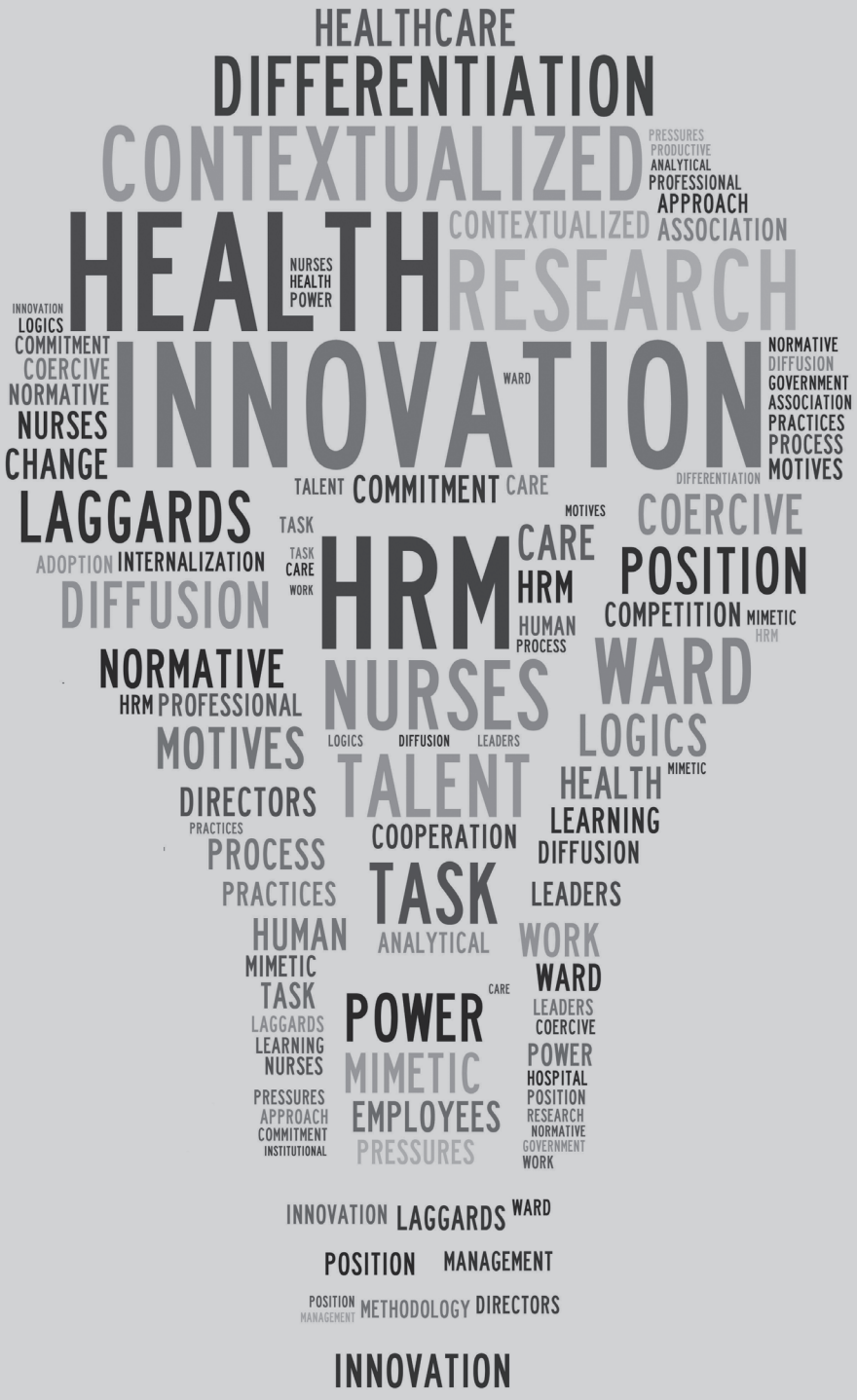
The findings indicate that 'The Productive Ward: Releasing Time to Care' in its initial appearance is indeed an example of the hybridization of multiple logics, but in reality is primarily aimed at accomplishing goals that fit the business-like logic instead of adhering to both logics. The organization presented the program as empowering nurses to make changes to their ward in order to increase the direct patient time, although the bottom line of the program

was increasing efficiency. Furthermore, several respondents did point at the fact that the pressure to economize in this hospital is increasing. In addition, respondents indicate that it is very difficult to engage nurses in change programs aiming at efficiency and that these initiatives lead to a lot of resistance in this professional group. 'Productive Ward: Releasing Time to Care' seems to be used to commit nurses to the change program by appealing to their professional logic, while it was actually another economizing program.

However, engaging nurses through presenting the program as fitting with their logic didn't deliver the intended results. In the beginning of the implementation process nurses were enthusiastic and saw this innovative program as a means for them to be empowered and improve the quality of care they deliver. Nevertheless, this perception changed. Due to the suspicion of nurses about the sincerity of the aims of the program, accompanied with the problematic implementation process and the lack of concrete results with regard to releasing time to care, it resulted in a lack of commitment of nurses towards the program. In the end, the nurses in the wards that participated in the pilot program did not appear to see the value of the program. Therefore, the program was implemented, but not internalized by the nurses. Hence, this case of 'Productive Ward: Releasing Time to Care' seems to be an example of ceremonial adoption of a new practice (Kostova & Roth 2002). This is problematic, because internalization is an important precondition for the sustainment of the innovation (Kostova & Roth, 2002).

Some limitations of this study can be indicated. First of all, this study focusses implementation of the pilot phase of the program. Therefore, it is not possible to observe whether the findings are consistent throughout the implementation of the full program. However, the decision to focus on this pilot phase was made, because it was expected that the role of institutional logics in the adoption and implementation of the practice would be most observable in the early phases of implementation. Due to the fact that only two wards were studied, external validity of this study is low. It is difficult to generalize the finding from this study to other contexts, though this was not the aim of this study. It might be interesting for future studies to investigate similar issues in other public service sectors, such as education and social care, in order to find out what logics are present in those sectors and whether they affect the innovation process. Future research on innovation in public services could take the complexity of the institutional environment into account, because this study indicated that this could affect the innovation process. Furthermore, future research is needed to enhance our understanding of hybridized practices and the ways internalization instead of only ceremonial implementation of these practices could be achieved.

In summary, the multiple logics that are expected to be present in the healthcare sector, nursing professional and business-like, are reflected in the findings. To answer the research question, it does seem to be more complex to successfully adopt and implement a new practice when multiple logics are at play. By hybridizing the logics in a practice, one runs the risk of sending conflicting messages that cause confusion. At the same time, focusing on one logic and neglecting the other could result in less commitment from the group adhering the neglected logic. The results show that practices appealing to the logic of the users initially enhance their commitment and degree of internalization of the practice, which is beneficial for the implementation process. However, in a context where multiple logics are at play, one should be careful when trying to implement a hybrid innovative practice aimed to appeal to multiple logics, because sending out multiple messages might create suspicion among the recipients of this message, which decreases the amount of commitment and internalization.


HEALTHCARE
DIFFERENTIATION
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PRESSURES
PRODUCTIVE
ANALYTICAL
PROFESSIONAL
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POSITION
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METHODOLOGY
DIRECTORS
INNOVATION

CHAPTER **6**

Institutional pressures on leaders and laggards in healthcare: The adoption of task differentiation and e-learning

This chapter is based on: Van den Broek, J., Boselie, P., & Paauwe, J. Institutional pressures on leaders and laggards in healthcare: The adoption of task differentiation and e-learning. Paper presented at the Dutch HRM Network conference, Leuven, Belgium, November 14-15, 2013.

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INTRODUCTION

Human Resource Management (HRM) innovations in healthcare are increasingly on the agenda of both practitioners working in this sector and scholars studying this sector (Rye & Kimberly, 2007; Walston, Kimberly, & Burns, 2001). Healthcare managers are in need for innovative Human Resource (HR) practices and models due to the challenges they are confronted with. For example, for overcoming inefficiencies in the healthcare sector (Thakur, Hsu, & Fontenot, 2012) and keeping up with technological developments (Länsisalmi, Kivimäki, Aalto, & Ruoranen, 2006). HR innovations seem to be of increasing importance to healthcare organizations, due to the fact that many healthcare sector developments are related to employment issues. For instance, the changes in demography of the population resulting in a higher demand for care and therefore a greater demand for healthcare employees to deliver care. However, nursing is viewed as a stressful occupation (Lee & Akhtar, 2011) and in many countries major issues regarding the recruitment and retention of nurses are present, resulting in increasing labor shortages (Länsisalmi et al., 2006). In addition, healthcare reforms initiated by governments throughout the world are aimed at reducing healthcare costs while increasing the quality of care delivery (Toth, 2010). All these developments put pressure on healthcare organizations to innovate the way employees are managed and work is designed. In this respect, job design is an example of HRM that received much attention (Gittel, Weinberg, Bennett, & Miller, 2008). HR innovations such as new nursing roles (e.g. Nurse Practitioners), new models for team working (e.g. Crew Resource Management) and new employee performance management systems are increasingly adopted by healthcare organizations.

From a scientific point of view, HR innovations, which can be seen as a subcategory of managerial innovations, are also increasingly being studied (Damanpour & Aravind, 2011). However, as Subramony (2006) notices, adoption patterns of HRM innovations are often not well explicable. In effect, HR practices that are backed up with a lot of evidence do not get adopted widely, while HR practices lacking this evidence base do show high adoption rates. This paradox urges scholars to theoretically and empirically investigate adoption motives. Theoretical perspectives offer several explanations for the drivers of the diffusion and adoption of HRM innovations. Laws and regulations, imitation of successful organizations, fashion following and strategic choices to improve competitive positioning are a few of the possible mechanisms that are proposed in the scientific literature. However, many of these explanations contradict each other. While new institutionalism predominantly emphasizes the importance of external pressures that force organizations to adopt certain innovations, researchers examining these processes from a strategic choice perspective claim that organizational actors make their own rational choices to adopt certain innovations. In addition,

several researchers (Mirvis, 1997; Paauwe & Boselie, 2005; Rogers, 2003) claim that motives for adoption differ for the timing of adoption, i.e. whether the organizations is an early or late adopter. In sum, there are conflicting theories and findings in studies on adoption motives related to timing of adoption.

In this study, the aim is to unravel these conflicting perspectives more in-depth in order to understand the mechanisms underlying the decision of organizational actors to adopt an HR innovation at a particular point in time. The focus is on the healthcare context, because especially here the context is very dynamic and creates a need for this type of innovations. In addition, two HR innovations that are relevant for hospitals are studied. The first innovation is task differentiation among nurses, which is about changes in work design and organizational restructuring. The second innovation is e-learning, which is a new HR practice using the possibilities technological developments have to offer. Both innovations are increasingly adopted by hospitals and represent possible ways to deal with the challenges they are confronted with. Hence, the research question of this study is: *How do motives for adoption of task differentiation and e-learning differ across hospitals at different points in time?*

This research provides new insights above and beyond existing studies in the area. Scientifically, this research is relevant because it addresses some key issues raised in the HR, innovation and healthcare literature. First of all, Kennedy and Fiss (2009) emphasize that most of the studies investigating innovation adoption motives only indirectly assess adoption motives, by looking at adopter characteristics or the implementation process. They argue that researchers should investigate adoption motives directly in order to better understand the mechanisms behind this process. In this study, these motives are directly addressed through in-depth interviews. In addition, this qualitative approach allows us to gain more in-depth understanding of the reasons behind and mechanisms underlying the innovation adoption decision making processes and our understanding of adoption motives from quantitative studies (Walston et al., 2001). As Cunningham, Felland, Ginsburg and Pham (2011) state, qualitative research "can address some of the limitations of a purely quantitative approach" (p. 39). In addition, some HRM scholars aim to shed more light on the adoption motives of HR practices (e.g. Ciavarella, 2003; Mayo, Pastor, Gomez-Mejia, & Cruz, 2009; Subramony, 2006). For example, Subramony (2006) identifies four theoretical approaches that might explain HR practice adoption; the economic approach, the alignment approach, the decision-making approach and the diffusion approach. While these approaches seem very relevant for explaining the adoption of HR practices, in-depth empirical studies of HR adoption motives reflected in these theories are needed. This study aims to contribute to the HRM literature by empirically investigating such theoretical approaches.

Furthermore, most studies investigating the adoption of HR innovations focus on the private sector organizations (e.g. Farndale & Paauwe, 2007; Mirvis, 1997). Little attention has been paid to investigate the adoption motives of new HRM practices in the healthcare context, while the healthcare sector is a context where studying these processes is highly relevant. In several countries, hospitals are confronted with many challenges that enhance their need to be innovative in the area of HRM. Thus, it is important to gain more insights in the motives and drivers of adoption of HRM innovations in the healthcare context. These insights are also relevant for practitioners, because it enhances their understanding of adoption decisions and will make them aware of the underlying motives. This could enable them to make better informed and more conscious decisions on innovation adoption. In sum, the aim of this study is to unravel the mechanisms leading to the adoption of innovative HR practices that might improve the performance of organizations.

THEORETICAL FRAMEWORK

While previously studies on the innovation process primarily focused on product innovations in private sector organizations, nowadays research is increasingly aimed at understanding managerial innovations, such as HR innovations (Damanpour & Aravind, 2011). Managerial innovation can be defined as "the invention and implementation of a management practice, process, structure, or technique that is new to the state of the art and is intended to further organizational goals" (Birkinshaw, Hamel, & Mol, 2008). The diffusion and adoption of innovations is a process that caught the attention of many researchers (Kennedy & Fiss, 2009; Strang & Soule, 1998). The aim of this study is to enhance our understanding of the adoption process of innovative HR practices in hospitals by combining new institutionalism and innovation theory perspectives. A distinction can be made between two types of HR practices: employment and work practices (Boxall & Macky, 2009). Employment practices can be defined as "all the practices used to recruit, deploy, motivate, consult, negotiate with, develop and retain employees, and to terminate the employment relationship" (p. 7). Work practices include practices that are related to the organization of work and work processes, such as job redesign. In this research, the adoption process of an innovative employment (e-learning) and work practice (task differentiation) will be studied.

Rational-economic perspective and new institutionalism

The adoption of innovations can be defined as "the decision to make full use of an innovation as the best course of action available" (Rogers, 2003, p. 177). Different theoretical perspectives propose several possible motives for the adoption of innovations. First of all, the rational-economic perspective assumes organizations will adopt innovations based on

information about the contribution of these innovations to the performance of the organization. For example, Fitzgerald, Ferlie and Hawkins (2003) investigated to what extent credible evidence affects the innovation adoption decisions made by healthcare professionals. Their study shows that even when robust evidence was available, the diffusion and adoption of the innovation could be described as "a complex and problematic process" (p. 225). As the example of Fitzgerald et al. (2003) shows, innovations that do result in proven benefits for the organization don't always spread (easily) across organizations (Dixon-Woods, Amalberti, Goodman, Bergman, & Glasziou, 2011). This paradox creates the need for alternative explanations for innovation adoption than rational choice models. According to Dixon-Woods et al. (2011) "it makes little sense to think of rationality as the main driver of innovation in health systems. Non-rational collective decisions should perhaps be considered the norm rather than the outlier: when health systems are faced with continual external and internal pressures for innovations combined with strong emotional, economic and political forces, the ability to engage in rational debate and planning is undermined" (p. 50). This observation is supported by Subramony (2006), who identifies both rational and non-rational theoretical perspectives to explain the adoption of HR practices. According to Subramony (2006), the economic approach and the alignment approach are the rational perspectives. The economic approach assumes that HR practices that will benefit the organizations economically will be adopted. According to the alignment approach, organizations will adopt HR practices that are aligned with strategic goals. The non-rational perspectives according to Subramony (2006) are the decision making approach and the diffusion approach. The decision making approach focuses on the non-rational, psychological elements in managerial decision making processes. The diffusion approach focuses on fads and fashions stimulating imitation of other organizations as drivers for HR practice adoption. However, when critically assessing this model, some inconsistencies can be discovered. When discussing the non-rational perspectives, Subramony (2006) neglects the rational motivations and considerations that are at play in decision making processes. In addition, he claims that according to the non-rational perspective of diffusion, an HR practice will be adopted when it is proven to be effective. However, taking into account the evidence base for the practice seems to be more part of a rational approach to an adoption process than a non-rational part. Therefore, the focus will not be on the specific model of Subramony (2006), but instead focus on the rational-economic and new institutional perspective on adoption processes. In this way, the fruitful idea of Subramony (2006) that rational and non-rational processes could be both at play in adoption processes is still reflected in the model of this study.

In line with the observation that non-rational processes might be at play in adoption processes, Dixon-Woods et al. (2011) propose several alternative reasons for the non-rational diffusion and adoption of innovations in healthcare, such as 'magical thinking' (acting is

better than not doing anything) and 'intuitive appeal' of certain innovations that foster diffusion and adoption. As Dixon-Woods et al. (2011) state, such an innovation "generates the excitement of newness and must-have – even before the evidence base has been firmly established" (p. 47). New institutionalism could also be such an alternative explanation for the non-rational diffusion and adoption of innovation. As the interests lie in paradigms that could be potentially integrated and in connecting motives with timing of adoption, the focus will be on new institutionalism and rational-economic motives in this study. These aspects will be discussed more in-depth in the following parts of this theoretical section. Researchers analyzing innovation adoption from an institutionalism perspective often take on the macro-level of analysis; the organizational field level. An organizational field can be defined as "sets of organizations that, in the aggregate, constitute a recognized area of institutional life" (DiMaggio & Powell, 1983). DiMaggio and Powell (1983) introduce the concept of isomorphism, which is "a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions" (p. 989). They distinguish between two types of isomorphism. The first type is competitive isomorphism, which resembles the rational-economic perspective and emphasizes economic rationality behind decision making processes. The second type of isomorphism is institutional isomorphism, which assumes a normative rationality that is reflected in conforming to social influences without thinking. In this respect, DiMaggio and Powell (1983) propose three institutional mechanisms to explain institutional isomorphism in an organizational field: coercive, mimetic and normative mechanisms. Paauwe (2004) argues that these institutional mechanisms affect the shaping of HRM innovations in organizations. Related to HRM, coercive mechanisms include, among others, the influence of the trade unions, labor legislation and the government. Mimetic mechanisms refer to imitations of strategies and practices of competitors as a result of uncertainty or fashionable fads in the field of management. Normative mechanisms refer to the relation between management policies and the background of employees in terms of educational level, job experience and networks of professional identification (for example universities and professional training institutes). Building on the typology of DiMaggio and Powell's (1983) mechanisms, Scott (2008) proposes three institutional pillars: regulative, normative and cultural cognitive pillar. These three pillars can be aligned with the three mechanisms of DiMaggio and Powell (1983) (Thornton, Ocasio, & Lounsbury, 2012). New institutionalism expects that organizations will respond to these societal pressures in order to achieve legitimacy and thereby enhance their probability for survival (Greenwood & Hinings, 1996).

Integration of perspectives

While many scholars view the institutional and rational-economic perspective as two separate paradigms, others have integrated both perspectives in one model. For example,

Paauwe (2004) integrated these two theoretical perspectives in his Contextually Based Human Resource Theory (CBHRT). This model shows how both competitive mechanisms (rational-economic perspective) and institutional mechanisms (new institutionalism perspective) affect the decision making processes in organizations, resulting in HR strategies and outcomes. According to Paauwe (2004), the aim of organizations is not only to achieve added value, which fits with the rational-economic perspective. The aim of organizations is also to achieve moral value, which is about achieving fairness and social legitimacy. The latter aim fits well with the institutional perspective. In addition, other scholars integrate both perspectives when they assume that organizations can strategically choose (rational-economic) how to respond to pressures from the external environment (institutional). For example, Oliver (1991) proposes several strategies for organizations to respond to external (institutional) pressures, ranging from "active organizational resistance to passive conformity and proactive manipulation" (p. 145). Another illustration of the assumption that organizations can strategically choose how to respond to pressures from the external environment is strategic balance theory. Strategic balance theory (Deephouse, 1999) acknowledges the fact that organizations need to adhere to institutional pressures that force them to become similar to other organizations. On the other hand, organizations are also confronted with market pressures that force them to differentiate from other organizations. This stands in contrast to competitive isomorphism, that proposes that market issues will force organizations to imitate each other and thus become more similar instead of becoming more differentiated. Strategic balance theory proposes that a firm should find a balance between differentiation and conformity; moderately differentiated firms that are able to balance the institutional and the market focus have higher performance than either highly conforming (emphasis on the institutional dimension) or highly differentiating firms (emphasis on the market dimension). Strategic balance theory highlights the importance of investigation of institutional and market pressures that could affect the adoption decision.

In sum, besides viewing institutional and rational-economic motives as two separate paradigms, researchers also integrate these two perspectives and propose that both institutional and rational-economic factors affect innovation adoption. This leads to the first proposition:

Proposition 1: *Both rational-economic and institutional pressures affect the adoption of employment and work innovations in healthcare organizations.*

Timing of adoption

In the innovation literature, this combination of perspectives is linked with the timing of adoption. From an innovation theory perspective, the categorization of adopter categories of Rogers (2003) inspired many scholars. He classified adopters of innovation in five catego-

ries, based on the timing of adoption: innovators, early adopters, early majority, late majority and laggards. Mirvis (1997) applied the ideas of Rogers to the HRM discipline. In his research, he empirically distinguished similar adopter categories, namely leaders, fast followers, slow followers and laggards. These categorizations have been used in order to enhance our understanding of the reasons organizations have to adopt innovations in the field of HRM.

Building upon these perspectives, Paauwe and Boselie (2005) developed a life-cycle model of HRM best practices. They distinguish, based on the categorizations of Rogers (2003) and Mirvis (1997), three groups of organizations: innovators/leaders, early adopters & early majority/fast followers and late majority & laggards/slow followers & laggards. For each group, characteristic features were derived from the literature on innovation adoption. This categorization is displayed in table 6.1. This model represents an integrative approach towards the study of innovation adoption motives, by combining strategic balance perspectives of Oliver (1991), Deephouse (1999) and Paauwe (2004) and innovation theory perspectives of Rogers (2003) and Mirvis (1997). For the purpose of this paper, three features of this model will be discussed in more depth: the rationality behind adoption, the key motivators for change and whether the adoption decision is strategic choice or represents a form of institutional isomorphism. The focus will be on these aspects of the model, because these aspects are most relevant for the research question. First of all, the model proposes that the timing of adoption is related to the rationality of decision making. Leaders and fast followers are expected to adhere to an economic rationality with respect to adoption decision making, while slow followers and laggards are probable to adhere to normative rationality. Economic rationality is associated with market pressures in terms of efficiency and effectiveness, while normative rationality is associated with social pressures instead of economic incentives. This observation is related to the second aspect that is highlighted, namely the motivations for adoption of innovations. Leaders are seen as entrepreneurial organizations that adopt innovation to stay ahead of the competition and be 'best in class'. Market pressures and social pressures will motivate respectively fast followers, and slow followers and laggards. Finally, the model proposes that in leading organizations managers will decide whether to adopt an innovation, while competitive isomorphism will affect the adoption of innovations of fast followers and institutional isomorphism influences the adoption in the case of slow followers and laggards.

Another important research model that connects timing of adoption with motives and pressures is the two stage model of Tolbert and Zucker (1983). They integrated an economic and a sociological perspective on explaining the adoption of innovations and linked this to the timing of adoption. The rational-economic perspective assumes that organizations will adopt innovations based on information about the contribution of these innovations to

Table 6.1: Life-cycle of a 'best practice' (Paauwe & Boselie, 2005)

Type according to Rogers (1995):	Innovators	Early adopters & early majority	Late majority & laggards
Type according to Mirvis (1997):	Leaders	Fast followers	Slow followers and laggards
Time	t1	t2	t3
Estimated % companies in a social system (Rogers, 1995)	2,5%	47,5%	50%
Estimated % companies in a sector (Mirvis, 1997)	11%	39%	50%
Rationality	Entrepreneurial/ economic	Economic	Normative
Strategic choice/type of isomorphism	Managers' intentionality	Competitive isomorphism	Institutional isomorphism
Risk of implementing a 'best practice'	High risk taking	Balanced risk taking	No risk
Aim	Pro-active, based on optimal absorptive capacity	Achieving competitive advantage	Avoiding competitive disadvantage
Key motivators for change	Best in class, stay ahead of competition	Market pressure (efficiency & effectiveness)	Social pressure (fairness & legitimacy)
Returns	Possible high returns, but also possible loss	Satisfying returns	No additional returns or even loss

the performance of the organization. This perspective explicitly takes into account the role of human agency and strategic choice in the innovation adoption decisions organizations make (e.g. Kennedy & Fiss, 2009). The sociological perspective is related to institutional theory. According to this latter perspective, innovations will be adopted by the organization in order to appear legitimate (DiMaggio & Powell, 1983). Tolbert and Zucker (1983) suggest that early adopters would adopt innovations due to reasons proposed by the rational-economic perspective, while late adopters would be motivated to adopt an innovation by legitimacy concerns. This model and the model of Paauwe and Boselie (2005) both assume that early adopters will be motivated by rational-economic considerations, while the decisions made by later adopters will be affected by institutional pressures. Other scholars confirmed this model. For example, Westphal, Gulati and Shortell (1997) show a shift in motivation from efficiency concerns affecting early adopters towards legitimacy concerns affecting later adopters. This brings us to the second proposition:

Proposition 2: *The motives for adoption of employment and work innovations in healthcare organizations differ for leading, following and lagging hospitals.*

However, this two stage model has also been criticized and questioned. For example, Kennedy and Fiss (2009) suggest that it might be the case that both type of motives play a role in the adoption decision making process simultaneously. They argue that late adopters are also motivated by efficiency concerns and that adopting an innovation early also results in enhanced legitimacy. Their study shows that apparently legitimacy motivations co-exist with economic motivations and that it might not be possible to view these pressures as separate forces affecting innovation adoption. In contrary, it suggests that legitimacy and economic concerns do not affect adoption decision making processes independently, but that these types of motivations are connected. This reflects the idea that adoption of employment and work innovations in healthcare organizations is affected by a combination of rational-economic and institutional motives, regardless of the timing of adoption. This is in line with the first proposition.

Due to the contradictions in the literature on motives for adoption, the focus of this research will be to investigate the adoption motives of organizations that adopted the same innovations at different moments in time. In this way, this study investigates whether organizations with different timing of innovation adoption do indeed, as proposed by several scholars, have different motives to adopt these innovations or whether regardless of the adoption timing rational-economic and institutional motives affect innovation adoption simultaneously.

METHODS

Case study context

To study the adoption motives of earlier and later adopting hospitals, the focus is on two HRM innovations in the healthcare sector and in-depth case studies were performed to investigate them. Through exploratory interviews in multiple Dutch hospitals, an overview of recent HRM innovations in these organizations was created by asking respondents working in different areas and at different levels to list the recently developed or adopted innovations in their organization. Based on this inventory, task differentiation and e-learning were selected, because both innovations are recently being diffused among hospitals in the Netherlands. In addition, these innovations are relevant for these organizations, because they could improve the efficiency and quality of hospitals that adopt them. In the HRM literature, considerable effort is devoted to distinguish more instrumental HR practices from work practices (Boxall & Macky, 2009). HR practices represent instruments organizations can use to manage their employees. On the contrary, work practices are explicitly focused on the design of work. According to Godard (2009), "alternative work practices normally entail 'new'

or 'flexible' forms of work organization". In order to include both types of HRM innovations, one work and one HR practice was included in this study. The first innovation under study is task differentiation, which can be categorized as a work practice, because it is represents a new way of working by redesigning the way work is executed. Secondly, e-learning can be categorized as HR practice, because it is focused on the management of human resources (Godard, 2009). These two innovations will be discussed in more detail.

The first innovation under study is task differentiation. In the Netherlands, nurses are being educated on different levels. The focus of this study is on the two highest levels of nursing education: level 4 and 5. Level 4 nurses completed an intermediate vocational education program, while level 5 nurses completed a higher vocational education program. However, when employed in a hospital they often perform the same tasks. Due to the different educational levels, Dutch hospitals want to introduce different tasks and roles for these two types of nurses. Level 5 nurses will then become senior nurses, and have additional tasks to the tasks of level 4 nurses, such as coordination, project management, innovation and improving quality of care. In addition, in the beginning of 2012, the national nursing association in the Netherlands introduced new professional profiles for nurses, emphasizing task differentiation between nurses with different educational backgrounds. Some Dutch hospitals already implemented task differentiation before the launch of these new nursing profiles, while other hospitals are still in the developmental phase.

The second innovation under study is e-learning, which is the introduction of computer based learning modules in the hospitals. Often these digital modules are only used to enhance the theoretical knowledge of nurses. Therefore, e-learning is often combined with exercises in skills labs to enhance the practical skills of nurses, i.e. blended learning.

In this study, it was investigated whether the motives of the hospitals that were among the first to adopt task differentiation and e-learning were different than the motives of the hospitals lagging behind. All hospitals included in this study are top-clinical teaching hospitals, with similar tasks and goals, in order to enhance comparability. A purposive sampling strategy was adopted (Miles & Huberman, 1994), in order to include hospitals in the leading, fast following and lagging adoption categories. For the task differentiation case, five hospitals are included, of which one is a leader, three can be labeled as fast followers and one is a laggard. The leading hospital adopted task differentiation in 2009, the following hospitals in 2010 and the lagging hospital in 2012. A similar categorization can be made for the five e-learning hospitals that are included in this study. The leader adopted e-learning in 2008, the followers in 2009 and the lagging hospital in 2011. These hospitals were selected and categorized based on exploratory interviews with organizational members involved in

either task differentiation or e-learning. These interviews were used to discover the stage of adoption of the specific hospitals. The timing of adoption was verified by the adoption dates reported in the project plans. This was again verified during the in-depth interviews that followed after selection of the hospital. In figure 1 below, a visual representation of the timing of adoption of both e-learning and task differentiation is presented.

Data collection and analysis

Ten in-depth case studies (Yin, 2008) were performed to unravel the adoption motives; five hospitals were included in the study to investigate the adoption of e-learning and five hospitals were included to investigate the adoption of task differentiation. In 2011 and 2012, semi-structured interviews were conducted with a member of the Board of Directors, the HR director, HR advisors, line managers, members of Nursing Advisory Board, nurses and

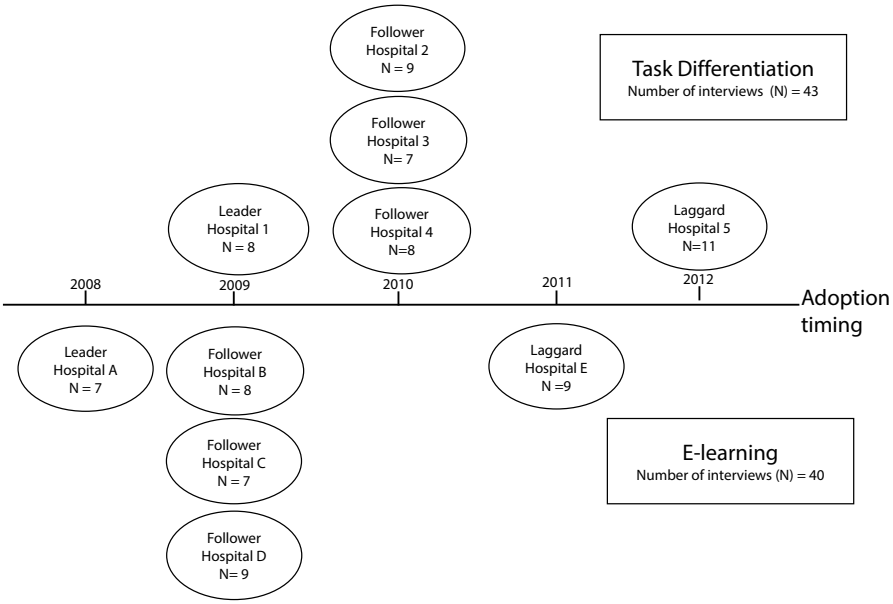


Figure 6.1: Visual representation of included hospitals and timing of adoption

members of the works council in each hospital. A multi-actor approach was adopted in order to provide a complete overview of the process from all perspectives. Interviews with leading and lagging hospitals were retrospective; the adoption decision was made before the interviews were conducted. Questions covered the diffusion, adoption and implementation process of the innovation under study. For the purpose of this study, the focus was on the drivers and motives for adoption of the innovation. 43 interviews were conducted for the

task differentiation case and 40 interviews were conducted for the e-learning case. In total, 83 interviews were included in the study. Interviews lasted approximately 1 to 1.5 hours. All interviews were fully transcribed. In addition, documents of the task differentiation and e-learning program of each hospital were studied and analyzed. These were among others implementation plans and advisory documents from the nursing advisory board.

The collected interview and document data was analyzed using Atlas.ti, following thematic analysis (Braun & Clarke, 2006). Firstly, all the interview data was transcribed and reread. Secondly, initial codes were generated, which were used to search for themes. These initial codes formed an initial list of ideas about what information is in the data. Literature on innovation adoption motives, in particular the rational-economic and institutional perspectives and the propositions, guided the analysis, but an open mind was kept for motives that would not fit these theoretical frameworks. These initial codes where then organized in broader categories based on repeated patterns across the data set: the themes. In this phase, the analysis was refocused at a broader level and codes where sorted into subthemes and themes. After that, the (sub)themes were reviewed in the light of the coded data extracts the initial codes refer to and the entire data set. Finally, the themes were defined and renamed. An illustration of this data analysis process is the emergence of the theme 'rational-economic motives'. Open codes 'cost savings', 'economizing measure', 'saving hours' and 'efficiency' were identified in the first stage of analysis. These open codes were then organized in the higher-level subtheme 'financial motives'. This subtheme was categorized under de theme 'rational-economic motives'. Other subthemes, such as 'organizational strategy', were also grouped under this theme.

FINDINGS

First of all, the findings with regard to e-learning will be presented. Secondly, the adoption motives of task differentiation will be shown. After that, findings of both innovations will be discussed to unravel patterns in adoption motives of leaders, followers and laggards.

E-learning

Hospital A is among the very first hospitals in the Netherlands to adopt e-learning. They had the opportunity to participate in a project subsidized by the European Union to introduce ICT in healthcare. Most respondents refer to the strategy of the hospital when explaining the motives for adoption. To enhance safety and patient centeredness appear to be important motives. In addition, multiple respondents refer to reducing the workload of nurses and keeping nurses at the bedside as important motives to adopt e-learning. Also,

some respondents refer to the proven effectiveness of e-learning and the efficiency gains it would generate. Finally, being an attractive employer by offering e-learning to employees is mentioned. Some comments are made that refer to more institutional motives, such as the claim that e-learning would facilitate nurses to fulfill the educational needs of the law on individual professions in healthcare (Law BIG), which sets standards on the amount of education needed to be allowed to remain at work as a nurse. However, most motives are related to the rational-economic perspective.

We are working towards being the most patient-centered and safe hospital. Patient safety doesn't only mean working with good instruments, but also working with good and expert people. That is what e-learning contributes to. (HR manager hospital A)

E-learning enables you to really learn, it has proven itself to be effective. Next to that, we want to be a good and attractive teaching hospital. (Project leader, hospital A)

Respondents from hospitals B, C and D, the followers, mention similar motives. In all these hospitals, the economic considerations to adopt e-learning are explicitly mentioned. While respondents from hospital C and D mention some more rational-economic motives in the sense that they refer to the strategic plan of the organization (hospital C) and making employees responsible for their own employability (hospital C and D), the institutional motives are much more prominent in the group of following hospitals than in hospital A. Respondents from hospital B,C and D all refer heavily to influences of the federal health inspection, national accreditation organizations, the Dutch Ministry of health and the quality register of a professional nursing association. All these institutions pressure hospitals to educate nurses regularly and the hospitals under study implemented e-learning to be able to fulfill these demands. In addition, respondents from hospitals B and D also refer to their status as top-clinical hospital, with education as a primary task, as reason to adopt e-learning.

What you try to do is to achieve more with the same means. (Educational advisor, hospital B)

If you do it via e-learning, you leave it more at the employees. That fits well with the strategic plan, that employees need to be more responsible and makes decisions about their own profession. (Educational advisor, hospital C)

The many external demands in healthcare are important. When they are omitted, hospitals immediately decrease their efforts...for example, the fact that we are a certified as a top-clinical hospital gave e-learning an enormous boost. (Educational advisor, hospital B)

A lot comes from the Ministry or the Inspection. Or the quality department that was visited by some sort of inspection that judges that too many wounds are poorly taken care of. That everyone needs to have a wound care training. Or an operating room in Almere was lit of fire, than all operating room staff in the Netherlands needs to have additional training. The only way to do that is via e-learning. (Educational advisor, hospital C)

*In this case, the V&VN [Dutch professional nursing association] enabled every nurse to register as nurse. If you get your accreditation points in time, you will remain a registered nurse...otherwise they will lose their license. That is a strong contextual factor that makes it for us as a hospital very important to make sure they will achieve those accreditation poin*ts. *We are able to do that because of e-learning.* (Manager educational department, hospital D)

Some respondents from the group of following hospitals refer to following fashion when explaining the adoption motives. However, this institutional motive is most dominant for the lagging hospital E. Many respondents from this organization refer to following the fashion of e-learning. In addition, some rational-economic considerations, saving time and money, and other institutional motives, influence of the national accreditation organization and being a top-clinical hospital are mentioned.

If you take a look at e-learning the thought was also "we have to do something with e-learning, because it is a trend or a cheap way to learn and develop". (HR advisor, hospital E)

I don't think this [e-learning adoption] was a conscious choice of the hospital. I think it is a trend in the hospitals to bring learning and development under the attention via the digital highway. (New business manager, hospital E)

In sum, rational-economic considerations are mentioned by all three adoption categories as motives for adoption of e-learning. Respondents from the leading hospitals explicitly refer to their organizational strategy, while interviewees from following hospitals primarily refer to economic and efficiency considerations in this respect. Institutional motives such as fulfilling the demands of Law BIG, of the federal health inspection and the Ministry, seem to be relevant for all adoption categories, from leaders to laggards. However, these motives are most prominent for the group of following hospitals. Respondents from these following hospitals sometimes refer to fashion and fad following motives. However, these latter motives are much more dominant for lagging hospital E.

Task differentiation

Respondents from the leading hospital, hospital 1, primarily explain the choice to adopt task differentiation between level 4 and 5 nurses by stating that they want to improve the continuity and quality of care and patient satisfaction. This is part of their organizational strategy, but they also received complaints from patients about the continuity of care. Task differentiation could help to diminish the amount of transfer moments and thereby improve the continuity of care. As to institutional motives, little reference is made to institutional pressures stimulating adoption of task differentiation. On the contrary, respondents indicate that there were normative pressures to not adopt this innovation: professional nursing associations were opposed to this differentiation.

> *One of the bottlenecks was continuity of care, which could not be guaranteed. The patient should be placed first, that is our mission in this hospital. So to organize care as well as possible you need continuity and as few transfer moments as possible. But there were mnay transfer moments. That is one of the main reasons to implement this model [task differentiation].* (Line manager, hospital 1)

> *The reason to adopt task differentiation is the amount of complaints we received from patients. The hospital board discovered that those complaints often had to do with transfer moments, with sharing information about a patient.* (HR manager, hospital 1)

> *I had to give interviews to national action committees: how could I think of task differentiation among nurses?...there was a lot of resistance and nurses found support by their national support groups and associations...for example, one professional nursing association wrote an article where they heavily criticized our model. It was an exciting period.* (Director, hospital 1)

Hospitals 2, 3 and 4 are categorized as fast following hospitals. Enhancing the quality of care and creating career paths for nurses are motives most often mentioned. When it comes to institutional pressures, some indications of institutional motives are present, but they do not appear to be the dominant motives. For example, many respondents of hospital 2 and 4 refer to the new professional profiles introduced by the largest professional nursing association in the beginning of 2012 as an important development when it comes to differentiating between higher and lower level nurses. However, they started implementing this differentiation between level 4 and 5 nurses before the introduction of these profiles, so this didn't affect their adoption decision directly. Although some managers from hospital 2 and 4 claim they saw this development coming and anticipated on this by adopting task differentiation on beforehand.

Quality is of course on top of the agenda here. To improve safety and quality of care. That is the underlying motive. (HR advisor, hospital 2)

At this clinical ward we had major difficulties with quality of care. We reorganized the ward and the question what functions do we need to establish the quality as good as possible. That led to task differentiation. (Line manager, hospital 2)

You have to be able to offer them [lever 5 nurses] a senior role, because they want to advance their career. (Line manager hospital 4)

I noticed that it was all at the same level here. Employees stood out, they could do and wanted to do much more. You have to give them a challenge. (Line manager, hospital 3)

I think the new nursing profiles don't affect it, because our manager was aware of this development early on. (Member hospital nursing association, hospital 2)

Respondents of hospital 5, which is currently planning to implement task differentiation and thus lagging behind the other hospitals, also often refer to these new professional profiles. Differently than the following hospitals, the introduction of these profiles appears to have a great effect on adopting task differentiation for hospital 5. Many respondents refer to these profiles as the development that was decisive for them to adopt task differentiation. While these respondents also mention motives such as that task differentiation could help them to realize their ambition to be the best hospital in the country, to deliver high quality care, and to provide career paths for nurses, the most dominant motive appears to be institutional.

As hospital nursing association we've been trying to get this [task differentiation] on the agenda for years. Sometimes this led to the introduction of a working group on task differentiation, but this died an early dead every time...now it is working, we needed the pressure [new nursing profiles], now we have to make a change. (Member hospital nursing association, hospital 5)

Of course the national pressure [new nursing profiles]. They say things are going to change and then you can't say 'no' as hospital. (Line manager, hospital 5)

In conclusion, rational-economic considerations to adopt task differentiation are apparent in all hospitals, but seem to be more dominant in the leading and following hospitals. On the other hand, institutional pressures are also present in all adopter categories, but they have the highest impact in the lagging hospital. In the leading hospital, institutional influences

against adoption of task differentiation were present, but this didn't withhold the hospital from adopting task differentiation.

CONCLUSION AND DISCUSSION

The aim of this study is to enhance our understanding of innovation adoption motives of earlier and later adopting hospitals. Similarities can be seen in the findings related to the adoption motives of e-learning and task differentiation. While both rational-economic and institutional motives seem to be present in all adopter categories, some differences can be observed. Rational-economic motives seem to be most relevant for leaders, while institutional motives are dominant for laggards. Both types of motives seem to be relevant for followers.

These findings shed some new light on well-known theories regarding the link between timing of adoption and motives for adoption. The findings are in line with those of Kennedy and Fiss (2009), claiming that both rational-economic and institutional motives play a role in the adoption process simultaneously. However, leading hospitals are primarily affected by rational-economic considerations, while lagging hospitals are mostly affected by institutional pressures. For the middle category, the followers, both types of motives seem to be relevant. This finding is supported by the models of Rogers (2003) and Paauwe and Boselie (2005).

Once a deeper look is taken into the nature of the rational-economic and institutional pressures, some differences with these models can be found. While Paauwe and Boselie (2005) propose that lagging hospitals are affected by institutional isomorphism, including coercive, normative and mimetic pressures, the distinctive institutional pressures affecting the adoption decisions of hospitals in this study are limited to those of a normative and fashion following (mimetic) nature. These seem to be the most relevant institutional motives for laggards. Not in accordance with theoretical models, coercive pressures are more dominant among the followers. Of course, all three groups of hospitals are confronted with coercive pressures, but organizations in the followers' category often mentioned these pressures during the interviews. The members of these organizations often refer to the federal health inspection and the Dutch government coercing them to adopt e-learning and task differentiation. This can be explained by the fact that most existing models on innovation adoption are predominantly used to study this process in private sector contexts. The fact that this study is conducted in a (semi-)public sector context, which is strongly affected by the Dutch government, might explain the dominance of coercive institutional pressures ex-

perienced by followers. These coercive pressures are also mentioned by members of lagging organizations, but these respondents mention fashion and fad following motives, mimetic pressures, more often. This could be because they are aware of the fact that they are lagging behind. Therefore they are more occupied with what other organizations do, which results in a focus on mimetic pressures, while coercive pressures move to the background.

In accordance to the model by Paauwe and Boselie (2005), this study shows that for the middle group of adopters (the followers) rational-economic factors as efficiency and effectiveness play an important role in the adoption process. This fits the classical rational-economic perspective well. However, institutional pressures also play an important role for these organizations. So a mixture of motives characterizes the adoption processes.

Furthermore, Paauwe and Boselie (2005) propose that leaders are motivated to stay ahead of the competition. The findings show that leaders are primarily motivated to adopt HR innovations in order to achieve strategic goals such as quality of care. This might be related to staying ahead of the competition in this specific sector. Quality and safety could be important indicators of competitive advantage in healthcare instead of for example efficiency for private sector organizations. However, when mentioning quality and safety, no reference is made by the respondents that they do so in order to beat the competition. This is surprising, given the fact that in The Netherlands more competition in the healthcare sector is introduced. This finding could be explained by the importance of safety and quality of care for the legitimacy of hospitals. Here, the rational-economic considerations (strategy) and institutional mechanisms (legitimacy) blend.

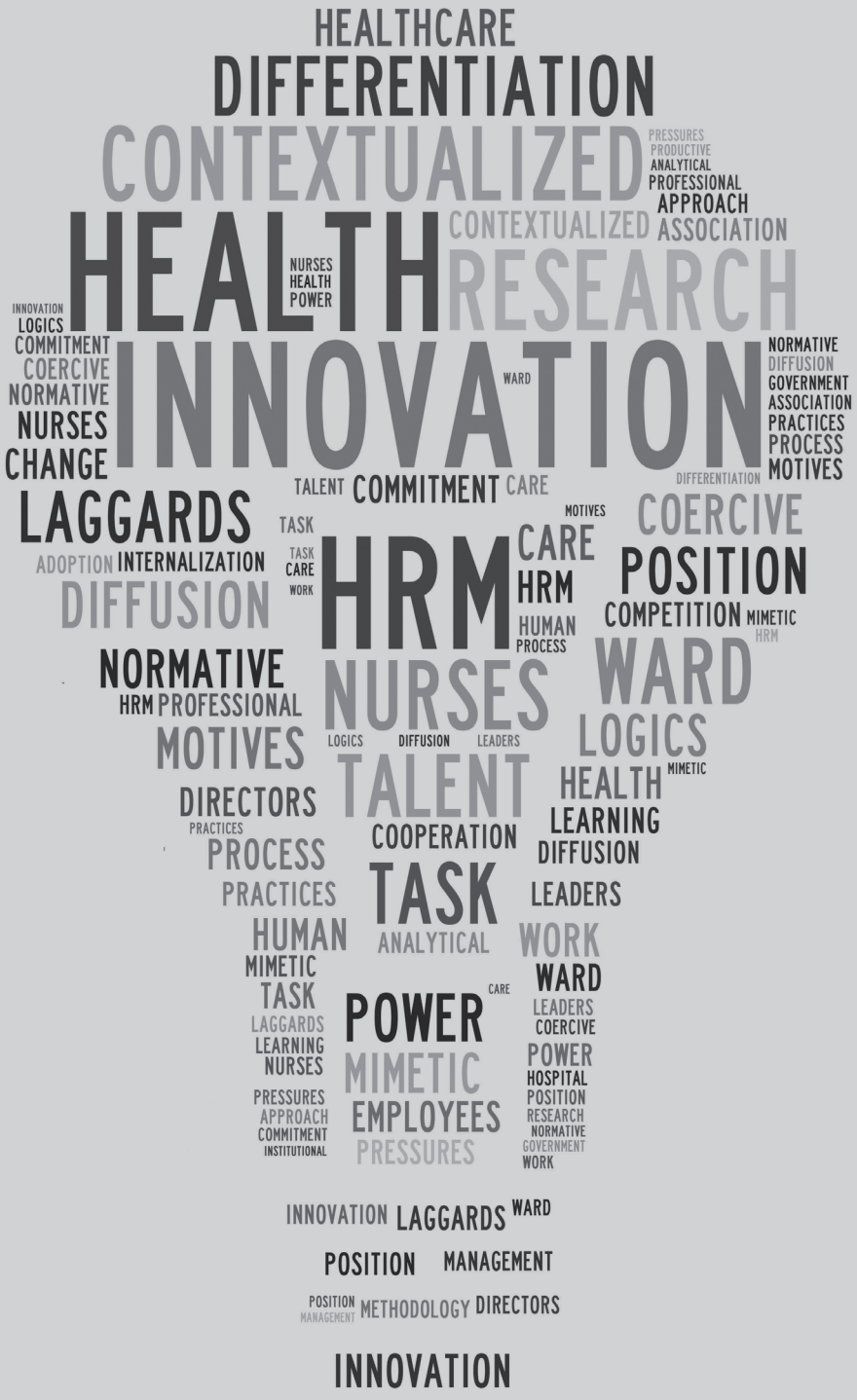
Most studies linking adoption timing to adoption motives differentiate between rational-economic motives on the one hand and institutional motives on the other. However, this study shows that this distinction is not be as clear cut as it seems. Apparently rational-economic adoption motives, such as enhancing quality of care and saving costs are often influenced by institutions and institutional mechanisms. For examples, the importance of saving costs for healthcare organizations is at least partly determined by the decisions of the national government to spend less money on national healthcare. In addition, the importance ascribed to quality in most hospitals is encouraged by nationwide scandals of hospitals failing to ensure patient safety, resulting in legitimacy losses. Therefore, in institutionalized sectors as the Dutch healthcare sector, institutional mechanisms could be the real underlying drivers for motives that are perceived and expressed as economic. Researchers in institutionalized fields such as healthcare should take this into account.

In addition, the institutional logics perspective might be relevant to explain these findings. Institutional logics can be defined as "the belief systems and associated practices that predominate in an organizational field" (Scott et al., 2000). According to Greenwood, Diaz, Li and Lorente (2010), "logics underpin the appropriateness of organizational practices in given settings and at particular historical moments" (p. 2). Several studies indicate that multiple institutional logics exist in healthcare fields; business-like logics and professional logics (Reay & Hinings, 2005, 2009). Both types of logics are represented in the adoption motives reported by the respondents in this study. Both business-like logics, such as economizing, and professional logics, such as enhancing quality of care, seem to be reflected in the motives for innovation adoption that would fit the rational-economic stream. Business-like logics could be related to economic rationality behind decision making processes, as discussed in the theoretical section of the paper. One could wonder how the adoption motives that were reported by the respondents are related to the institutional logics that dominate the healthcare sector. These institutional logics might be the underlying drivers that affect employees' perceptions of adoption motives. For example, the business-like logic affects healthcare employees due to developments such as economizing in the healthcare sector. In turn, this business-like logic becomes the underlying belief system that leads employees to refer to rational-economic motives when discussing adoption motives. Thus, these motives actually represent the multiple logics present in the healthcare sector. This explains the fact that respondents from all adopter categories at least partly refer to rational-economic motives; these represent the business-like logics apparent in the healthcare field. Therefore, these institutional logics guide the decision making process and affect the type of motives respondents referred to. This view is supported by scholars such as Ocasio (1997), stating that institutional logics potentially guide the attention of organizational decision-makers and thereby affect organizational decision making motives. Therefore, institutional logics might be important explanatory factors in adoption decision making processes in healthcare organizations and therefore need to be taken into account by future studies on this topic.

Another interesting finding, which also calls for more research, is the finding that one leading hospital experienced (normative) institutional pressures against the adoption of task differentiation. Despite this anti-adoption pressure, they still managed to adopt the innovation. Leading organizations could have certain mechanisms in place to shield them from these types of anti-adoption pressures. This is related to research from for example Oliver (1991), claiming that organizations can adopt different strategies in order to respond to institutional pressures. Explaining and investigating the generalizability of this finding is an interesting avenue for future research.

In sum, this study enhances our understanding of motives for adoption of innovative HR practices. Of course, this research has some limitations. The main limitation would be the limited amount of cases studied. Studying more cases could enable us to see whether these findings are consistent across more innovations and hospitals. However, some interesting results from the data could inspire other researchers to expand the research in this topic area.

The insights gained from this research are also beneficial for practitioners. In particular, healthcare managers could take advantage of these findings. In studying the adoption of e-learning and task differentiation, this study shows that different motives are at play in the adoption decision making process in healthcare organizations. First of all, rational-economic motives such as achieving organizational goals are important in this process. Secondly, institutional pressures such as adhering to standards of governmental agencies and influence of professional nursing associations are at play. This study shows that it is important for decision makers in healthcare to balance legitimacy concerns and efficiency or effectiveness concerns. This awareness could help practitioners to make better decisions and ensure successful succession of the adoption decision. Practitioners should emphasize the right reasons for adoptions at the right time. This would enable them to anticipate on interests and responses of different stakeholder groups. For example, managers could be motivated to support the HR practice when they are made aware of the fact that this practice will enhance their performance. Nurses might be better convinced by the argument that their professional association supports the idea of the new practice. Considering these differences is important to gain enough support for the adoption decision. As a consequence of increased support for the practice, the implementation phase that follows the adoption decision is expected to be more successful.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METHODOLOGY
DIRECTORS
INNOVATION

CHAPTER 7

Conclusion and Discussion

The aim of this dissertation is to enhance our understanding of the HRM innovation process in the healthcare sector, by unraveling the diffusion, adoption and implementation of HRM innovations and taking into account specific contextual characteristics of this sector. The research question of this dissertation is *What characterizes the diffusion, adoption and implementation of HRM innovations in Dutch healthcare organizations and how do agents, organizations and institutions influence these phases of the HRM innovation process?* In this chapter, the findings of this dissertation are being discussed.

CONCLUSION

In order to be able to answer the main research question, several more specific research questions are developed. The main findings answering these questions are described in this section.

What kind of HRM innovations are adopted in healthcare organizations?

First of all, this study shows that several HRM related innovations can be identified. These innovations can be grouped in three categories (chapter 2). The first category consists of employment innovations that can be related to traditional employment instruments such as training and development. The innovation processes of the employment innovations e-learning (chapter 6) and Talent Management Pool (chapter 4) are reported in this dissertation. The second category consists of work innovations, which are new practices that are related to the design of work. An example of a work innovation is task differentiation. The innovation process of task differentiation among nurses of different levels is reported in this dissertation (chapter 6). Thirdly, innovations that fit in a broader category than employment or work practices and which still encompass a strong HRM component can be identified. These innovations are labeled organizational innovations. Organizational restructuring and cultural change programs are examples of these organizational innovations. In the dissertation the innovation process of organizational innovation Productive Ward: Releasing Time to Care (chapter 5) is reported. However, this distinction between three types of HRM innovations is not entirely clear cut. For example, Productive Ward: Releasing Time to Care is categorized as an organizational innovation, but also encompasses some work design practice characteristics, as this innovation allows nurses to redesign work processes. This practice was categorized as an organizational innovation, because the principles and goals of the program are broader than work redesign. Despite this, the categorizations are useful in providing us with an overview of the type of HRM innovations in the healthcare sector (chapter 2).

Which underlying mechanisms are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how can this be explained?

The second question focuses on identifying and explaining specific underlying mechanisms for the diffusion, adoption and implementation of HRM innovations in healthcare. This research reveals that innovation processes in healthcare are typically long lasting processes that could take years. For example, in chapter 5 the longitudinal case study focusing on the implementation of the pilot Productive Ward: Releasing Time to Care is reported. After the adoption decision was made, this implementation period was nine months and covered the implementation of the program in two wards. By the end of this period the elements of the program that needed to be implemented for the pilot were completed, but the other elements of the program still needed to be carried out. In addition, the adoption decision was already made before the study started, which also took several months. The length and dynamics of such processes can be explained by the large amount of actors involved throughout the innovation process, the tensions associated with innovations in the sector and the barriers that could be identified in this respect. These elements are discussed in the following paragraphs.

Which actors are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how do they affect this process?

Several actors play important roles in the diffusion, adoption and implementation of HRM innovations in healthcare. Internal actors, such as line managers, HR managers, directors and physicians, are considered to play important roles as well as external actors such as governmental institutions and other hospitals. These actors are taken into account in this dissertation in several ways. First of all, interviews were conducted with several organizational actors. For example, the views of HR professionals, line managers, hospitals directors and nurses are included in the research. Secondly, one of the studies focusses on the role of HR professionals in innovation processes (chapter 2). This study reveals difficulties these HR professionals face in convincing others of their ideas. Thirdly, external actors are taken into account by paying attention to institutional pressures on healthcare organizations. External actors also appear to affect the innovation process quite strongly. More specifically, the study on leaders and laggards with regard to the adoption of e-learning and task differentiation (chapter 6) shows that institutional pressures, such as normative and mimetic pressures, influenced organizational decision making on the adoption of these innovations for leading and lagging organizations. In addition, respondents reported that external pressures can be used to convince others of an innovative idea. For example, national nursing associations that actively supported task differentiation by introducing new nursing profiles helped

organizational actors to convince others within the organization of their task differentiation initiative.

Regarding the amount of stakeholders, the study on the Talent Management Pool (chapter 4) shows that the initiators of the innovation, the HR directors of four hospitals, needed to convince several stakeholders to support their idea before the adoption decision was made and implementation process could start. In effect, they needed to convince the board of directors of their hospitals, because a financial investment was needed for the development of the pool. They also needed to convince their own HR staff, so that they would spread the word to line managers they advise. Convinced line managers were crucial for success of the pool, because they needed to allow their employees to participate in the pool. Furthermore, employees needed to be convinced that participating in the pool would generate benefits for them. Also external stakeholders needed to be convinced. For example, the governmental institution occupied with preventing illegitimate cooperation among competing organizations accused the hospitals of creating an illegitimate cartel agreement.

Which possible tensions are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how can this be explained?

In addition, the exploratory analysis reveals several tensions associated with HRM innovation processes in healthcare organizations. The tensions between competition and cooperation, business-like and professional logics and rational-economic and institutional motives are reported in the studies following the exploratory analysis that is reported in chapter 2. These studies show that there are some tensions associated with different internal actor groups. For example, the combination of business-like logics that are often dominant in the decision making of line managers and professional logics that are highly valued by healthcare professionals such as nurses and physicians could hinder the innovation process in healthcare organizations. The study on Productive Ward: Releasing Time to Care study (chapter 5) reveals that the tensions arising from a combination of business-like and professional logics could harm the implementation and internalization of an innovative practice. In addition, the more long term focus of HR professionals on cooperative innovation is expected to clash with the more short-term and results oriented focus of line managers. The Talent Management Pool study (chapter 4) shows that the tensions arising from simultaneous competitive and cooperative pressures could affect the innovation process negatively. Therefore, such tensions are likely to become barriers in the innovation process.

Which enablers and barriers are specific for the diffusion, adoption and implementation of HRM innovations in healthcare organizations and how can this be explained?

Furthermore, enablers and barriers of HRM innovation processes in healthcare were studied. For instance, enablers and barriers of the involvement of HR professionals in innovation processes (chapter 3) and enablers and barriers throughout the implementation process of 'Productive Ward: Releasing Time to Care' (chapter 5) were identified. The study on the role of HR professionals in innovation processes reveals for example that the lack of credibility of the HR department and their lack of involvement in and understanding of the core business of the healthcare organization hindered their involvement in innovation processes. On the other hand, visibility of the HR department and delivering HR services in a way that satisfied managers are examples of factors that favored their role.

In sum, the analysis of actors, tensions, enablers and barriers in the HRM innovation processes in healthcare organizations enhances our understanding of these processes. The main research question of this dissertation is: *What characterizes the diffusion, adoption and implementation of HRM innovations in Dutch healthcare organizations and how do agents, organizations and institutions influence these phases of the HRM innovation process?* The findings show that both internal and external actors play an important role in the HRM innovation process in healthcare. Internal actors such as HR professionals, line managers, professionals and the Board of Directors play a prominent role in the process, but external actors, such as governmental institutions, professional associations and other hospitals also play an important role. The involvement of these different actors in the HRM innovation process creates tensions for healthcare organizations engaging in HRM innovation. Context-specific tensions such as the tension between cooperation and competition are relevant as well as tensions that are more widely acknowledged across contexts in the literature such as the tension between institutional and rational-economic pressures. Several elements resulting from the studies in this dissertation ask for a more in-depth discussion.

DISCUSSION

In this section, there will be a more in-depth discussion of the issues that are raised by this research. First of all, the research design will be reflected on. The aim of the research approach was to embed the research in the healthcare sector by introducing and adopting a contextualized process methodology. Secondly, the influence of the external (institutional) context on the HRM innovation process will be discussed, because this appeared to be of substantial influence on the innovation process in healthcare. In addition, the need for more

research attention towards implementation of innovative HRM practices will be discussed. Furthermore, a reflection on the innovation concept and more specifically managerial innovations will be presented. This discussion will end with an overview of limitations of this study and recommendations for future research and for practice.

Contextualized process methodology

First of all, in this dissertation, several aspects of the analytical approach developed by Boxall, Purcell and Wright (2007) are adopted. In particular, the acknowledgement of context as vital for the understanding of HRM in organizations (Paauwe, 2004; Boselie, 2011) is one of the foundational ideas of this dissertation. Iterative research methods that allow for the adaptation of the research design to context specific topics and developments also inspires this research (Orton, 1997). Therefore, the aim of the dissertation is to embed the research in the healthcare context through a contextualized process methodology. This methodology consists of two stages. The aim of the first stage is to explore to context and gain insights in elements that characterize a process in a specific context. Using information from scientific literature, documents and explorative interviews with key actors in the research context, a heuristic framework was developed that guided the in-depth investigation of contextually relevant issues. This approach yields several advantages. First of all, it allows for identification of innovations that are unknown by researchers. For example, the Talent Management Pool and Productive Ward: Releasing Time to Care are innovations that were only identified because interviewees in the first research stage brought the existence of these innovations to our attention. As these innovations were not fully developed at the moment research started, the awareness of these innovations for further study was only raised through the exploratory interviews. Furthermore, adopting this approach allows researchers to truly embed the research in a specific context, in this case the healthcare context. Several elements that emerged from the first research stage helped in tailoring this research to the healthcare context and guided the second stage of this study. In this latter stage, qualitative studies were performed in order to study these elements in-depth. Many HRM studies take existing theory as a starting point for developing a conceptual model that will be tested empirically. Often, these theoretical ideas are of a general nature, i.e. they are not developed specifically for the research context under study. Scholars often assume that these general theories are also applicable to the context they study. On the contrary, the approach developed in this dissertation takes into account these general theories, but avoids taking these theories as the central starting point. Instead, they are combined with context specific information. In addition, while many HRM scholars take a deductive approach to research, this approach combines inductive and deductive approaches. By taking this approach, the aim of this research is to respond to the calls of several researchers to take into account context better in HRM research and to build more theory on HRM to enhance our understanding of

processes and mechanisms relevant for HRM (e.g. Boxall & Purcell, 2008; Guest, 2011; Paauwe, 2004; Paauwe, Guest & Wright, 2013). In this contextualized process methodology, a heuristic model that will guide the semi-structured interviews is partly developed based on insights of previous research. Yet, key in this first stage is keeping an open mind for elements specific for the context under study. Therefore, these elements can be derived from the collected data more inductively. The heuristic framework that was developed in this research was used to focus the semi-structured interviews on certain broad topics (e.g. the adoption of innovations). The contextually important themes were derived from the interview data (e.g. the power and position of HR in healthcare). These findings led to refinements of the heuristic framework and were used to guide the second stage of the dissertation research, enabling a focus on relevant themes in the healthcare sector. In sum, this contextualized process methodology represents an example of rigorous methodology that enables researchers to take on a contextual approach. This approach enables a critical assessment of current theories and models in the HRM and innovation process literature. While many of these models represent theoretically based predictions of the innovation process, the contextualized process methodology enables a more open an emergent view on this process.

Institutional influences and individual actors: pressures, logics and public values

In line with the context specific focus of this dissertation, the importance of the institutional context is evident. This is one of the core elements that were derived from the interview data in the first stage of the contextualized process methodology. In chapter 4 and 6 explicit attention has been paid to respectively institutional logics and institutional pressures.

This dissertation shows that the institutional developments and pressures healthcare organizations are confronted with are of great importance for HRM innovation processes (Jensen, Kjærgaard, & Svejvig, 2009; Paauwe and Boselie, 2005). Therefore, a prominent role of institutional theory in the analysis of organizational processes is justified. Institutional theory is often criticized for downplaying or neglecting the role of actors and agency in organizational change processes (Thornton, Ocasio, & Lounsbury, 2012). This research shows that the perception and interpretation of organizational actors play an important role in these processes. These perceptions affect their responses to these institutional pressures. This is in line with research from for example Oliver (1991), proposing several responses organizations can have to institutional influences. Besides accepting and conforming to these institutional pressures, organizational actors may also choose to try to manipulate of ignore these influences. Therefore, a plea is made for combining institutional theory with theories that focus on the perceptions and choices of actors.

The institutional logics perspective is an example of a theory that aims to consider the role of agency in relation with the institutional context (Thornton et al., 2012). Governmental reforms in the Netherlands aimed at stimulating competition in the healthcare sector result in a more business-like orientation and a focus on efficiency in hospitals (i.e. business-like logic). The study on institutional logics in chapter 5 shows that business-like logics and professional logics co-exist in the healthcare sector (Reay & Hinings, 2009). Nurses adhere primarily to professional logics by focusing on quality of care and time spent on patients. On the contrary, managers predominantly take on a more business-like approach and refer to efficiency concerns when discussing reasons to adopt innovations. However, nurses also refer to business-like elements. For example, increasing efficiency was mentioned by nurses as a reason to implement the Productive Ward: Releasing Time to Care program. The healthcare reforms and economizing measures introduced by the Dutch government seem to be important drivers of the emergence of this business-like approach. In addition, in chapter 4 the perceptions of competition in the healthcare field are reported. In 2006, the Dutch government introduced a healthcare reform aimed to increase the amount of competition among healthcare provider organizations. This development is related to a more business-like approach towards healthcare management and is therefore in accordance with the emergence of New Public Management (NPM) (Bekkers, Edelenbos, & Steijn, 2011; Diefenbach, 2009; Doolin, 2001, Jespersen, Nielsen, & Sognstrup, 2002; Noordegraaf, 2007).

The notion of New Public Management originates from the public administration literature (Diefenbach, 2009). Similar to the developments within institutional theory, the emergence of the awareness that actors play an important role in organizational processes can also be observed within the public administration literature, for example when the introduction of the public value perspective is considered (Leisink, Boselie, Van Bottenburg, & Hosking, 2013). According to Leisink et al. (2013), in many public management studies, organizational actors are viewed as passive receivers of public values that are imposed on them top-down. For example, Moore (1995) argues that the determination of the successfulness of organizations operating in the public sector, such as healthcare provider organizations, should be based on the amount of public value that is created by these organizations and that these public values are determined by politicians and the government. However, the active role of other actors such as citizens and professionals in determining these public values is increasingly being acknowledged. According to scholars supporting this view, actors such as citizens and healthcare providers are not mere receivers, but co-creators of these public values. Nowadays, not only delivering high quality of care is seen as public value that is being created by healthcare organizations, but the role of costs is considered to be important as well. This development fits well with the developments that are observed in institutional theory; the

role of agency of organizational actors is increasingly being acknowledged and business-like logics have become more prominent in the public sector domain.

The influence of the institutional context on the diffusion, adoption and implementation of HRM innovations is also noticeable in other chapters of this dissertation. For example, chapter 6 focuses on the motives of hospitals adopting HRM innovations at different times. Rational motives, such as efficiency concerns, appear to be most dominant for the hospitals that were among the first to adopt such an innovation (leaders), while late adopters (laggards) are primarily motivated by institutional motives and legitimacy concerns. However, both types of motives appear in all adopter categories (i.e. leaders, followers, and laggards). A potential explanation for this finding is that dominant institutional logics in the healthcare sector (e.g. business-like and professional logics) are the underlying drivers of these motives mentioned by respondents in the study. For example, the business-like logic affects healthcare employees due to developments such as economizing in the healthcare sector. In turn, this business-like becomes the underlying belief system that leads employees to refer to rational-economic motives when discussing adoption motives. These motives then actually represent the multiple logics present in the healthcare sector. As a consequence, motives and logics could represent similar concepts on different levels: motives are the more directly observable representations of the logics that exist on a deeper level.

On the one hand, institutional influences could negatively affect innovation processes in the healthcare sector. For example, the study on multiple institutional logics (chapter 5) shows that a combination of professional and business-like logics hinders the implementation and internalization of an innovative project. In this case, nurses became suspicious when business-like logics were explicated in the labeling and communication about his project. The pressures from the institutional environment to economize were perceived as threats to the fulfillment of professional logics. On the other hand, institutional influences also appear to stimulate innovation processes, by justifying the adoption of innovations. Developments in the institutional context can create a sense of urgency among organizational actors to make changes in their organizations and can be used to create support for innovations throughout the organization. Developments such as economizing measures from the Ministry of Health that increase the need to work more efficiently in healthcare organizations and technological developments that enable the development of online learning spaces have stimulated the diffusion, adoption and implementation of e-learning in the healthcare sector (chapter 6). Not only coercive pressures, from for example the government, appear to be important stimulating factors for HRM innovation in healthcare. In this respect, mimetic institutional pressures, imitating other organizations in order to keep up with technological developments, are important drivers of the diffusion and adoption of e-learning as well. In

addition, normative pressures, for example nursing professional associations supporting developments such as task differentiation, also stimulate the adoption of innovations (chapter 6). This dual role of institutional pressures, hindering and facilitating innovation processes, might also be applicable in other public sector contexts, as they are confronted with similar pressures.

Importance of perception: competition and cooperation

Developments in the healthcare sector simultaneously stimulate competition and cooperation among healthcare provider organizations. On the one hand, the government, healthcare insurance companies and hospital rakings are examples of actors and factors stimulating competition among hospitals. For instance, healthcare insurance companies are stimulated by the government to be more selective in purchasing care and some healthcare insurance companies only purchase care with hospitals that provide the best quality care. In addition, hospital rankings published in media evoke a competitive spirit among hospitals to rank higher than others. On the other hand, there are also developments in the sector that stimulate cooperation across hospitals. Pressures to concentrate care delivery in order to increase quality and reduce costs are prominent. For example, hospitals need to perform a minimum amount of specific surgeries per year in order to be allowed to proceed with these surgeries in the future. This creates the need for hospitals to cooperate, because many hospitals are not capable to satisfy this requirement independently.

Therefore, the study on coopetition, a relationship between organizations that involves both competition and cooperation (Brandenburger & Nalebuff, 1995), is very relevant for the healthcare sector (chapter 4). The research approach adopted in this study entailed multiple actors in the study of HRM innovation processes. This enabled tracing differences in perceptions between actors. This study shows that differences in perceptions between different actors have a great influence on the diffusion, adoption and implementation of innovations. For example, building on the previous discussion on NPM and the introduction of competition in the healthcare sector, the findings of the study reported in chapter 4 show that the perceptions of competition differ among different organizational actors (Bengtsson, Erikson & Wincent, 2010; Sørensen & Torfing, 2011). In effect, line managers experienced a lot of competition among hospitals and were therefore reluctant to cooperate with other hospitals, while HR managers were more focused on cooperation instead of competing with other hospitals. They did not emphasize the increased amount of competition among these organizations. As a result, the implementation of the Talent Management Pool, that required cooperation with other hospitals, was hindered due to a lack of support from line managers for this cooperative project. These findings show that the perceptions of institutional developments and contextual changes differ significantly among different groups of actors.

It is important to take this into account, especially because nowadays the awareness that line managers play an important part in the effective execution and implementation of HRM is growing.

Strategic fit or strategy-as-practice: implementation

In the strategic HRM literature, there is a widely supported assumption that in order for HR to add value to the organization and to help achieving strategic goals, the HR strategy should be aligned with the organizational strategy (e.g. Boxall & Purcell, 2000). A more recent perspective in strategic management is focused on how to put strategy into practice, i.e. strategy-as-practice (Jarzabkowski, 2004; Regnér, 2008). In line with these insights, the findings of this dissertation indicate that the focus of HR should not be to simply fit their strategy with the organizational strategy, but to become much more occupied with implementation and translation of these strategies. As HRM is about the management of human resources, and these employees need to put the strategy into use, HR professionals seem to be suited for this job. Unfortunately, research often indicates that becoming a strategic partner for the board of directors and line managers is a challenge for many HR professionals (e.g. Guest & Bryson, 2009; Reilly, Tamkin, & Broughton, 2007). Chapter 3 of this dissertation confirms this. The findings show that many factors are at play hindering the involvement of the HR function in organizational change process and strategic decision making. Based on the findings of the study on the HR function in healthcare organizations it is suggested that HR professionals should not focus too much on employment practices, but become more involved in developing and implementing work practices, because this is the area where most organizational changes in healthcare have emerged. In addition, it is suggested that HR professionals should become more connected; with different actors in the organizational and organizational field, with the core business of the organizations and with other initiatives in the organizations. This is expected to be the key for a more influential position of HR in healthcare organizations, but also in other organizations due to the fact that connectedness seems to become a crucial element for HRM implementation (Regnér, 2008).

While earlier research on HRM and performance focused on the mere presence of HR practices to make inferences on the relationship between HRM and performance, there is a growing awareness among HRM scholars that this is an imperfect indicator for the effectiveness of HRM in organizations. HRM scholars increasingly recognize the importance of effective implementation of these HRM practices for the generation of positive outcomes of HRM practices (Becker and Huselid, 2006; Paauwe, 2009). In their process model of SHRM, Wright and Nishii (2013) make a distinction between intended practices (mainly policies related to strategy, often designed by HR professionals), actual practices (as implementated by line managers) and perceived practices (perceptions of those who receive the actual practices,

the employees). After the HR policies and practices are designed (intended practices), they need to be implemented. This implementation process can therefore be represented by a shift from intended practices to actual practices. According to Wright and Nishii (2013), the aim of the implementation of HRM practices is to make sure that new behavior of employees resulting from these practices will become routine. While intended and perceived practices receive substantial research attention, research on actual practices and the implementation process seems to be lagging behind and there are pleas for more research in this area (Guest & Bos-Nehles, 2013).

As HRM scholars increasingly recognize, line managers are frequently responsible for the implementation of new, innovative HRM practices, but they are often not motivated or willing to implement HRM innovation (e.g. Purcell & Hutchinson, 2007), which is expected to negatively affect the success of these HRM innovations. When HR professionals are more connected with the rest of the organization, including the wards and other organizational departments, they are better aware of the challenges and issues line managers are confronted with. This may allow them to adhere to line managers needs with the HRM innovations they propose, which could motivate line managers to implement these practices. Alternatively, this study suggests that creating support for the innovation throughout the organization could also be achieved in other ways. For example, prominent external institutional pressures could be employed by innovators to create a sense of urgency for the innovation and therefore enhance support for it.

Innovations

The focus of this dissertation is on unraveling the innovation process of HRM innovations in healthcare organizations. While many people think of something brand new when they hear the word innovation, this is not necessarily the case. An innovation can also be something that is new for a specific organization, regardless of whether the innovation is already implemented in other organizations (Rogers, 2003). Because the focus of this study is on the diffusion, adoption and implementation of something that is new for the adopting organization, the fact that an innovation is perceived as new by actors in the adopting organization is sufficient for the purposes of this research. Thus, the focus of this study is not on the particular innovation, but on the process that is needed to come up with an idea or practice that is new for an organization, the decision making process to adopt this innovation and the implementation process. Yet, the type of innovation under study will probably affect this innovation process. Many innovations in healthcare are medical innovations, such as new medicines and new technologies to treat patients. The focus of this dissertation is on innovations of a different nature, namely HRM innovations. The findings of this study show that in particular the adoption and implementation processes of these managerial innova-

tions are complicated. For example, it appears to be difficult to convince professionals of the added value of such an innovation. Medical innovations are expected to have a more direct and more visible effect on the quality of care, and therefore might appeal to professionals more than managerial innovations. It can be expected that for medical innovations the role of professionals is more prominent and that they will be more likely to be the initiators of the innovations.

Methodological limitations

Although the research design of this study enables in-depth and contextually tailored investigation of HRM innovation processes in the healthcare sector and enables an enhanced understanding of these processes, some limitations should be acknowledged. First of all, the generalizability of the research findings to other contexts is limited due to this contextual approach. However, the contextualized process methodology that was introduced and developed in chapter 2 is applicable to the investigation of organizational processes in other contexts. Secondly, the research focuses on the Dutch healthcare sector and the highly institutionalized nature of this field. Hence, studies on healthcare systems that are less institutionalized, such as privatized healthcare organizations, might not be as affected by institutional factors as the organizations included in this dissertation. In those sectors, business-like developments could be more dominant in affecting innovation processes. In addition, the majority of the organizations under study in this dissertation are hospitals. Therefore, it is more difficult to generalize the research findings to other healthcare organizations, such as long-term care organizations. Still, in chapter 3, long term care organizations (such as mental- and homecare organizations) are included. Furthermore, only a limited amount of cases are included in this dissertation; the focus is on a limited amount of HRM innovations. Although this approach provides in-depth insights in the innovation process of these innovations, it remains uncertain that these findings are also applicable to the diffusion, adoption and implementation of other types of innovations. In addition, a downside of the research method introduced here is that it is quite a labor-intensive way to study organizational processes due to the necessity of thorough in-depth investigation of the research context in the first stage of research. Nevertheless, this approach does generate useful input for the design of the study by indicating contextually relevant elements to be studied in-depth in the second stage of the study. In addition, this approach enables an increase of the societal relevance of this study. By involving practitioners at an early stage and using their insights and experience in the development of the research, the in-depth studies focus on topics that are not only relevant for science, but also for practice. This justifies the investment that needs to be made in exploring the context before designing the rest of the research.

Implications for future research

Besides the recommendations made earlier in this discussion section, some additional avenues for future research can be proposed based on this dissertation. First of all, due to the methodological limitations of this dissertation it is interesting to study similar themes in other contexts, such as other sectors and countries. Comparison between these contexts could result in interesting observations on contextual differences and provide us with explanations on these differences. In line with this recommendation, the contextualized process methodology could be used to investigate similar or different research topics in other contexts. In this dissertation, this research approach enabled the emergence of context specific themes with regard to the HRM innovation process, which could also be of benefit for other studies. In addition, the involvement of practitioners in an early stage enabled the researcher to embed herself in the study context and enabled the development of studies that are both scientifically and practical relevant. For example, at the start of the dissertation process, explorative interviews were conducted with experts in the field. Especially practitioners working in healthcare provider organizations that were involved in the innovation process were interviewed in order to identify important research topics in the area of HRM and innovation. Based on these discussions and the scientific literature, the heuristic framework and associated interview protocols were developed. Additionally, the research findings were translated into information that is useful for practitioners and this information was reported to the participating healthcare organizations. This allows them to put recommendations into practice and base their managerial decisions and actions on scientific evidence. By adopting a similar approach, the societal relevance of research can be improved.

Theoretically, the study of innovation processes requires more investigation. This research shows that the HR function could play an important role in HRM innovation processes, but that line management is not to be left out of the equation. More specifically, more research is needed on explaining the different perceptions HR and line managers often have.

Additionally, more research is needed on the role of the institutional context, and especially institutional logics in innovation processes. Although there is a growing body of research investigating organizational processes from an institutional perspective, our understanding of institutional processes and mechanisms is not complete. More specifically, this dissertation shows that hybridization of logics is an interesting topic area in need for development. Productive Ward: Releasing Time to Care can be seen as a hybrid practice, incorporating both business-like (Productive Ward) and professional logics (Releasing Time to Care). Theoretically, this seems to be a solution to cope with multiple, conflicting logics in a sector. By combining them in a single practice, it can be expected that organizational actors adhering to a business-like logic (such as managers) and actors adhering to a professional logic (for example nurses) will both support this practice. Consecutively, this is expected to positively

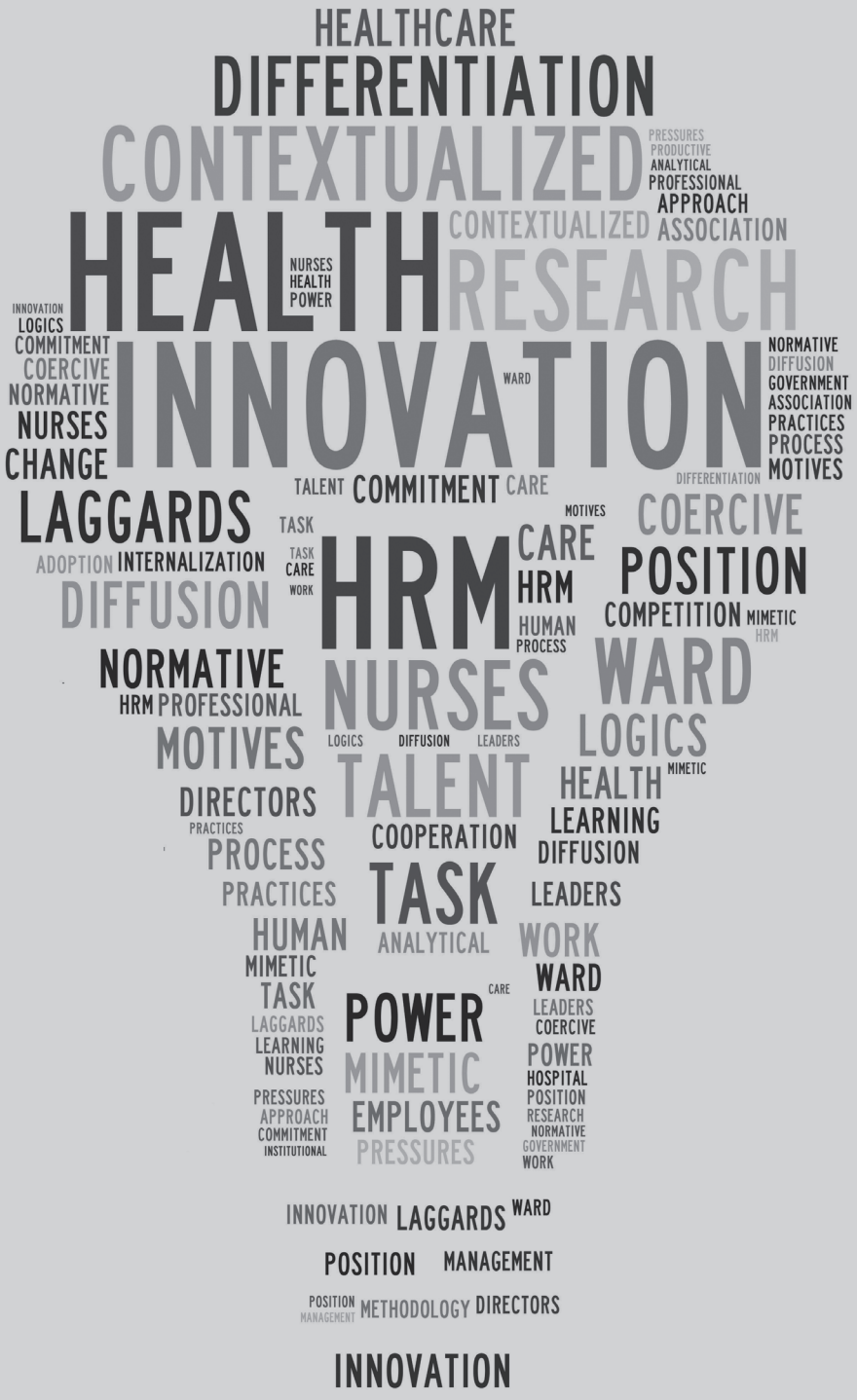
affect the innovation process. Yet, this research (chapter 5) shows that the acceptance of a hybridized practice by both groups of actors is not that straightforward.

Implications for practice

This research also provides us with recommendations for practitioners. First of all, the study shows that many HRM innovations are developed in healthcare organizations. This indicates that many good ideas to improve the management of human resources in healthcare organizations are being developed. However, the findings show that it remains a struggle for HR professionals to ensure a solid strategic position in organizations and convince others of the added value of these ideas. The current study identifies several factors that enhance the credibility and influence of HR professionals, such as more core business involvement. In addition, the findings show that it is important for the HR function to connect with other organizational actors en organizational developments in order to be able to play a significant role in organizational change processes. Furthermore, the findings show that large differences in perceptions between HR and line managers exist and complicate HRM innovation processes. Therefore, paying attention to communication among these actors is of significant importance. Moreover, with regard to implementation processes, the research shows that open communication is very important. The hybridization of practices so that they will adhere to multiple logics, as was done by Productive Ward: Releasing Time to Care, could enhance commitment of actors adhering to different logics. On the other hand, it also runs the risk to backfire and create suspicion. Furthermore, the investigation of adoption processes shows that decision processes are not always rational, but that political and institutional elements play an important role. Therefore, it is crucial for organizations actors aiming to introduce and implement an innovation in organizations to be aware of these processes and take them into account.

Concluding remarks

The aim of this dissertation was to enhance our understanding of the diffusion, adoption and implementation of HRM innovations in Dutch healthcare organizations. Taking on a contextualized research approach enabled the unravelling of several important aspects of these innovation processes. Although much remains to be discovered about these processes, the findings of this dissertation provide fruitful avenues for future research and several recommendations for practitioners. Therefore, I hope that this dissertation inspires researchers and practitioners to study, develop and optimize HRM innovation processes in healthcare and other sectors even further.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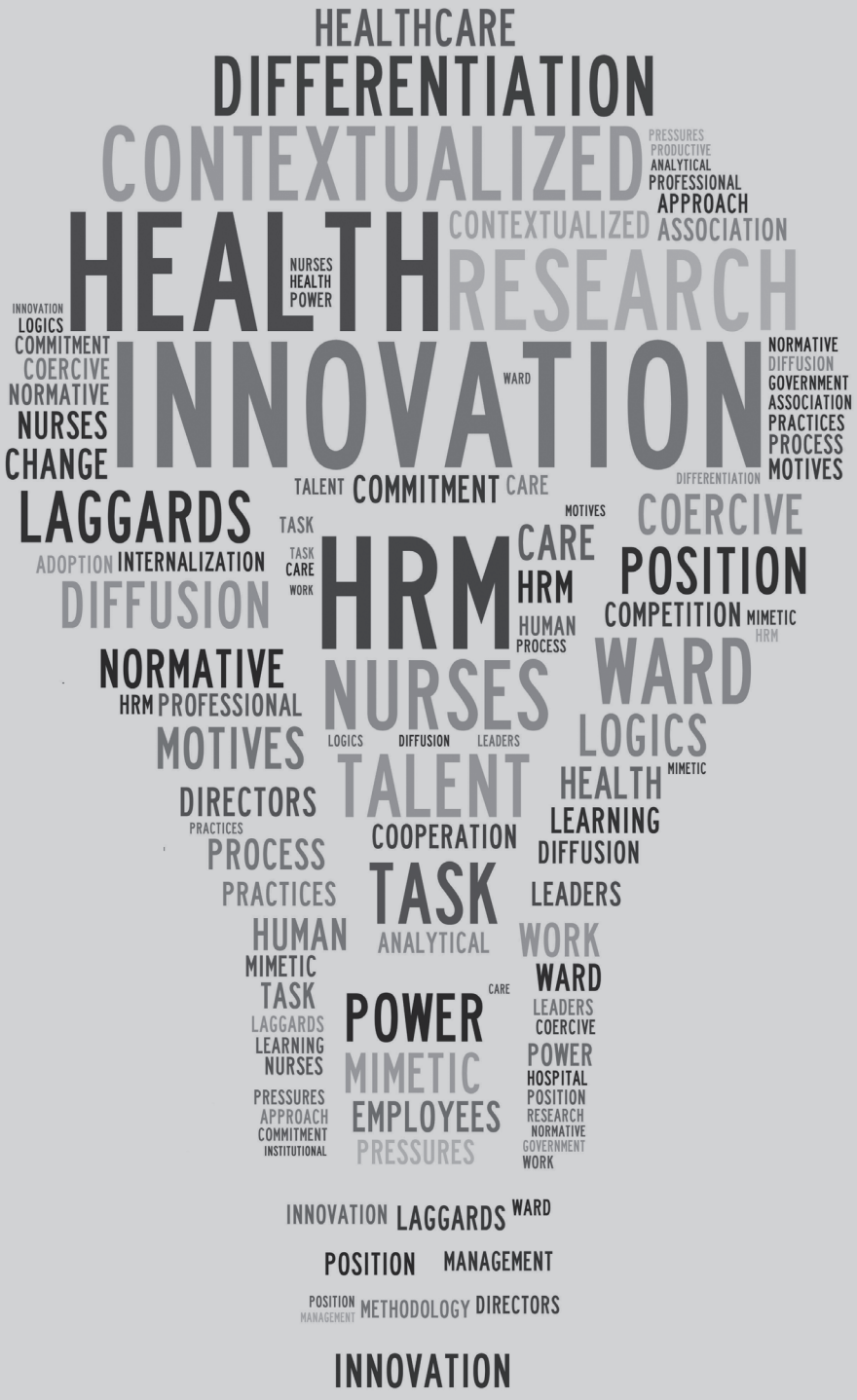
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Appendix

APPENDIX: INTERVIEW TOPIC LIST AND SCHEME STAGE 1

Interview topic list stage 1

Introduction

- Introduction of the researcher
- Introduction of the research project. The concept of innovation and the diffusion –adoption – implementation innovation process model will be explained briefly to the interviewee on beforehand
- Introduction of the respondent

1. Innovation process in general

Example questions:

- What recent innovations in the area of Human Resource Management are adopted and/ or implemented in this organization recently?
- What are the reasons to innovate in this area?

2. Diffusion of innovations

Example questions:

- Did you develop these innovations by yourself or adopted it from others?
- If adopted from others, where do they come from?
- What role do networks have in this respect?

3. Adoption of innovation

Example questions:

- Who are involved in the innovation adoption decision making process?
- What are the motives of persons involved to adopt the innovation?
- What are the goals that are pursued by adopting the innovation? Is this evidence- based?
- Which factors affect the adoption decision?
- What are facilitating or hindering factors (internal and external factors)?

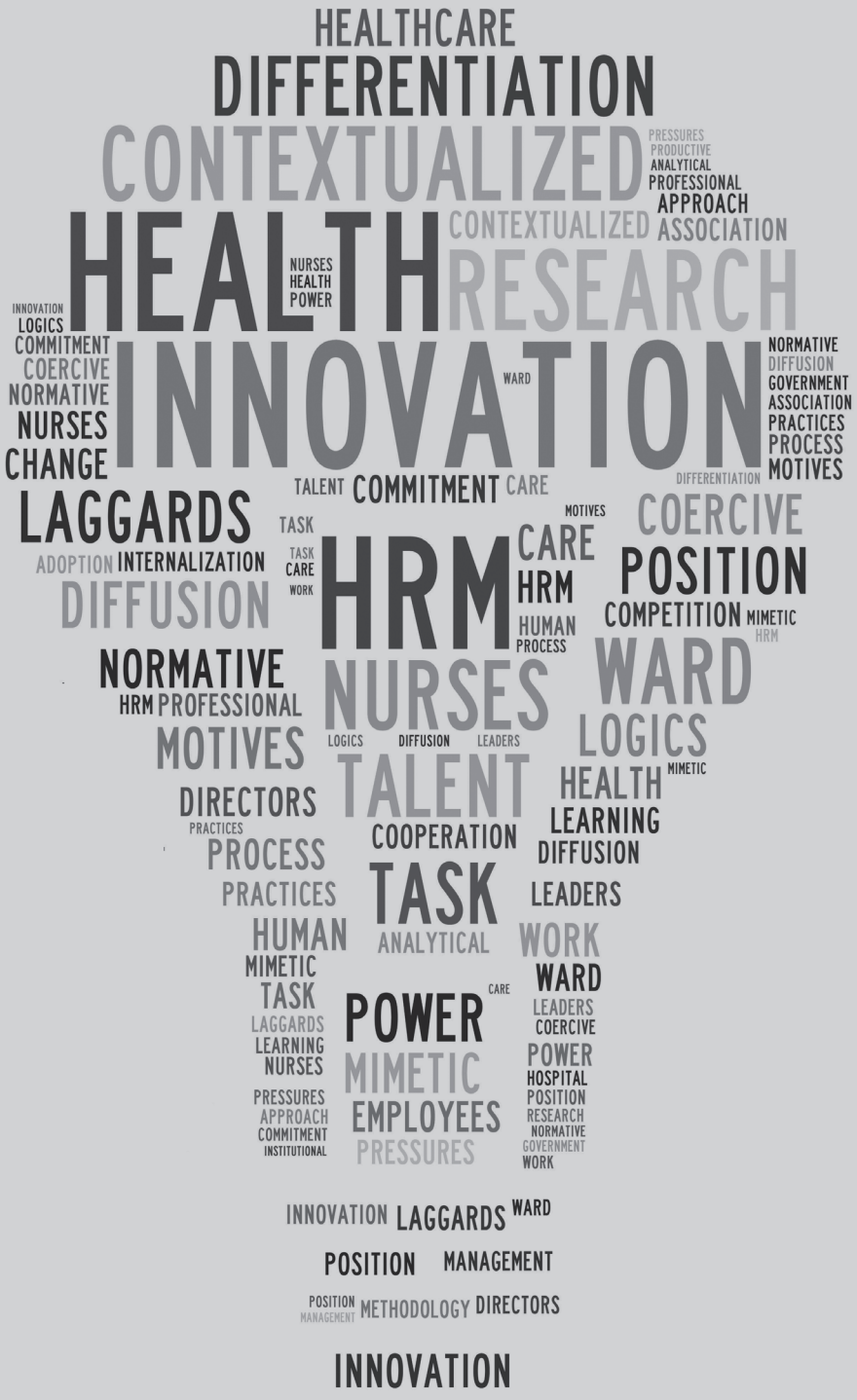
4. Adaptation/ Implementation

Example questions:

- Who are involved in the implementation process?
- To what extent does an innovation change during the implementation process (adaptation to organization)?
- To what extent are stakeholders involved? How?
- To what extent is there internal support for the innovation? What stimulates this?

- Is the innovation viewed as valuable by organizational stakeholders? What stimulates this?
- To what extent is the innovation implemented as intended?
- To what extent do innovations fulfill their aims?
- What are facilitating or hindering factors?

Interview scheme	Diffusion	Adoption	Implementation		
	Sources	Decision	Implementation	Internalization	Adaptation
Influence stakeholders					
- External					
- Network					
- HR department					
- Healthcare Professionals					
- Board of Directors					
Role network					
Motives					
Internal Barriers					
Internal facilitators					
External barriers					
External facilitators					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Summary

SUMMARY

Taking care of innovation. The HRM innovation process in healthcare organizations

In this dissertation, research on the innovation process of Human Resource Management (HRM) innovations in Dutch healthcare organizations is reported. Healthcare organizations are being confronted with several challenges, such as the pressure to deliver high quality care while containing costs and demographic developments such as the ageing population (Townsend & Wilkinson, 2010). Since these challenges increase the need for innovations in the way work processes are being designed and employees are being managed (Human Resource Management), it is important to enhance our understanding of such innovation processes in healthcare.

Innovation can be defined in several ways. In this study, an instrument, method or project is considered an innovation when it is new for the organization under study (Rogers, 2003). This is related to the focus of this research on the innovation process in healthcare organization. In order to be able to investigate this, it is important that the innovation is new for the organization, but not necessarily for a sector or country. The innovation process that is referred to above consists of three phases: diffusion, adoption and implementation. The spread of innovations and innovative ideas between and within organizations is the focus of the first phase. After an innovative idea is developed, the adoption process can begin. This is the decision making process within an organization that is needed to decide whether an innovation will be implemented or not. Finally, the implementation phase follows. In the phase, the innovative idea will actually be implemented in the organization.

Relatively many studies focus on product innovations, but research on managerial innovations, such as HRM innovations, is underdeveloped (Damanpour & Aravind, 2011). In the private sector, relatively many studies on (parts of) the innovation process are conducted. Research in sectors such as the healthcare sector in this area is lagging behind (Länsisalmi, Kivimäki, Allto, & Ruoranen, 2006). It can be assumed that innovation processes in the healthcare sector differ from other sectors, because specific developments and characteristics of this sector could affect this process. For instance, institutional pressures are deemed to play a larger role in healthcare organizations than in private sector organizations (Scott, Ruef, Mendel, & Caronna, 2000). Yet, increasingly elements from the private sector are being introduced in the healthcare sector, such as competition and more attention for efficiency (Bekkers, Edelenbos, & Steijn, 2011). In order to understand how these and other characteristics of the healthcare sector affect the HRM innovation process, a new approach is developed in this dissertation that allows researchers to take the context of organizations under study as a starting point and be better able to study organizational processes, such as innovation

processes. This approach is called the contextualized process methodology and consists of two stages. In the first stage, the emphasis is on familiarization with the research context and the topic under study. Besides scientific literature, explorative interviews and relevant documents such as project plans and news messages are being studied. Based on this information a heuristic framework will be developed. This framework serves as a starting point to conduct semi-structured interviews with different relevant actors. Using the findings from these interviews, the heuristic framework will be extended with context specific elements. In the second stage of the contextualized process methodology, the extended heuristic framework is used to design studies that do justice to the context of the organization under study. After completing the research, the findings will be translated to implications and recommendations that could help practitioners to improve organizational processes. This approach incorporates characteristics of iterative research methods, because researchers cycle back and forth between theory, data and research design (Orton, 1997). Additionally, this approach answers the call of many scholars to conduct more contextualized research on organizational processes and HRM (Boselie, 2011; Paauwe, 2004). This approach follows the analytical approach (Boxall, Purcell, & Wright, 2007) that is being characterized by research embedded in context, an evidence-based approach and rigorous methods.

In chapter 2 of this dissertation, the contextualized process methodology is explained and applied to the Dutch healthcare sector. Relevant actors, dynamics and fields of tension are being identified that appear to be relevant for the HRM innovation process in healthcare. In chapter 3, 4, 5, and 6 of this dissertation, in-depth studies on these elements are reported.

In chapter 3, the role of HR professionals and the HR department in innovation processes is investigated. The aim of this chapter is to identify the factors that hinder and facilitate HRM innovation in healthcare, focusing on the role and position of the HR professional. The findings show that HR professionals are often not sufficiently involved in organizational change processes. This is, among other things, related to the lack of knowledge and skills to contribute to these processes. In addition, HR professionals are primarily focused on instrumental HR practices such as recruitment and selection and training, instead of the design of work processes. However, this latter category of work practices allows them better to demonstrate their added value for organizational processes. In sum, HR professionals in healthcare are often not well connected to developments in the organization, while this connectedness can improve their credibility and position. This is expected to facilitate the HRM innovation process.

The tension between cooperation and competition in healthcare is the focus of chapter 4.

Four Dutch hospitals developed the Talent Management Pool together, which allows them to exchange employees. Due to the labor shortages at the time the pool was developed, cooperation and competition appear to be combined. This is being called coopetition in the scientific literature (Brandenburger & Nalebuff, 1996). On the one hand, the hospitals cooperate to create a pool of talented employees. On the other hand, they compete over these talented employees. The findings show that large differences in the perceptions about the amount of competition in this area exist between different stakeholders in the four hospitals. While HR professionals emphasize the benefits of cooperation, line managers are primarily concerned with competition aspect. This withholds them from participating in the innovative project and hinders the innovation process.

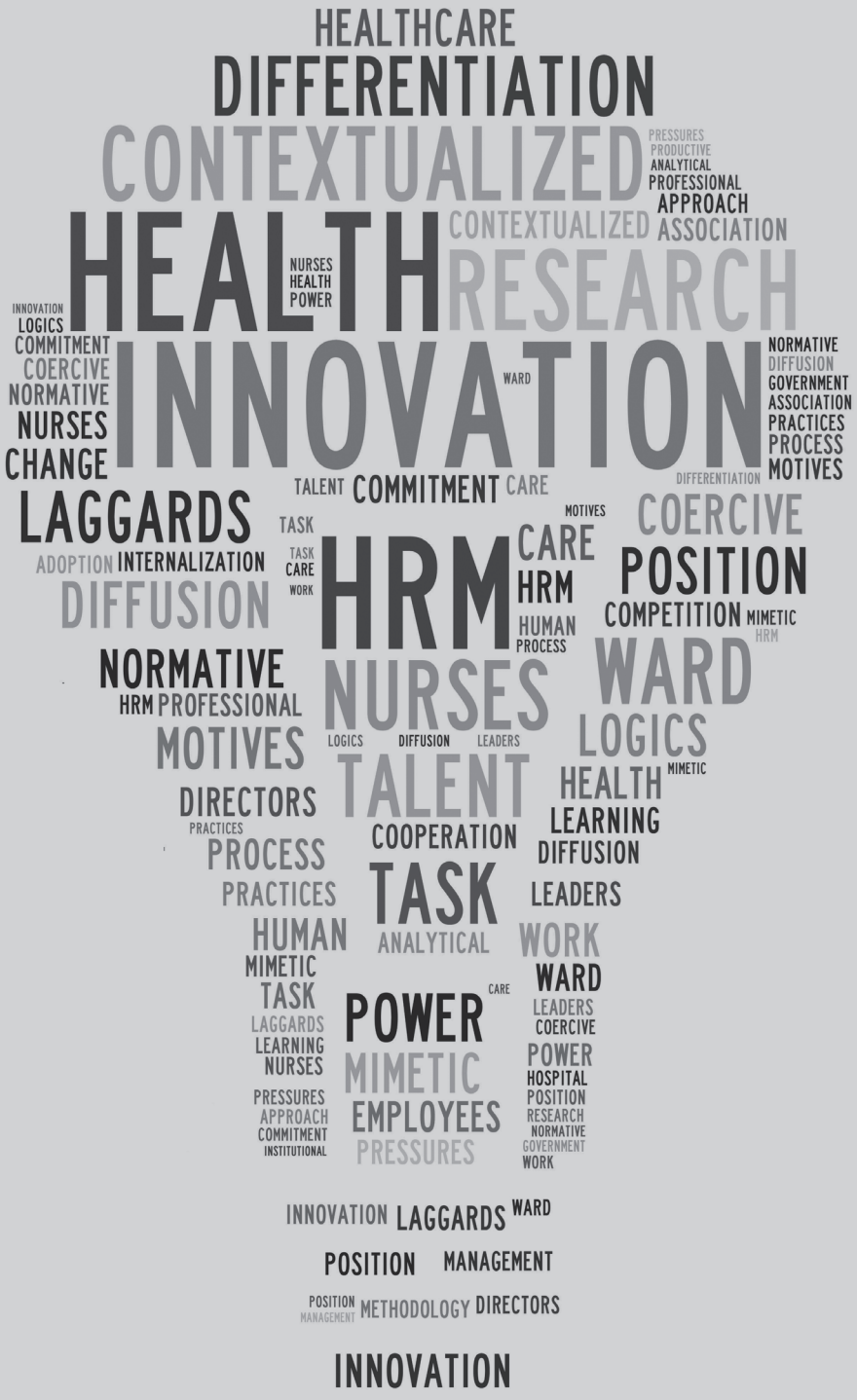
In chapter 5 of this dissertation, the focus is on the role of institutional logics. Institutional logics determine the appropriateness of practices in specific contexts (Greenwood, Diaz, Li, & Lorente, 2010). Besides the professional logic, emphasizing quality of care and time for patient care, business-like logics, emphasizing efficiency and financial considerations, are increasingly important in the healthcare sector (Reay and Hinings, 2009). In this chapter, the role of these logics is studied during the adoption and implementation of the project Productive Ward: Releasing Time to Care. This project empowers nurses to improve their wards. Both logics appear to be included in this project: both productivity and efficiency improvements and releasing more time for patient care are central elements of the project. The findings show that the presence of both logics in the project complicates the adoption and implementation of the innovation, because this creates suspicion among nurses which negatively affects their commitment to the project.

Finally, in chapter 6 an investigation of the motives for the adoption of e-learning and task differentiation in different hospitals is reported. In this study, the reasons to adopt e-learning and task differentiation among nurses of leading hospitals are compared with reasons from hospitals that are following or lagging behind. The findings partly show a pattern that is different from theory on this subject (Kennedy & Fiss, 2009; Paauwe & Boselie, 2005, Rogers, 2008). For all groups of adopting organizations institutional pressures, such as coercive measures from the government, appear to play a role in the decision to adopt an innovation. Rational and economic motives, such as saving costs, also appear to be relevant for all adopter categories. Nevertheless, rational motives play a larger role in the decision making process of leading hospitals. Furthermore, this study shows that the distinction that is made in the literature between institutional and ration-economic motives is not as clear cut: both types of motives appear to be interconnected.

Based on this dissertation, it can be concluded that the context of organizational processes is of great importance. Different context specific factors and tensions were investigated in this research in order to enhance our understanding of the HRM innovation process in healthcare organizations. Therefore, this study contributes to the scientific knowledge base in this research area and provides a basis for practical recommendations.

The contextualized process methodology that was developed and introduced in this dissertation could be used for the investigation of organizational processes in different contexts. In addition, at the start of the research, explorative interviews were conducted with experts in the field. This involvement of practitioners in an early stage enabled the development of studies that are both scientifically and practical relevant. Additionally, research findings were translated into information that is useful for practitioners. By adopting a similar approach, the societal relevance of research can be improved.

This research also provides us with recommendations for practitioners. The current study identifies several factors that enhance the credibility and influence of HR professionals, such as more core business involvement and connectedness with other organizational actors and organizational developments. The hybridization of practices so that they will adhere to multiple institutional logics could enhance commitment of actors adhering to different logics. On the other hand, it also runs the risk to backfire and create suspicion. Furthermore, the investigation of adoption processes shows that decision processes are not always rational, but that political and institutional elements play an important role. Therefore, it is crucial for organizations actors aiming to introduce and implement an innovation in organizations to be aware of these processes and take them into account.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Summary (in Dutch)

SUMMARY (IN DUTCH)

Zorgdragen voor innovatie. Het HRM innovatieproces in zorgorganisaties.

In dit proefschrift is onderzoek naar het innovatieproces van Human Resource Management (HRM) innovaties in de Nederlandse gezondheidszorg gerapporteerd. Zorginstellingen worden geconfronteerd met allerlei uitdagingen, zoals druk om hoge kwaliteit zorg te leveren tegen lage kosten en demografische ontwikkelingen zoals de vergijzing (Townsend & Wilkinson, 2010). Aangezien deze uitdagingen vragen om vernieuwingen met betrekking tot de manier waarop werkprocessen worden ingericht en met medewerkers wordt omgegaan (Human Resource Management) is het van belang te beter te begrijpen hoe dergelijke veranderingsprocessen in de zorg verlopen.

Innovatie kan op verschillende manieren worden gedefinieerd. In dit onderzoek wordt een instrument, methode of project als innovatie beschouwd als datgene nieuw is voor de organisatie die wordt bestudeerd (Rogers, 2003). Dit heeft te maken met de focus van dit onderzoek op het innovatieproces in zorgorganisaties. Om dit te kunnen bestuderen is het van belang dat de innovatie nieuw is voor de organisatie, maar niet noodzakelijk voor een sector of land. Het innovatieproces waaraan hierboven wordt gerefereerd bestaat uit drie fasen: verspreiding, adoptie en implementatie. De verspreiding van innovaties en innovatieve ideeën tussen en binnen organisaties staat centraal in de eerste fase. Nadat een innovatief idee is ontstaan kan het adoptieproces in gang worden gezet. Dit behelst het besluitvormingsproces binnen een organisatie waarin een keuze wordt gemaakt om de innovatie al dan niet te implementeren. Ten slotte volgt dan de implementatie van de innovatie. Dit is de fase van het innovatieproces waarin het innovatieve idee daadwerkelijk wordt gerealiseerd in de organisatie.

Er is relatief veel onderzoek gedaan naar productinnovaties, maar onderzoek naar management innovaties, zoals HRM innovaties, is nog niet goed ontwikkeld (Damanpour & Aravind, 2011). In de private sector is relatief veel onderzoek gedaan naar (onderdelen van) innovatieprocessen. Echter blijft onderzoek in sectoren als de zorg op dit gebied nog achter (Länsisalmi, Kivimäki, Allto, & Ruoranen, 2006). Er kan verondersteld worden dat het innovatieproces in de zorg anders verloopt dan in andere sectoren, aangezien specifieke ontwikkelingen en kenmerken van de zorgsector dit proces kunnen beïnvloeden. Institutionele druk wordt bijvoorbeeld geacht een grotere rol te spelen in zorginstellingen dan de private sector (Scott, Ruef, Mendel, & Caronna, 2000). Maar er zijn ook ontwikkelingen gaande die kenmerkende elementen uit de private sector introduceren in de zorg, zoals competitie en meer aandacht voor efficiëntie (Bekkers, Edelenbos, & Steijn, 2011). Om te begrijpen op welke manier deze en andere kenmerken van de zorgsector het innovatiepro-

ces van HRM innovaties beïnvloeden, is in dit promotieonderzoek een nieuwe benadering ontwikkeld die onderzoekers in staat stelt om de context van de organisaties die worden bestudeerd als uitgangpunt van het onderzoek te nemen en op deze wijze organisatieprocessen, zoals innovatieprocessen, beter te kunnen bestuderen. Deze benadering wordt *contextualized process methodology* genoemd en bestaat uit twee fasen. In de eerste fase ligt de nadruk op het bekend raken met de onderzoekscontext en het onderzoeksthema. Naast wetenschappelijke literatuur, wordt hierbij ook gebruik gemaakt van verkennende interviews en het bestuderen van relevante documenten, zoals projectplannen en nieuwsberichten. Op basis van deze informatie wordt een heuristisch raamwerk ontwikkeld. Dit raamwerk dient als basis voor semi-gestructureerde interviews met verschillende actoren die van belang zijn voor het proces en de context die worden bestudeerd. Op basis van deze gegevens wordt het heuristisch raamwerk uitgebreid met context specifieke elementen. In de tweede fase van de *contextualized process methodology* wordt dit heuristisch raamwerk als uitgangspunt genomen om een onderzoeksaanpak te ontwikkelen die recht doet aan de kenmerken van de specifieke omgeving en processen die worden bestudeerd. Na uitvoering van dit onderzoek worden de bevindingen vertaald naar resultaten die bruikbaar zijn voor de praktijk. Deze benadering bevat kenmerken van iteratieve onderzoeksmethoden (Orton, 1997), waarbij theorie, data en onderzoeksontwerp elkaar herhaaldelijk beïnvloeden. Daarnaast beantwoordt deze benadering de vraag om meer contextbewust onderzoek naar organisatieprocessen en HRM (Boselie, 2011; Paauwe, 2004). Hiermee geeft deze benadering invulling aan kenmerken van de *analytical approach* (Boxall, Purcell, & Wright, 2007), waarin onderzoek wordt ingebed in de context, een *evidence-based* benadering wordt gekozen en grondige methoden en technieken worden gebruikt.

In hoofdstuk 2 van dit proefschrift de *contextualized process methodology* nader toegelicht en uitgewerkt. In datzelfde hoofdstuk wordt deze benadering toegepast op de Nederlandse zorgsector. Door middel van onder meer interviews in verschillende ziekenhuizen zijn actoren, dynamieken en spanningsvelden geïdentificeerd die relevant zijn voor het HRM innovatieproces binnen de zorgsector. In hoofdstuk 3 tot en met 6 van dit proefschrift wordt gerapporteerd over diepgaand onderzoek dat is ontwikkeld en uitgevoerd op basis van deze bevindingen.

In hoofdstuk 3 wordt de rol van HR professionals en de HRM afdeling in innovatieprocessen onderzocht. Het doel van dit hoofdstuk is om de factoren die HRM innovatie in de zorg hinderen en bevorderen te identificeren, met nadruk op de rol en positie van HR professionals. De bevindingen laten zien dat HR professionals vaak niet (voldoende) betrokken zijn bij veranderingsprocessen in de organisatie. Dit heeft onder meer te maken met tekort aan kennis en vaardigheden om hieraan bij te dragen. Daarnaast blijken HR professionals voornamelijk

bezig te zijn met instrumentele HR praktijken zoals werving en selectie en training, in plaats van ontwerp en invulling van werkprocessen, terwijl zij door middel van deze laatste categorie hun bijdrage aan andere organisatieprocessen beter kunnen laten zien. Geconcludeerd kan worden dat HR professionals in de zorg vaak geen goede aansluiting weten vinden bij ontwikkelingen in de organisatie, terwijl dit onder meer hun geloofwaardigheid en positie kan bevorderen. Door een goede verbinding tussen HR professionals en ontwikkelingen in de organisatie zal het doorvoeren van innovaties op het gebied van HRM naar verwachting beter verlopen.

Het spanningsveld tussen samenwerking en concurrentie in de zorg staat centraal in hoofdstuk 4. Vier Nederlandse ziekenhuizen hebben gezamenlijk een Talenten Management Bank ontwikkeld, waarmee zij onderling personeel kunnen uitwisselen. Vanwege de schaarste van personeel ten tijde van de oprichting van de bank, lijkt hier een combinatie te ontstaan tussen samenwerking en competitie. Dit wordt in de wetenschappelijke literatuur ook wel *coopetition* genoemd (Brandenburger & Nalebuff, 1996). Enerzijds werken de ziekenhuizen samen in het ontwikkelen van een bank met getalenteerd personeel. Anderzijds kan verondersteld worden dat zij concurreren over het beschikken over dit getalenteerde personeel. De resultaten laten zien dat grote verschillen bestaan tussen de perceptie van de mate van concurrentie tussen de ziekenhuizen. Terwijl HR professionals de voordelen van samenwerking benadrukken, zijn lijnmanagers vooral bezig met het concurrentieaspect. Dit weerhoudt hen van deelname aan de gezamenlijke innovatie en belemmert het innovatieproces.

In hoofdstuk 5 van dit proefschrift wordt aandacht besteed aan de rol van zogenaamde *institutional logics*, die de gepastheid van innovaties in een bepaalde context bepalen (Greenwood, Diaz, Li, & Lorente, 2010). In de zorgsector lijkt naast een logica van professionals, met de nadruk op kwaliteit van zorg en tijd voor patiëntenzorg, ook steeds meer aandacht te komen voor een meer bedrijfsmatige logica, waarbij de nadruk ligt of efficiëntie en financiële voordelen (Reay and Hinings, 2009). In dit hoofdstuk wordt de rol van deze logica's bestudeerd tijdens de adoptie en implementatie van het project *Productive Ward: Releasing Time to Care*. Dit is een project dat verpleegkundigen in staat stelt verbeteringen te bewerkstelligen op hun eigen afdeling. Beide logica's lijken aanwezig te zijn in dit project; zowel productiviteitsverbetering en efficiencywinst als meer tijd om aan patiënten te besteden staan centraal. De resultaten laten zien dat de aanwezigheid van beide logica's in dit project het adoptie en implementatieproces bemoeilijken, onder meer doordat dit tot achterdocht bij verpleegkundigen leidt wat ten koste gaat van hun betrokkenheid bij de implementatie van het project.

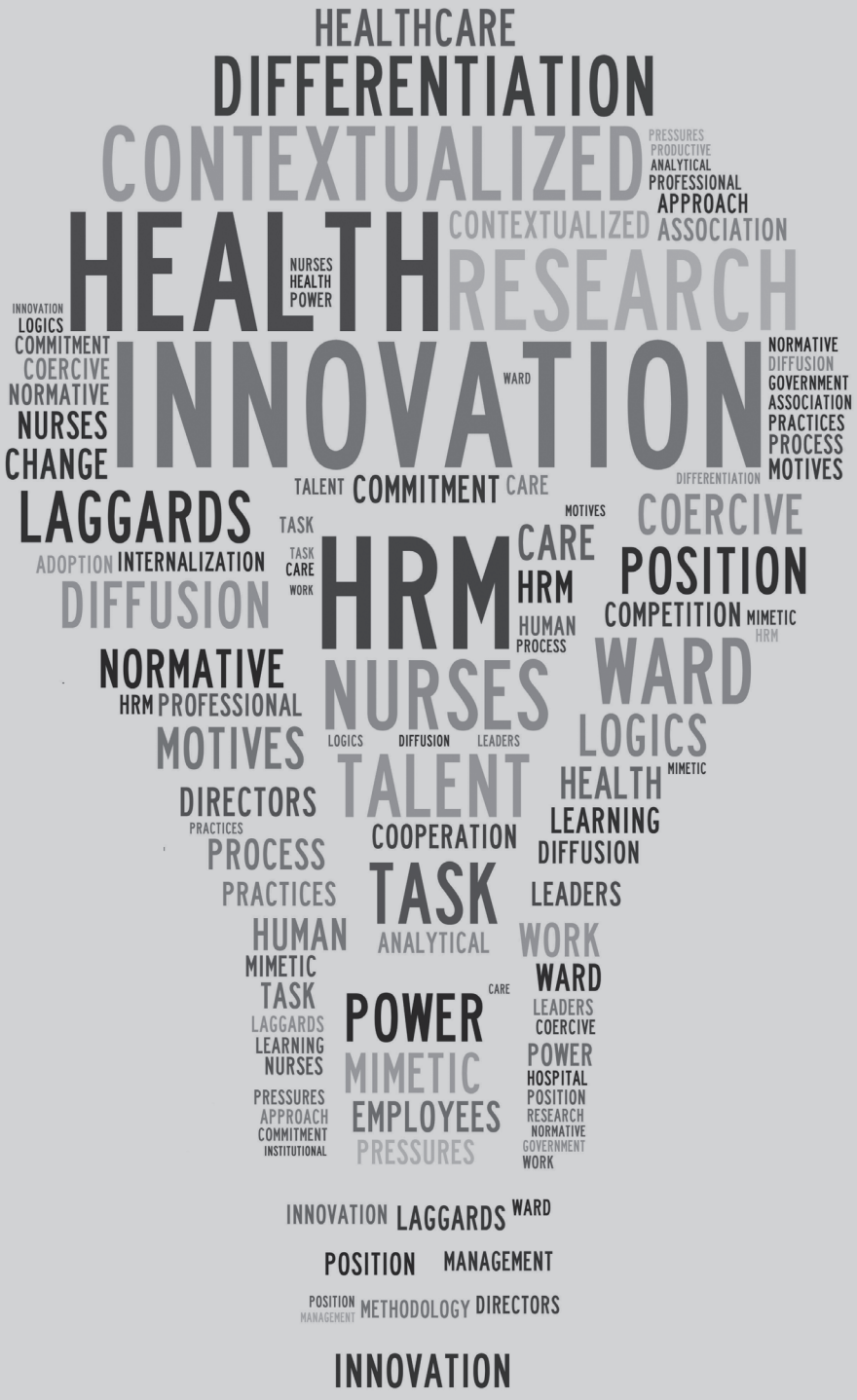
Ten slotte volgt in hoofdstuk 6 een studie naar de motieven voor de adoptie van e-learning en functiedifferentiatie in verschillende ziekenhuizen. In dit onderzoek worden de redenen om e-learning en functiedifferentiatie voor verpleegkundigen in te voeren van organisaties die vooroplopen vergeleken met de redenen van organisaties die in meer of mindere mate achteroplopen. De resultaten laten gedeeltelijk een ander patroon zien dan door theorie wordt verondersteld (Kennedy & Fiss, 2009; Paauwe & Boselie, 2005, Rogers, 2008). Voor alle groepen blijkt institutionele druk, zoals maatregelen van de overheid, een rol te spelen in het besluit de innovatie te gaan invoeren. Ook lijken rationele en economische motieven, zoals kostenbesparingen, voor alle groepen mee te spelen in het besluit. Echter, rationele motieven blijken een grotere rol te spelen bij de besluitvorming van voorlopers. Ook laat deze studie zien dat het onderscheid dat in de literatuur wordt gemaakt tussen institutionele motieven en rationeel-economische motieven niet zo duidelijk is; beide typen motieven lijken met elkaar samen te hangen.

Op basis van dit proefschrift kan geconcludeerd worden dat de context waarin processen plaatsvinden van belang is. Verschillende contextspecifieke factoren en spanningsvelden zijn in dit onderzoek uitgewerkt om het proces van HRM gerelateerde innovaties in de zorgsector beter te begrijpen. Daarmee draagt dit onderzoek bij aan de wetenschappelijke kennis op dit gebied en brengt het ook implicaties voor de praktijk met zich mee.

De in dit proefschrift ontwikkelde *contextualized process methodology* kan gebruikt worden om organisatieprocessen, zoals innovatieprocessen, in verschillenden contexten te onderzoeken. Aan het begin van dit promotietraject zijn verschillende verkennende interviews gehouden met experts uit het veld. Omdat deze personen al in een vroege fase van het onderzoek betrokken zijn, kon onderzoek worden ontwikkeld dat zowel voor de wetenschap als voor de praktijk relevant is. Ook zijn onderzoeksbevindingen vertaald naar bruikbare informatie voor de praktijk. Hierdoor kan de maatschappelijke relevantie van onderzoek worden vergroot.

Ook volgen er uit deze studie aanbevelingen voor de praktijk. Uit dit onderzoek komen verschillende factoren die de geloofwaardigheid en invloed van HR professionals kunnen vergroten, zoals meer betrokkenheid bij de kernprocessen van de organisatie en grotere verbondenheid met andere actoren en ontwikkelingen in de organisatie. Het hybride maken van praktijken zodat zij bij verschillende *institutional logics* passen kan een manier zijn om de betrokkenheid van verschillende actoren bij de praktijk te vergroten. Echter, dit onderzoek laat zien dat dit ook een tegengesteld effect kan hebben doordat dit achterdocht kan creëren. Bovendien laat dit onderzoek zien dat adoptieprocessen niet altijd rationeel zijn, maar dat politieke en institutionele elementen een belangrijke rol spelen. Daarom is het van

cruciaal belang voor organisaties die een innovatie willen introduceren en implementeren om zich bewust te zijn van deze processen en hiermee rekening te houden.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PhD Portfolio

PHD PORTFOLIO

Summary of PhD training and teaching

Name PhD student: Judith van den Broek
iBMG Department: HSMO
Research School: n.a.

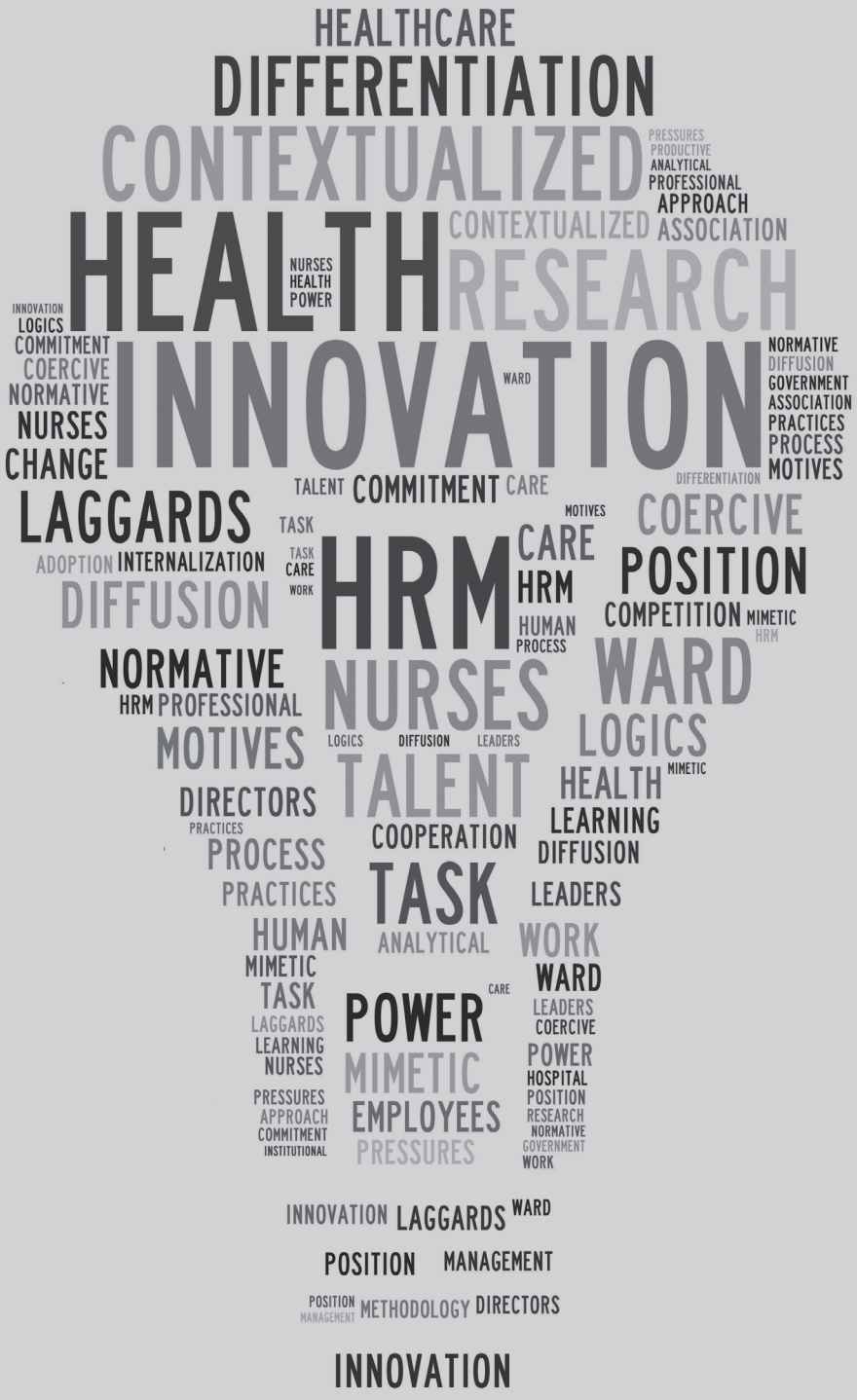
PhD period: 03-2010 – 03-2014
Promotor(s): Prof. Dr. Jaap Paauwe
Prof. Dr. Paul Boselie

1. PhD training

	Year	Workload (Hours/ECTS)
General academic skills		
- A successful doctoral track	2010	1 ECTS
- Academic writing in English for PhD students	2010	2 ECTS
- PhD Course Service Operations Management	2011	2 ECTS
- Advanced Studies in HRM	2011	6 ECTS
- PhD Course Evidence Based Management	2011	2 ECTS
- Intensive course English	2011	2 ECTS
- The art of presenting science	2011	1,5 ECTS
- How to write (and publish) a world-class paper	2011	8 hours
- PhD course Continuous Improvement Methods in Healthcare	2012	2 ECTS
- English language C1 qualification CEFR	2013	
Didactic skills		
- Basic course in didactics	2010	2 ECTS
- Training in Problem-based Learning (Dutch PGO)	2010	1 ECTS
- Teaching: Introductory module	2012	8 hours
- Teaching: Supervision of writing assignments	2012	14 hours
- Teaching: Teaching 1, tutoring (working groups)	2013	8 hours
- Teaching: Teaching 2, lecturing	2012	8 hours
- Teaching: Assessment 1	2013	8 hours
- Teaching: Assessment 2	2013	8 hours
- Teaching: Course design	2013	8 hours
- Evaluation senior staff: Co-evaluation Master	2012/2013	
- Evaluation senior staff: Supervising Master thesis	2012/2013	
- Teaching: Thesis supervision	2014	16 hours

	Year	Workload (Hours/ECTS)
Research skills		
- Advanced Qualitative Methods	2010	6 ECTS
- Multilevel Analysis	2011	8 hours
- Qualitative Research in Healthcare	2011	1 ECTS
- 4 Days of Qualitative Research in Healthcare	2012	2 ECTS
- Structural Equation Modelling (SEM)	2014	12 hours
- Advanced Qualitative Research Methods	2014	2 ECTS
- NVIVO course	2014	8 hours
Presentations		
- HSMO colloquium	2010	
- STZ HR network	2010	
- Research Meeting HRS	2010	
- HSMO colloquium	2011	
- Results presentation participating hospitals PhD research	2011	
- People Management Centre Roundtable sustainable deployment	2012	
- PhD presentation Tilburg University	2013	
(Inter)national conferences		
- Improving people performance in healthcare 2010 (Dublin, DCU)	2010	1 ECTS
- CIBMP: Global Conference on Innovations in Management 2011 (London, CUL)	2011	1 ECTS
- Improving people performance in healthcare 2011 (London, KCL)	2011	1 ECTS
- Dutch HRM network conference 2011 (Groningen, RUG)	2011	1 ECTS
- IRSPM conference 2012 (Rome, URTV)	2012	2 ECTS
- British Academy of Management conference and doctoral symposium 2012 (Cardiff, CBS)	2012	3 ECTS
- Improving people performance in healthcare 2012 (Rotterdam, iBMG)	2012	1 ECTS
- Improving people performance in healthcare 2013 (Dublin, DCU)	2013	1 ECTS
- Dutch HRM network conference 2013 (Leuven, KUL/VBS)	2013	2 ECTS
Seminars and Workshops		
- Innovations in hospitals in times of economic crisis	2010	
- HRM in healthcare conference	2010	
- Leadership in absenteeism	2010	
- Public matters	2010	
- Seminar Patient safety: how do we do that?	2010	
- Towards a new professionalism in health care?	2010	
- HR conference changes in healthcare	2011	
- HRM in healthcare conference	2011	
- HRM in healthcare conference	2012	
- HRM in healthcare conference	2013	

	Year	Workload (Hours/ECTS)
Other		
- Study trip/company visits with students Cornell University, the Netherlands and Belgium	2010	
- Co-organizing HRM & Healthcare track conference 25 years HRS	2012	
- Co-organizing seminar Improving People Performance in Healthcare	2012	
- Project 'duurzame inzetbaarheid' (sustainable deployment) in Dutch teaching hospitals	2012	
- Professional PhD program, Dutch ministry of Education, Culture and Science	2013	
2. Teaching activities		
Lecturing		
- Introductie in de Gezondheidszorg (Bachelor)	2010/2011	
- Organisatiewetenschappen (Bachelor)	2011/2012	
- Performance Management (Master)	2011/2012	
- Kwaliteit van Zorg (Pre-Master)	2011/2012	
- Organisatiewetenschappen (Bachelor)	2012/2013	
- Organisatiewetenschappen (Pre-Master)	2012/2013	
- Human Resource Management (co-coordination and lecturing) (Master)	2012/2013	
- Talentmanagement (Master)	2012/2013	
- Organisatiewetenschappen (Pre-Master)	2013/2014	
- Organisatiewetenschappen (Bachelor)	2013/2014	
- Organizational Behavior (co-coordination and lecturing) (Master)	2013/2014	
Supervising Bachelor's and Master's theses		
- Bachelor thesis (BMG)	2011/2012	
- Master thesis (HCM/ZoMa)	2012/2013	
- Master thesis (HCM)	2013/2014	
Coevaluate Master's theses		
- Master thesis (HRS)	2010/2011	
- Master thesis (HCM/ZoMa)	2010/2011	
- Master thesis (HCM/ZoMa)	2011/2012	
- Master thesis (HCM/ZoMa)	2012/2013	
- Master thesis (HCM/ZoMa)	2013/2014	
Other		
- Supervise cultural simulation game (Tilburg University)	2010	
- Trial study day Human Resource Studies (Tilburg University)	2010/2013	
- Organizing & developing new minor Teamwork for Trauma (Erasmus University)	2010	
- Co-organizing PhD courses "Evidence based Management" and "Continuous improvement methods healthcare" (Erasmus University)	2011/2013	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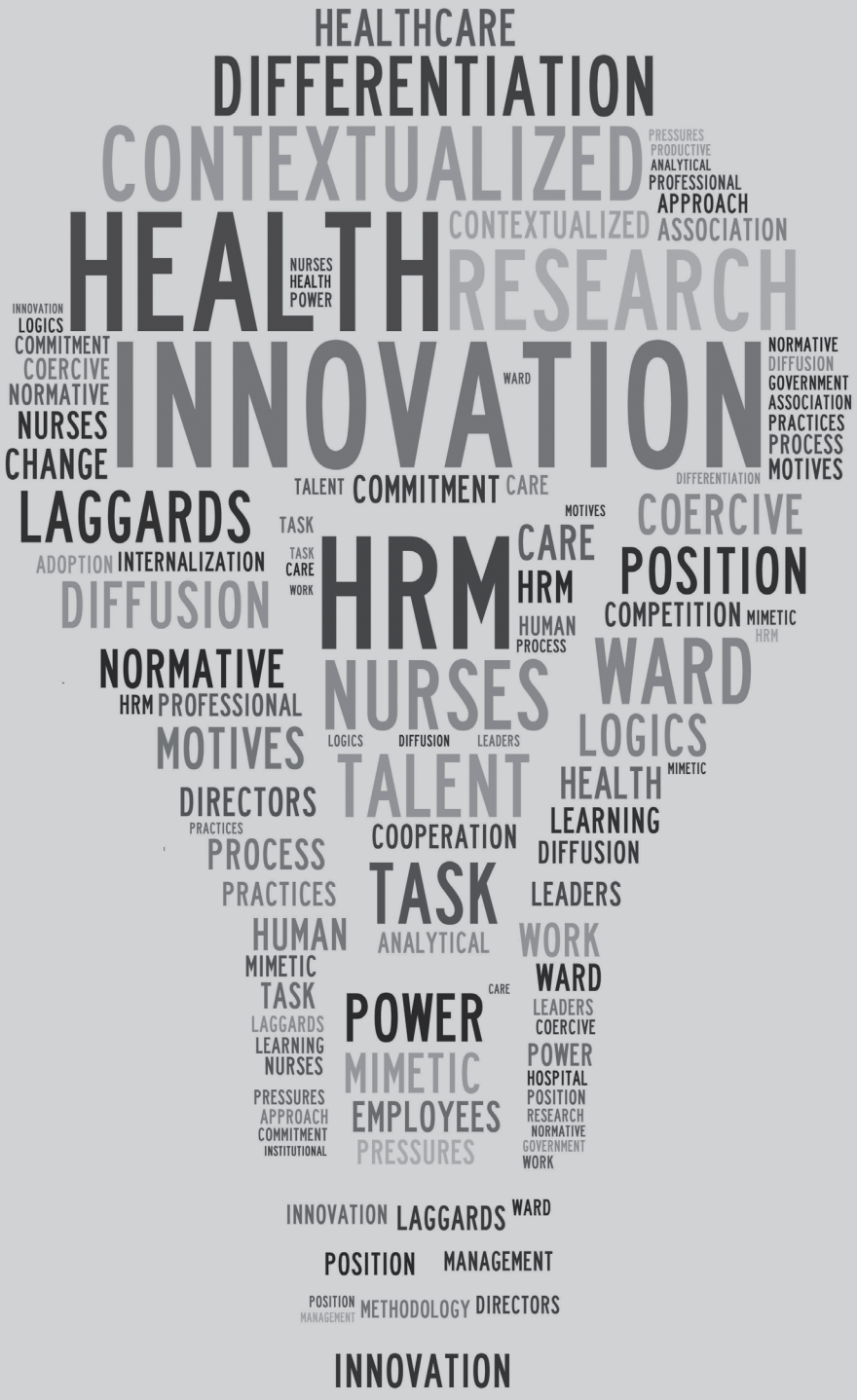
About the author

ABOUT THE AUTHOR

Judith van den Broek was born in Roosendaal on August 6, 1987. After graduating from secondary school in 2005 (VWO, Norbertuscollege Roosendaal), she started studying Human Resource Studies at Tilburg University. She graduated cum laude (with honor) in 2009. After working as a junior lecturer at the department of Human Resources Studies (Tilburg University), she was employed as a PhD candidate at the Institute of Health Policy and Management (Erasmus University Rotterdam) in 2010. As a member of the People Performance and Healthcare Group, she worked on her dissertation both at the institute of Health Policy and Management and the department of Human Resource Studies. Her dissertation research was conducted in cooperation with several Dutch hospitals and she was also involved in another research project for these hospitals. Additionally, she worked on an assignment for the Dutch Ministry of Education during her PhD appointment. She presented her research at several national and international academic conferences (e.g. Dutch HRM Network conference, Improving People Performance in Healthcare conference, British Academy of Management Conference, International Research Society of Public Management conference) and acted as reviewer for conference and journal papers. Besides conducting research, she was also involved in teaching and supervising students (Bachelor, Pre-master and Master level). In addition, she was involved in organizing conferences and courses (e.g. Improving People Performance in Healthcare conference, Evidence Based Management course). Judith will continue her work as an Assistant Professor in Human Resource Management.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Vervolgens wil ik graag de commissie bedanken voor hun bereidheid om mijn proefschrift te beoordelen en aanwezig te zijn tijdens de verdediging.

Ook wil ik mijn collega's bedanken. Dankzij de samenwerking tussen de Universiteit van Tilburg en de Erasmus Universiteit Rotterdam heb ik de mogelijkheid gekregen vier jaar lang aan beide universiteiten te werken. In 2005 ben ik bij het departement Human Resource Studies in Tilburg begonnen als student Personeelswetenschappen. Na afronding van de Master Human Resource Studies heb ik de overgang gemaakt van student naar docent bij deze opleiding. Tijdens deze periode als junior docent heb ik ervaren hoe leuk het is om te werken binnen een team gemotiveerde wetenschappers. Dit heeft zeker een rol gespeeld in de keuze om promotieonderzoek te gaan doen. Dit was mogelijk in samenwerking met het instituut voor Beleid en Management van de Gezondheidszorg in Rotterdam, bij de sectie HSMO. Joris, bedankt voor het vertrouwen in mij om als promovenda bij HSMO aan de slag te laten gaan en om nu als universitair docent mijn carrière te vervolgen. Werkzaam zijn op twee werkplekken zorgde ervoor dat mijn *time management* vaardigheden snel werden ontwikkeld, dat ik gebruik kon maken een combinatie van verschillende expertisegebieden en veel betrokken collega's had. Alle collega's van zowel Tilburg als Rotterdam wil ik dan ook enorm bedanken voor jullie steun, gezelligheid en interesse. In het bijzonder wil ik de junioren van beide werkplekken bedanken voor gezelligheid tijdens en buiten werktijden, zoals de etentjes in Rotterdam, Tilburg en omstreken. Ook de leden van de People Performance

and Healthcare Group (PPHC) mogen hier niet ontbreken. Carien, Jaap, Martina, Monique en Relinde; op naar de volgende congressen en andere interessante zaken die we met onze groep organiseren.

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Daarnaast wil ik ook alle collega-onderzoekers die ik heb ontmoet tijdens netwerkbijeenkomsten, werkbezoeken en congressen, zoals *the Dutch HRM Network Conference* en *the Improving People Performance in Healthcare conference* bedanken. *A special thanks to the colleagues studying HRM & healthcare from Dublin City University en King's College London; I really enjoyed the joint conferences of our research groups and already learned a lot from you. I hope to continue our collaboration in the future.*

Natuurlijk mogen in dit dankwoord de zorgorganisaties die hebben deelgenomen aan mijn onderzoek niet ontbreken. Allereerst de afdelingen P&O van de STZ ziekenhuizen in Noord-Brabant. Dankzij jullie steun vanaf het begin van de dataverzameling is het mogelijk geweest mijn onderzoek uit te breiden naar andere regio's. Ilse Harings, Theo van de Schepop, Bruno de Hoogd, Gerry van de Berg, Ruud Nijnens en Cecile Timmersmans; jullie wil ik hier in het bijzonder voor bedanken. Ook HR managers en medewerkers van organisaties die later zijn ingestroomd en alle geïnterviewden wil ik bedanken. Zonder jullie was het schrijven van dit proefschrift niet mogelijk geweest.

Ook het thuisfront kan ik niet vergeten te vermelden in dit dankwoord. Familie en vrienden, enorm bedankt voor jullie steun en interesse in mijn werkzaamheden als promovenda. In het bijzonder wil ik hierbij mijn ouders bedanken, die me de kans hebben gegeven om mijn eigen ambities op studie- en werkgebied te volgen. Mijn vader René, voor alle gesprekken en discussies over de zorgsector. Mijn broer Stef, voor alle vergelijkingen met het Amsterdamse studentenleven. Ook mijn schoonfamilie wil ik hierbij bedanken voor hun interesse in mijn werk. In het bijzonder wil ik hierbij Henny, Nelly, Femke, Bart, Fleur, Sofie en Opa en Oma van der Laan noemen; bedankt voor jullie luisterend oor en de gezelligheid zoals tijdens onze bezoekjes aan de Efteling. Daarnaast wil ik mijn vrienden bedanken. Niet alleen

het luisteren naar mijn verhalen over werk en allerlei andere zaken, maar ook afleiding in de vorm van onder meer etentjes, bioscoopbezoekjes, lunches, shopsessies en sportavondjes zijn erg belangrijk geweest. In het bijzonder wil ik hierbij Eva en Larissa en Kim, Rebecca en Yvonne noemen; we hebben elkaar leren kennen op de middelbare school en ik vind heel bijzonder en leuk dat we alle veranderingen in onze levens nog steeds samen meemaken.

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Taking care of innovation

The HRM innovation process in healthcare organizations

In this dissertation, research on the innovation process of Human Resource Management (HRM) innovations in Dutch healthcare organizations is reported. Healthcare organizations are being confronted with several challenges that increase the need for innovations in the way work processes are being designed and employees are being managed (Human Resource Management). Therefore, it is important to enhance our understanding of such innovation processes in healthcare. Relatively many studies focus on product innovations in private sector organizations, but research on managerial innovations in healthcare organizations is underdeveloped. In order to understand how characteristics of the healthcare sector affect the HRM innovation process, a new approach is developed that allows researchers to take the context of organizations under study as a starting point to study organizational processes. This approach is called the contextualized process methodology. Using this approach, the focus of this dissertation is on several context specific elements in the HRM innovation process: the role and position of HR professionals, coopetition (simultaneous cooperation and collaboration), multiple institutional logics and institutional pressures. Therefore, this study contributes to the scientific knowledge base in this research area and provides a basis for practical recommendations.