HR Practices and commitment to change: An employee-level analysis

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Abstract

This article explores the relationship between HR practices and commitment to change in three health service organisations in Ireland. The research focuses on employee views of HR practices and resulting employee level consequences including commitment to change, perceptions of the industrial relations climate and the psychological contract, and work-life balance. The findings indicate that the practices valued by employees, and which are related to a range of employee-related consequences, are very different to the lists of sophisticated HR practices that appear in the high performance literature. The research suggests that organisations need to ensure that attention is still paid to the basics of the employment relationship and that these are not lost in the rush to introduce more sophisticated approaches to managing employees.

In the last ten years, a vast amount of effort has been expended on exploring the relationship between HRM and performance. The results of this effort are mixed and a recent review suggests that 'the "Holy Grail" of decisive proof remains elusive' (Boselie *et al.*, 2005: 82). However, the attention that the topic has been given has surfaced a range of issues that provide promising avenues for exploration both in their own right, and as potential contributors to the HRM-performance debate. In particular, although neglected in the earlier studies of HRM and performance, there is now widespread agreement that there is a need to explore in much greater detail the employee experience of HRM (Boselie *et al.*, 2005), and the influence of contextual factors (Boselie *et al.*, 2003; Combs *et al.*, 2006; Michie and West, 2004; Paauwe, 2004).

This article seeks to contribute to the restoring of employees' experience of work to 'the heart of HRM research and practice' (Boselie *et al.*, 2005: 82) with a study conducted in the Irish health service. The research set out to consider the role of HR practices in understanding employees' commitment to the major changes that are resulting from the reorganisation of the Irish health service. Change is one of the features of organisational life that employees increasingly experience. Yet very little is known about the role that HR practices may play in influencing the commitment of employees to such change initiatives. The article begins by considering some of the issues surrounding HR practices and change before reporting on a study undertaken to investigate the relationship between human resource practices and commitment to change in three health service organisations.

HR PRACTICES AND COMMITMENT TO CHANGE

While there is now a good deal of information on the causes and consequences of, and strategies for, organisational change (for example, see Armenakis and Bedeian, 1999), there are still many challenges to understanding the change process (Pettigrew, Woodman and

Cameron, 2001). In particular, there is still a dearth of evidence on employee reactions to change. One way of assessing employee reaction to change is by measuring their commitment to the change initiative. Conner (1992: 147) describes commitment to change as 'the glue that provides the vital bond between people and change goals while Herscovitch and Meyer (2002: 475) define commitment to change as 'a mindset that binds an individual to a course of action deemed necessary for the successful implementation of a change initiative'. Following from Meyer and Allen's (1991) original conceptualisation of organisational commitment, this mindset can take different forms: (a) a desire to provide support for the change based on a belief in its inherent benefits (affective commitment to change), (b) a recognition that there are costs associated with failure to provide support for the change (continuance commitment to change), and (c) a sense of obligation to provide support for the change (normative commitment to change). Thus, employees can feel bound to support a change initiative because they believe that the change is valuable, because they feel that it will be costly not to, or because they feel an obligation to support it. Research conducted by Herscovitch and Meyer (2002) investigating commitment to a change among a sample of nurses indicates that affective and normative commitment to a change are associated with higher levels of support for the change than continuance commitment. Their study also indicated that all three forms of commitment to change combine to predict behaviour (e.g. active or passive resistance, compliance, co-operation or championing of the change). It was found that all three forms of commitment correlate positively with compliance with the change, but only affective and normative commitment correlate positively with cooperation and championing. The wider commitment literature has revealed that behavioural outcomes of affective commitment in particular, include absenteeism, turnover intention, job performance and organisational citizenship behaviour (Meyer and Allen, 1997).

While the outcomes of commitment to change have been identified to some limited extent, the antecedents to such attitudes are less well understood. For example, Iverson (1996) in a study of 761 hospital employees in Australia found that organisational commitment acted as both a determinant and a mediator in the change process. Herscovitch and Meyer (2002) consider that many of the most widely recommended strategies for implementing change such as training, participation and empowerment are likely to impact on support for, and identification with, the change and thus promote affective commitment to change. They suggest that normative commitment to change may arise due to perceptions among employees that the organisation has fulfilled its obligation to them, perhaps through the provision of secure employment or training and career development opportunities, and that HR practices relating to rewards and performance management may contribute to the development of continuance commitment. In addition, it is recognised that effective communications processes are a vital element in successful change initiatives (Armenakis and Harris, 2002; Goodman and Truss, 2004). In considering the types of HR practices that might impact on employee commitment to change, it is useful to consider the differentiation that is now emerging between management-centred and employee-centred HR practices (Boselie *et al.*, 2005). Boselie *et al.*'s analysis of the high performance literature and the HR practices chosen by researchers as constituting HRM within these studies indicates that the 'top four' practices were 'training and development, contingent pay and reward schemes, performance management (including appraisal) and careful recruitment and selection' (p. 73). However, they point out that the 'often-cited core elements of "strategic HRM" that are also likely to be of benefit to employees seem to feature less in empirical research' and they suggest that such a list might include: 'good basic pay (i.e. level and equitability), discretion over work tasks, employment security, diversity and work-life balance' (p. 73). This differentiation of HR practices is supported in research undertaken by Kinnie *et al.* (2005:

19), which showed that 'commitment levels in three employee groups (managers, professionals and workers) are linked to satisfaction with different combinations of HR practices'. Across the groups as a whole, the three practices of rewards and recognition, communication and work-life balance were associated with commitment. Similarly, in another employee-level study, this time of job satisfaction in the UK (Guest and Conway, 2001), Guest (2002: 352) reports that 'with the exception of the job design measure, the practices associated with work satisfaction are those often emphasised by unions and reluctantly acceded to by organisations, rather than those emphasised in any models of the HRM-performance relationship'. Given the distinction that emerges between management-centred and employee-centred HR practices within employee-level research, it could be expected that employees' commitment to change initiatives might be affected more by their experience of employee-centred rather than management-centred practices. It might also be the case that their perceptions of their psychological contract with the organisation (Guest, 2004) will also be impacted by their experience of HR practices within the organisation.

Leadership is now recognised as a crucial factor influencing the way in which HR practices are enacted within an organisation (Purcell *et al.*, 2003), and there is a good deal of evidence that the quality of leadership is important during major organisational change (Kiffen-Petersen and Cordery, 2003). The type of leadership style that might be adopted during such times varies considerably but one way of differentiating between such styles has been to distinguish between transformational and transactional leadership. Transformational leaders are described as charismatic individuals with whom employees identify emotionally (Yukl, 1999). These leaders create and communicate a vision for the company that brings employees together to accomplish important goals. Transformational leadership has been associated with employee satisfaction, commitment and perceptions of leader effectiveness (e.g. Lowe, Kroeck and Sivasubrabramanian, 1996). In contrast, transactional leadership is

associated with followers accepting or complying with the leader in exchange for praise, rewards or the avoidance of disciplinary action. It is associated with close monitoring of performance and taking appropriate action as soon as deviant behaviours occur (Bass *et al.*, 2003). Research indicates that transactional leadership is associated with employee commitment, satisfaction and performance (e.g. Bycio, Hackett and Allen, 1995; Podsakoff *et al.,* 1984).

One of the outcomes of successful leadership will be a positive industrial relations (IR) climate within the organisation. This climate can be described as the perceptions of organisational members regarding the nature of union-management relations (Blyton, Dastmalchian and Adams, 1987) and more favourable industrial relations climates are associated with improved employee relations and better economic performance (Belman, 1992), with greater levels of commitment among employees (Deery *et al.*, 1994; Iverson, 1996), and with more acceptance of organisational change (Iverson, 1996). As some research has shown that employees who are union members are less accepting of change than those who do not belong to a union (Iverson, 1996), then a positive IR climate will be particularly crucial in a heavily unionised organisation.

Commitment to change in context: the Irish health service

The notion that the context within which organisations operate may be important in affecting employee behaviour and performance has recently been given more prominence in the literature (Combs *et al.*, 2006; Michie and West, 2004; Paauwe, 2004). For example, Combs *et al.* (2006: 524) suggest that one of the challenges for future research on high performance work practices (HPWPs) is to 'reach beyond the service versus manufacturing designation … to identify other important contextual variables and to programmatically match HPWPs to both context and strategy'. Combs *et al.* point to the need to move away from the traditional

manufacturing/service divide, but even within these two sectors very specific features of context may operate which can create requirements for particular types of employee behaviour. One such context is healthcare and there is now extensive research into the effectiveness of health care systems and a recognition that the attitudes and behaviour of employees are central to the quality of patient care (Michie and West, 2004; West *et al.*, 2002). In addition, leadership and management present particular challenges in health care settings with mounting evidence in relation to the types of role conflicts and overloads that can occur in the new managerial roles that have emerged (Fitzgerald *et al.*, 2006) as well as the role that health care professionals may play in creating barriers to the spread of innovations in this sector (Ferlie *et al.*, 2005).

The Irish health service is currently experiencing substantial change that has been driven by the extensive reform of the sector. As well as the structural changes that underpin this reform, there are moves to give effect to the stated policy of more effective people management and enhanced service delivery with an expanded and improved HRM function identified as a key component in this change process. In addition, there are a number of initiatives designed to alter the management culture within the service including one aimed at people-centeredness, and a commitment to patient and client focused service enhancement (*Quality and Fairness: A Health System for You,* 2001). The substantial change currently experienced by the Irish health service appears in line with the experiences of health services in other European countries. Research from the UK (Barnett *et al.*, 1996; Bach, 1995) reports on the ongoing restructuring within the National Health Service and indicates that HR systems within the health service are still underdeveloped. This pattern is confirmed by in Ireland in recent consultancy reports (Eastern Regional Health Authority, 2000).

In order to better understand from an employee perspective the role of HRM in this institution-wide change initiative, our research sets out to explore how a number of variables work together to influence commitment to change. We do this by considering the wider context within which change takes place and the proximal impact (i.e. local versus global) on commitment to change. In doing so, we build upon recent efforts to contextualise HRM in a healthcare setting (Michie and West, 2004) and to capture the complexity of HRM by adopting an integrated approach (e.g. Harney and Dundon, 2006). Specifically, this paper focuses on exploring: (a) what is the influence of context on commitment to change and (b) what types of HR practices are related to outcomes that are relevant at the employee level? In the case of the Irish research, these outcomes include commitment to change, perceptions of the industrial relations climate and psychological contract, and work-life balance.

THE RESEARCH

Research was undertaken among a random sample of staff in three areas of the Irish health service in 2004. Questionnaires were administered to all employees of a central administration division; all employees working in the community care sector of one region; and all employees working in a maternity hospital. Information was sought on a wide range of issues including commitment to change, satisfaction with HR practices, attitudes to leadership, and satisfaction with various aspects of work. Although 1277 questionnaires were distributed, only 259 were completed, a response rate of 20 per cent. The response rate was disappointing but appears in line with that being achieved in many similar studies, particularly in Ireland where the relatively small number of organisations in existence is creating difficulties for undertaking survey research. There was little variation across the three sectors with a 23 per cent response from the administration group, 17 per cent from the community care group, and 21 per cent from the maternity hospital. Further analysis of

the profile of respondents in terms of gender, job type and level in the organisation suggests that it is representative. In addition to the questionnaire survey, interviews were conducted with key informants such as human resource managers, line managers and union representatives.

Context

In order to explore the context within which employees were working, respondents were asked to identify, from a list of on-going changes, one change that was currently affecting them and about which they had a strong opinion. The list of changes was derived from interviews with the human resource managers in the various locations. The changes that respondents identified as affecting them to the greatest degree were: the move to patient/ client focused service (45%), the wider health service reform (30%), or some other change (25%). This change was then used as the basis for responses to items on commitment to change. Dummy variables were created in order to capture which change was nominated (1 yes; 0 = no).

A number of additional background variables were also included in the analysis. These were: length of service in the health service (months), whether or not an individual held a managerial position (1 = yes; 0 = no), and location (community care and hospital, 1 = yes; 0 = no).

HRM Practices

A measure of employee satisfaction with HR practices was developed for the Irish research. Responses were based on a 7-point Likert scale and ranged from 1 (extremely dissatisfied) to 7 (extremely satisfied). A principal components factor analysis using varimax rotation identified factors relating to the following: career and performance development (7 items; α

=.*91*), autonomy (4 items; α =.*88),* communication (5 items; α = .84), training (5 items; α = .86), staffing (4 items; α =.*72*), and reward (2 items; α =.*61*). In addition, two single items were included relating to teamworking and job security. The items contained in each scale are presented in Appendix 1.

Employee-related consequences

Perceptions of leadership style. Transformational leadership behaviour was measured using the 22 items devised by Podsakoff *et al.,* (1990). Scores ranged from 1 (strongly disagree) to 7 (strongly agree).   The reliability for the scale was α = .96. Transactional leadership was measured using five items (α = .77) employed by Waldman *et al.,* (2001) and based on Bass's (1985) Multifactor Leadership Questionnaire (MLQ). Scores ranged from 1 (not at all) to 5 (frequently, if not always).

Commitment to change. The study utilised Herscovitch and Meyer's (2002) 18-item measure of commitment to change. This comprises the three sub-scales of affective, continuance and normative commitment to change, each containing six items. Only the affective commitment to change scale was employed in the present research. Responses were based on a seven-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). The reliability of the scale was .89.

Work-life balance. The importance given to work-life balance has increased as organisations have become more diverse and there is now a good deal of research that argues for the positive impact that such policies have on organisational performance (De Cieri *et al.,* 2005). A single item measuring satisfaction with the balance between work and life outside work (Guest, 2002) was utilised in order to obtain some insights into the work-life interface.

Perceptions of the Industrial Relations (IR) climate. Perception of the IR climate was measured using the scale devised by Dastmalchian, Blyton and Adamson (1991). Scores ranged from 1 (strongly disagree) to 5 (strongly agree). The scores for each of the ten items were summed to achieve an overall score of perception of the IR climate.

Psychological contract. The psychological contract was measured using the three items previously employed by Guest and Peccei (2001) relating to trust, fairness and employment security. Scores for these items ranged from 1 (very low) to 5 (very high). Note that for analysis with this variable, the single item job security (HR) measure was excluded as an independent variable.

THE FINDINGS

Descriptive statistics and correlations are presented in Table 1.

Insert table 1 about here

Tables 2 and 3 present the findings for the hierarchical regression analysis. Table 2 shows that the context of change had most influence in determining affective commitment to change. In particular, the move to patient focused services was the most significant predictor variable included in the model ($\beta = .371$, $p < 0.001$). Regarding satisfaction with HR practices, two practices – relating to communication ($\beta = .268$, $p < 0.05$) and reward ($\beta = .183$, $p < 0.05$) - explained some additional variance. This analysis also shows that transactional leadership had a negative impact on affective commitment to change ($\beta = -.206$, $p < 0.05$), whilst transformational leadership did not explain any significant incremental

variance. In the case of work-life balance, satisfaction with one HR practice - relating to staffing (β = .289, p< 0.01) - had a significant impact on this outcome.

Regarding perceptions of industrial relations climate, the analysis finds that the community care sample viewed this climate much less favourably than respondents in the other two locations (β = -.190, p< 0.05). Satisfaction with communications (β = .288, p < .01), staffing (β = .203, p< 0.05) and rewards (β = .182, p< .05) were all significantly associated with perceptions of this climate. In addition, perceptions of a manager with a transformational leadership style (β = .288, p< 0.01) was a significant predictor of perceptions of the industrial relations climate.

Finally, in the case of the psychological contract as an outcome, satisfaction with communications (β = .288, p< 0.01) was significant. In addition, positive associations with the psychological contract emerged regarding perceptions of a manager with a transactional (β = -.262, p< 0.01) and a transformational (β = .261, p< 0.05) leadership style.

Insert tables 2 and 3 about here

Table 3 shows that, with the exception of commitment to change where context was a key predictor, satisfaction with HR practices explained most of the variance in the employee-related consequences. In the case of perceptions of the industrial relations climate and the psychological contract, perceptions of leadership style explained additional variance.

DISCUSSION

Employee-centred HR practices and employee outcomes

While the analysis showed that there was consistency in the types of HR practices that were most strongly related to the four elements of what have been clustered together as 'employee-related consequences', only three practices emerged as significant: communications, staffing and rewards. The strongest relationships emerged with communications and this was related to affective commitment and perceptions of both the IR climate and the psychological contract. Staffing emerged as significantly related to both work-life balance and IR climate, while rewards was significantly related to affective commitment and perceptions of the IR climate. The three practices that emerged as significant can perhaps best be described as 'basic' HR practices. For example, the measure labelled 'communications' comprised five items including the extent to which information was provided on new initiatives, how the organisation was performing and its future plans, the grievance/dispute resolution system, and the approach taken in dealing with bullying. These represent top-down information mechanisms rather than high involvement practices. The focus by employees on these types of HR practices rather than the sophisticated or high involvement practices that predominate in the high performance literature is in line with the findings of other studies that have concentrated on employees' experiences of HRM. For example, Kinnie *et al.* (2005) found that rewards and recognition, communication and work-life balance were the three HR practices that were important for all groups in their study of commitment. Guest (2002: 352) found from the analysis of a sample of 2000 workers in various UK employment (Guest and Conway, 2001) that practices 'of the sort rarely identified in the literature on HRM and performance' were significantly associated with higher work satisfaction. These practices included 'keeping people well-informed about developments, equal opportunities, practices to limit harassment at work and family-friendly practices'. In contrast, much of the HRM and performance literature suggests that it is

'progressive' HR practices or 'high performance' work systems that lead to positive psychological consequences for employees (Michie and West, 2004). For example, West *et al.* (2002: 1307), in a study of the relationship between HR practices and patient mortality, found that it was the 'sophistication and extensiveness of appraisal and training for hospital employees and the percentage of staff working in teams in the hospitals' that were 'significantly associated with measures of patient mortality'. However, this research relied on employer rather than employee-level perceptions of HR practices.

Another explanation for the focus on 'basic' HR practices may be that it is the case that it is during times of change that more 'basic' HR practices come to the fore and are particularly important. For example, communications has been identified as crucial to the success of change initiatives (Armenakis and Harris, 2002; Goodman and Truss, 2004; Skinner, Saunders and Duckett, 2004). However, the reality of communications as experienced by employees and as reported in the questionnaires indicated that communications were frequently limited or restricted. One respondent commented: 'information is given on a need-to-know basis. The rumour mill is the main source of information' (Female Nurse Manager). Yet the lack of communication and the activity of the consequent rumour mill were giving rise to concerns among employees. For example, another respondent described how 'the lack of information has left an evident mark of paranoia and fear regarding the loss of jobs within the organisation' (Male Support Officer) and another stated: 'There is a huge amount of insecurity within the Health Service and the lack of communication is quite distressing. I like my job but what is going to happen is a worry' (Female Administrative Officer). There was also an impression gained from questionnaire comments that resistance to change was being handled though the industrial relations system: 'any questioning of change has resulted in labour commission/labour court

proceedings … Historically employees not involved or even informed of changes/intended changes' (Female Nurse Manager).

In addition to communications, rewards and staffing emerged as HR practices that were related to positive employee-related consequences. Again, while these are perhaps more 'basic' HR practices, their importance during times of change is understandable when employee concerns are focused on whether there will be sufficient staff to undertake the new working arrangements that emerge from the proposed changes, and whether the reward system will reflect the new responsibilities incurred by such changes. The relationship between staffing and work-life balance is not surprising and confirms research in the UK which found that flexible hours work systems and personal discretion over starting and finishing times tended to reduce the problem of work-life spillover (White *et al.,* 2003). In addition, rewards represent a basic hygiene factor in promoting favourable employee reactions during times of change. In a broader context, the link between rewards and perceptions of the industrial relations climate perhaps reflects the relative harmony that has existed in Ireland in recent years following partnership deals and pay agreements at a national level.

Leadership has been identified as a crucial factor in the enactment of HR practices (Purcell *et al.*, 2003) and this emerged as a significant factor that impacted on three of the four elements that were included under the heading of employee-related consequences. The positive relationship between transformational leadership and perceptions of the industrial relations climate is an interesting finding in light of the heavy levels of unionisation that exist within the Irish health sector and perhaps contradicts research within the UK which found that trade unions are associated with lower levels of job satisfaction and a poorer assessment of the employment relationship. An anti-union stance on the part of

management also appears to worsen the employment relationship and reduce job satisfaction in unionised firms (Guest and Conway, 2004).

There was a negative relationship between perceptions that leaders exhibit a transactional leadership style and both commitment to change and the psychological contract. This suggests that transactional leaders are less effective in promoting employee commitment in a change context and that employee perceptions that managers display more transformational rather than transactional leadership are positively associated with the perceptions of fairness, trust and job security implicit in the psychological contract. However, no relationship was found between transformational leadership and commitment to change. This is perhaps surprising given that the literature indicates that transformational leadership is associated with change situations. However, the qualitative data revealed that there were problems within the health service in relation to the way in which leadership was operating. For example, the creation of new management positions in nursing was perceived as taking expertise out of the health system. In the questionnaires, one of the Nurse Managers stated that 'Promotion brings us away from the front line, away from the patient. It is a practical job and the patient is the judge of what is good and bad'. Another respondent reported that: 'One of the main complaints of staff on the ground, i.e. midwives, is the amount of good midwives taken out of the loop by "clipboard jobs"' (Female Manager). The role conflict that emerges here between clinical and managerial responsibilities has also been reported in the UK in the National Health Service (Fitzgerald *et al.*, 2006). The UK study refers to what are termed 'hybrid managers' and outlines the vast range of tasks and responsibilities that are now associated with such roles and the potential for conflict that this creates. The study also points out that while this term has been applied primarily to doctors, there is the issue of whether nurses and allied professionals are also involved in hybrid posts.

The restructuring of the health service was also seen by respondents as creating leadership difficulties at senior management level. One questionnaire respondent suggested: 'If we want real reform we need to change the personnel in senior management who have been partly responsible for creating the current system and structures' (Senior Executive Officer); another that 'the service is drowning under the weight of parasitic functions and over management' (Male Professional); while another pointed to 'a substantial deterioration in management – more hung up on meetings at high level than giving support on the ground or even staying in touch with the issues for staff. Management seems to be more interested in protecting their interests – all seem quite insecure in their positions' (Female Professional). These comments uneasiness with some aspects of leadership during the change process and reflect the complexity of leadership in health service organisations that has been reported in the UK (Fitzgerald *et al.*, 2006).

The impact of context

Two aspects of context emerged: the particular nature of the change initiative and the location in which the change took place. In relation to the change initiative, respondents were asked to nominate a change that they had 'a strong opinion about' and 42 per cent nominated the move to patient or client focused services. This change involves the creation of a multifaceted approach to patient care with the provision of a range of co-ordinated services for the patient. The findings show that respondents had a positive commitment to these changes. While the shift to patient focused services is, in effect, embedded within the wider health service reform programme, respondents choosing the wider reform as the focus for their responses indicated low levels of commitment to this change. Several interpretations of these apparently contradictory responses are possible. For example, it could be the case that some individuals are either committed or resistant to change – no

matter what that change involves. Alternatively, it may be that individuals are best able to commit to local changes that impinge directly on their working lives, rather than macro-level changes that appear distant and perhaps threatening. This latter interpretation fits with research that indicates that organisational change needs to be developed from within, that it cannot simply be imposed from outside, and that staff engagement is critical to the success of change initiatives (Sheaff *et al.* 2004). In relation to the particular location, those working in the community care site reported negative perceptions of the IR climate there suggesting contextual differences between the three locations in the study. Both these findings therefore provide support for the importance of context and its inclusion in studies of HRM and performance (Combs *et al.,* 2006; Michie and West, 2004).

There are several limitations to the study. First, data was based on only a 20 per cent response rate to the questionnaires, although a good-sized population of 259 was achieved. Unfortunately, these low rates appear to be in line with more and more published research as organisations reach saturation point not just with the demands made by external researchers but with their own internal surveys. However, as already indicated, there did not appear to be differences between those who answered the questionnaire and those who did not respond. Second, the R^2 achieved in the statistical analysis varies between the elements explored, but explains considerably less of the variance in the case of affective commitment to change and work-life balance outcomes. In particular, there is a fairly weak association between satisfaction with HR practices and commitment to change. This is surprising considering the associations between HR practices and organisational commitment reported elsewhere in the literature. However, there were stronger associations with perceptions of industrial relations climate and psychological contract.

IMPLICATIONS FOR PRACTICE

There are a number of implications of the research for organisations and HR managers. First, while many organisations invest heavily in advertising and promoting large scale organisation-wide change, such change may be too remote to be of concern for many employees, except perhaps in a negative way. The study indicated that employees are more likely to be committed to change which is locally focused and where it has immediate implications for their jobs and working conditions. This suggests that resources need to be channelled into local rather than national level initiatives and in translating system-wide change into initiatives with which employees can easily identify and make sense in relation to their own work situations. Second, the focus on 'basic' HR practices that emerged from the findings suggests that in organisations undergoing extensive change there is a need to ensure that attention is given to the fundamental elements of the employment relationship. Good communications had a role to play not just in relation to commitment to change but also in relation to perceptions of the psychological contract and industrial relations climate within the organisation. This suggests that such basic practices must not be forgotten in the rush to introduce the more sophisticated approaches that have been associated with high performance. Third, the analysis identified that a variety of factors were related to perceptions of the IR climate within the organisation, indicating that this climate is important and that it can be managed. This neglect of the IR climate in the high performance literature may represent part of the shift to more sophisticated approaches to HRM in which elements such as unions or management-employee relationships are given scant regard. However, consideration of employee-level views of the IR climate suggests that it is important across a number of dimensions of organisational life. Finally, there are implications for leadership within the health service. Although not explored specifically in this research, questionnaire and interview data indicated evidence of the role conflict that has been associated with the

'hybrid manager' (Fitzgerald *et al.,* 2006). This suggests that the way in which these managers are trained and developed needs to be considered carefully as they have specific needs in relation to the complexity of managing the diverse range of activities in which health service reform demands that they must now engage.

CONCLUSIONS

The findings add to the growing body of evidence that there may be a disconnect between the HR practices that are perceived by employers as leading to high performance, and those that appear to be valued by employees. The Irish data confirms other studies that indicate that employees are concerned with HR practices such as rewards, communications and work-life balance (Guest and Conway, 2001; Kinnie *et al.,* 2005). In contrast, employers, at least as perceived by researchers of HRM and performance, appear to focus instead on more sophisticated systems that involve contingent pay, performance management and training and development (Boselie *et al.*, 2005). One of the reasons for this divergence may lie in the potential that various HR practices are perceived to offer to motivate and differentiate performance at the level of the individual. In many organisations, particularly in those such as the health service that are unionised, HR practices that relate to reward, communications or work-life balance are often centrally negotiated and/or implemented. In contrast, HR practices that relate to performance management or training and development, while they may share core elements, may be individualised and therefore hold out the potential for discrimination between employees. However, it is the HR practices valued by employees that appear to be linked to outcomes such as commitment and job satisfaction that have been associated with high performance. The divergence that is emerging in this and other research between employee-centred and management-centred approaches to

HRM, suggests that future research would benefit from the insights of a multiple stakeholders.

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TABLE 1 *Means, standard deviations, correlations and reliabilities for variables*

MEASURES	M	SD	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.
1.Affective to change	5.89	1.11	(.89)														
2. Work-life balance	5.14	1.52	.17*	-													
3. IR climate	3.07	0.69	.24***	.23***	(.89)												
4. Psy. Contract	3.29	0.73	.20**	.12	.62***	(.74)											
5.Career/ performance	4.21	1.45	.21**	.29***	.46***	.53***	(.91)										
6. Autonomy	4.62	1.54	.17**	.25***	.42***	.50***	.80***	(.88)									
7. Communication	4.11	1.37	.26**	.21**	.57***	.57***	.69***	.63***	(.84)								
8. Training	4.27	1.40	.14*	.24***	.43***	.45***	.74***	.65***	.67***	(.86)							
9. Staffing	4.28	1.32	.16*	.39***	.50***	.39***	.57***	.59***	.62***	.63***	(.72)						
10. Rewards	3.66	1.49	.18**	.22**	.41**	.37***	.45***	.39***	.39***	.35***	.41***	(.61)					
11. Job security	5.39	1.57	.10	.12	.16*	.34***	.28***	.28***	.30***	.19**	.16*	.19**	-				
12. Teamwork	5.27	1.55	.09	.21**	.30***	.34***	.58***	.57***	.43***	.43***	.32***	.17**	.28***	-			
13. Transactional	2.87	0.77	.06	.15*	.35***	.27***	.49***	.41***	.46***	.44***	.36***	.27***	.08	.29***	(.77)		
14. Transformational	4.60	1.28	.12	.17**	.45***	.42***	.69***	.59***	.57***	.54***	.43***	.33***	.15*	.41***	.70***	(.96)	
15. Manager	0.52	0.50	.00	-.01	.04	.20**	.23***	.24***	.16*	.32***	.15*	-.10	.15*	.19**	.12	.08	-
16. Length of service (years)	13.08	9.49	.10	.01	.00	.14*	.14*	.13*	.14*	.23***	.06	-.16*	.13*	.09	.06	.10	.35***
17. Patient focused	0.45	0.50	.36**	-	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Wider reform	0.30	0.46	-.19**	-	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Other change	0.25	0.44	-.22**	-	-	-	-	-	-	-	-	-	-	-	-	-	-

TABLE 2 *Results of regressing employee-related consequence variables on context/ background variables, satisfaction with HR practices and leadership (Standardised Betas)*

	Variables	ACC	WLB	IRC	PC
1	*Context/ background variables:*				
	Hospital	.036	.161	-.021	.042
	Community Care	-.007	-.101	-.190*	.032
	Managerial responsibilities	.025	-.143	.012	.072
	Length of service	.057	-.016	-.125	-.015
	Move to patient/ client focused service	.371***	-	-	-
	Wider health service reform	-.028	-	-	-
2	*HR practices:*				
	Career and performance development	.127	.190	-.005	.219
	Autonomy	-.161	.014	-.088	.014
	Communication	.268*	-.156	.288**	.367***
	Training	-.145	.048	-.071	-.109
	Staffing	-.032	.289**	.203*	.032
	Rewards	.183*	.058	.182*	.121
	Job Security	-.043	.079	-.018	-
	Teamwork	.095	.103	.113	.081
3	*Leadership style:*				
	Transactional leadership	-.206*	-.009	-.074	-.262**
	Transformational leadership	.118	-.039	.288**	.261*

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

ACC (affective commitment to change); WLB (work-life balance); IRC (industrial relations climate); PC (psychological contract).

TABLE 3 *Results of regressing employee-related consequence variables on context/ background variables, satisfaction with HR practices and leadership (*R²* values)*

	ACC	WLB	IRC	PC
Step 1: Context/ Background				
R²	.143***	.044	.044	.030
Change in R²	-	-	-	-
Step 2: HR Practices				
R²	.239	.231	.433	.421
Change in R²	.096*	.183***	.389***	.391***
Step 3: Leadership Style				
R²	.259	.231	.459	.455
Change in R²	.020	.001	.026*	.034**

* p < 0.05; ** p < 0.01; *** p < 0.001

APPENDIX 1: Satisfaction with HR practice variables used in statistical analysis
Each item was preceded with the statement 'please indicate your level of satisfaction with the following practices in your organisation'.

Career/ Performance Management (Alpha = 0.91)

- The way in which your performance is managed
- The information given to you about career paths in your job and the ways in which a position can be reached
- The opportunities you have in your job to make full use of your skills and abilities
- The efforts made by the hospital to promote people 'from within' the hospital
- The opportunities you have to discuss your career with your manager
- Your promotion opportunities
- The opportunities that you have to discuss aspects of your performance with your manager

Autonomy (Alpha = 0.88)

- The amount of flexibility that you have in deciding how your job should be done
- The opportunities you have to make suggestions about issues affecting your work
- The opportunities that you have to choose your own job assignments
- The influence that you have in deciding the way your work is organised

Communication (Alpha = 0.84)

- The information provided to you concerning important new initiatives at work
- The grievance or complaints resolution system
- The information provided to you about how the hospital is performing
- The organisation's approach to dealing with harassment/bullying
- The information provided to you on future plans for the hospital

Training (Alpha = 0.86)

- The amount of training that you receive
- The opportunities you have to engage in training and education activities that are beyond that needed in your job
- The financial support you can receive from your employer for further education

- The influence that you have in deciding on the type of training that you receive
- The level of training provided to new staff

Staffing (Alpha = 0.72)
- Your present workload
- The materials and equipment needed to perform your job
- The efforts made by the hospital to ensure that staffing levels are adequate
- The opportunities that you have to work flexibly (e.g. job sharing, flexi-time)

Employee Reward (Alpha = .61)
- The extent to which your pay reflects the contribution that you make
- The benefits package that you receive

Job security
- Your level of job security

Teamwork
- The opportunities you have to work as part of a team