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In recent years, downsizing has become a ubiquitous phenomenon of organizational life, even though an increasing body of evidence suggests that it may produce few lasting benefits (Heenan 1989; Mentzer 1996). Organizational scholars, in a burgeoning literature focusing on the downsizing process, suggest that downsizing is not merely the reverse of organizational growth and, therefore, requires a unique perspective (Cameron, Sutton, and Whetton 1988).

Although downsizing is often stimulated by a change in strategy, a diminution in the availability of critical resources, or declining markets, a decline in performance is not necessarily a precursor (Cameron, Freeman, and Mishra 1993). For instance, organizations may downsize to prune an ineffective bureaucracy, lower overhead costs, hasten decision making, smooth communication, increase entrepreneurship, or improve productivity (Cascio 1993; Tomasko 1987). However, in the long run, achieving any of these benefits may stem mainly from an organization's ability to manage its human capital.

The overuse and misuse of downsizing—in a first response to environmental decline or in the pursuit of short-term, tactical objectives—have been shown to produce lasting deleterious effects on an organization's human resources (Armstrong-Stassen 1993; Brockner 1988, 1992; Noer 1993). Nevertheless, how reductions are carried out may play a seminal role in mitigating the dysfunctional human consequences too often associated with organizational retrenchment (Cameron, Freeman, and Mishra 1991). Managing the workforce effectively under conditions of decline and cutback remains a unique and enduring challenge (Feldman and Leana 1994; Gilmore and Hirschhorn 1983).

Progressive management of an organization's human resources has long been considered crucial to its effectiveness and, increasingly, a means by which an organization can secure strategic advantage (Lawler 1986; Pfeffer 1994, 1998; Schuler and Jackson 1987). Few researchers have examined the impact that human resource management (HRM) practices associated with higher levels of organizational performance have on an organization experiencing decline or retrenchment. However, this area of research is one of the field's most promising in recent years (Cook and Ferris 1986; Ferris, Schellenberg, and Zammuto 1984). We are only now beginning to understand how such practices affect performance (Huselid 1995; Sheppeck and Milltello 2000; Younkt et al. 1996), yet we know almost nothing about their ability to do so when the organization is undergoing significant change—including labor force displacements.

Although the activities and practices identified in the literature as being high performing, high involv-
ing, or progressive are numerous and diverse, no clear consensus dictates which practices should be included. In some instances the practices identified as innovative are based on the researcher’s judgement or preference. Nevertheless, a growing body of evidence suggests that organizations may benefit from adopting a wide variety of work innovations. However, how these practices affect performance remains unclear. It is presumed that participatory practices help promote employee commitment, that team processes help improve communication and motivation, that performance-based pay better aligns employee goals with those of the organization, and that training and job security enhance competency, commitment, and satisfaction levels (Pil and MacDuffie 1996). For organizations undergoing dramatic structural and process changes, these innovative work practices may increase employee participation, communication, and acceptance of the change strategy.

To better understand how HRM practices contribute to performance in healthcare organizations undergoing significant workforce reductions, we examined a large sample of Canadian hospitals experiencing unprecedented restructuring and downsizing. During the last decade of the 20th century, hospitals in Canada experienced budgetary cuts necessitated by reductions in federal transfer payments to the provinces that administer health services (Naylor 1999). In the years between 1991 and 1995, Canadian public hospitals experienced an average annual growth rate of -2.4 percent in their operating budgets (Tully and Saint-Pierre 1997). These budgetary shortfalls have forced hospitals in Canada to reduce their workforces and restructure their operations (Rondeau and Wagar 1998). Between 1986 and 1994, more than 30,000 short-term-care beds were removed in all categories of public hospitals, despite increases in population and an aging society. Before or during these cutbacks, many hospitals in Canada began to adopt a variety of HRM innovations, including such things as quality of worklife initiatives, shared governance programs, quality-improvement teams, job sharing and flexible work hours, and incentive-based pay systems. In some situations, these initiatives were introduced as short-term measures to improve employee morale, commitment, and satisfaction. However, their acceptance by management has often centered on the promise of improved labor relations and productivity enhancements (Godard and Delaney 2000).

Although downsizing’s negative impact on people has been widely observed and reported in the literature (Mishra, Spreitzer, and Mishra 1998), it has not been established whether organizations adopting more progressive work practices are better able to withstand its disruptive effects than those who continue to use more traditional approaches to managing the workforce. Our objective in conducting this study was to determine the impact HRM practices have on perceptions of organizational performance for hospitals undergoing planned workforce reductions. We addressed the following research questions:

- Among hospitals conducting permanent workforce reductions, do hospitals that have implemented certain HRM practices perform any better than hospitals without such practices?
- What is the potential of high-performance (high-involvement) HRM practices to mitigate the negative performance effects in hospitals undergoing extensive downsizing and restructuring?

METHODS

Survey Participants and Procedure

We sent a survey questionnaire in 1996 to the chief executive officer or site administrator of 1,014 Canadian hospitals. All Canadian acute and chronic care institutions with an organized medical staff, eight or more beds, and at least five full-time equivalent employees were considered eligible to participate. We informed all involved that their participation in the study was voluntary and that their responses would remain anonymous and confidential. Six weeks after the initial mailing, we sent another questionnaire to those who did not respond to the first request. In total, 441 usable questionnaires were returned, providing an overall response rate of 43.5 percent. Using published data from the Canadian Healthcare Association to check the representativeness of the participating institutions, we found small and rural hospitals to be slightly underrepresented in our study sample (Canadian Healthcare Association 1995).

Measures and Design

Dependent Variables

Organizational performance. We asked survey participants to assess subjectively the degree of relative change on performance variables, including gross perceptual measures of internal operations,
employee relations, consumer satisfaction and service quality, and the ability of their hospital to respond to environmental challenges and strategic opportunities. Using a six-point Likert-type scale ranging from 1 (substantial decrease) to 6 (substantial increase), we asked respondents to indicate the extent of change over the past two years on 18 key performance indicators. Although the use of perceptual data can increase the extent of measurement error as well as the potential for monomethod bias, the practice has been used by other researchers and has been found to correlate positively (i.e., with moderate to strong associations) with a number of objective measures of performance (see Delaney and Huselid 1996; Rondeau and Wagar 2001). The use of perceptual measures of performance also allowed us to compare hospital performance across the ten provincial jurisdictions in which hard performance data is either unavailable or not easily compared.

**Independent Variables**

*HRM practices.* We asked survey respondents to assess the importance of eight HRM activities generally considered in the literature to be high performance, high involvement, or progressive (Hiltrop 1996). Using a six-point Likert-type scale ranging from 1 (very low importance) to 6 (very high importance), we asked participating institutions to consider the present state of their organization and indicate the degree to which their organization emphasizes (1) employee career planning, (2) employee multiskilling, (3) employee participation, (4) employee training, (5) staff education and development, (6) quality improvement teams, (7) self-managing teams, and (8) a commitment to job security. We constructed a scale assessing progressive (high performing/high involvement) HRM practices as a composite of these eight measures. The scale produced an alpha of .81 indicating acceptable internal reliability.

*Workforce reduction.* We asked respondents to indicate the total number of employees who were working at the time of the study and the total number who were working two years previously. We also asked them to indicate the extent or size of workforce reduction as a percentage of total employment in five employment categories: managerial, nursing, clerical support, maintenance support, and professional or technical staff. We asked those respondents who had permanently reduced their workforce during the past two years to indicate whether they had done so through the use of (1) attrition, (2) voluntary severance, or (3) permanent layoffs.

We evaluated only those hospitals that had permanently reduced their workforce over the previous two years. Our results showed that almost 89 percent of respondents had done so. After we omitted those organizations for which key data were missing, 285 hospitals remained to constitute our net study sample. Table 1 provides some descriptive statistics for our hospital sample.

We classified participating institutions on the basis of the size of the workforce reduction over the preceding two years and the extent to which they were perceived to have implemented a number of progressive or high-performance HRM practices. Using the arbitrarily chosen mean value for workforce reduction (11.7 percent) and the mean score for progressive HRM practices (4.17) on the eight variables that composed our index, we placed hospitals into one of four categories. In the first category (labeled LARGEPRO) we placed 55 hospitals that had experienced large workforce reductions over the previous two years (reductions greater than 11.7 percent of their total workforce) yet reported having more progressive HRM practices (scores greater than 4.17). In the second category (labeled LARGEREG) we placed 45 hospitals that had experienced larger workforce reductions but had lower progressive HRM practice scores. The third category (SMALLPRO) comprised 85 hospitals that had experienced smaller workforce reductions over the preceding two years yet reported a greater emphasis on progressive HRM practices scores. The fourth category (SMALLREG) comprised hospitals that had smaller workforce reductions and reported lesser adoption of progressive HRM practices.

**Control Variables**

We performed separate regressions for each of the 18 measures of organizational performance serving as the dependent variable. Using the SMALLREG category as the comparison group, we entered a number of control variables to effectively capture other organizational and environmental factors that are related to both the adoption of HRM practices and the perception of organizational performance. We selected control variables on the basis of their potential to explain some of the variance in our dependent variable. We believed that organizational size and percentage of unionization had the poten-
TABLE 1
Descriptive Statistics of Hospital Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in performancea</td>
<td>4.71</td>
<td>.94</td>
<td>281</td>
</tr>
<tr>
<td>Management stress</td>
<td>4.48</td>
<td>.91</td>
<td>282</td>
</tr>
<tr>
<td>Operating efficiency</td>
<td>4.32</td>
<td>.93</td>
<td>281</td>
</tr>
<tr>
<td>Community support</td>
<td>4.31</td>
<td>.84</td>
<td>277</td>
</tr>
<tr>
<td>Organization reputation</td>
<td>4.27</td>
<td>.94</td>
<td>282</td>
</tr>
<tr>
<td>Organization flexibility</td>
<td>4.11</td>
<td>.71</td>
<td>280</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>4.05</td>
<td>.94</td>
<td>277</td>
</tr>
<tr>
<td>Access to service</td>
<td>4.01</td>
<td>.75</td>
<td>278</td>
</tr>
<tr>
<td>Patient care quality</td>
<td>3.68</td>
<td>1.22</td>
<td>278</td>
</tr>
<tr>
<td>Organization fiscal health</td>
<td>3.47</td>
<td>1.02</td>
<td>280</td>
</tr>
<tr>
<td>Organization conflict</td>
<td>3.43</td>
<td>1.01</td>
<td>275</td>
</tr>
<tr>
<td>Nurse quality of worklife</td>
<td>3.43</td>
<td>1.01</td>
<td>275</td>
</tr>
<tr>
<td>Physician job satisfaction</td>
<td>3.37</td>
<td>1.06</td>
<td>282</td>
</tr>
<tr>
<td>Staff resistance to change</td>
<td>3.14</td>
<td>.95</td>
<td>281</td>
</tr>
<tr>
<td>Employee morale</td>
<td>2.90</td>
<td>1.01</td>
<td>277</td>
</tr>
<tr>
<td>Legal liability exposure</td>
<td>2.83</td>
<td>1.16</td>
<td>280</td>
</tr>
<tr>
<td>Employee grievances</td>
<td>2.76</td>
<td>.98</td>
<td>269</td>
</tr>
<tr>
<td>Patient morbidity</td>
<td>2.39</td>
<td>1.05</td>
<td>281</td>
</tr>
<tr>
<td>Nurse turnover</td>
<td>2.36</td>
<td>1.12</td>
<td>281</td>
</tr>
<tr>
<td>HRM practicesb</td>
<td>4.87</td>
<td>.99</td>
<td>284</td>
</tr>
<tr>
<td>Employee participation</td>
<td>4.65</td>
<td>.94</td>
<td>284</td>
</tr>
<tr>
<td>Employee education/development</td>
<td>4.55</td>
<td>.96</td>
<td>280</td>
</tr>
<tr>
<td>Employee training</td>
<td>4.47</td>
<td>1.24</td>
<td>278</td>
</tr>
<tr>
<td>Quality improvement teams/circles</td>
<td>3.96</td>
<td>1.12</td>
<td>281</td>
</tr>
<tr>
<td>Commitment to job security</td>
<td>3.94</td>
<td>1.19</td>
<td>285</td>
</tr>
<tr>
<td>Employee multi-skilling</td>
<td>3.83</td>
<td>1.30</td>
<td>283</td>
</tr>
<tr>
<td>Self-managing teams</td>
<td>3.11</td>
<td>1.13</td>
<td>284</td>
</tr>
<tr>
<td>Employee career planning</td>
<td>3.11</td>
<td>1.13</td>
<td>284</td>
</tr>
<tr>
<td>Other characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of employees</td>
<td>665.4</td>
<td>1,145.6</td>
<td>285</td>
</tr>
<tr>
<td>Number of beds</td>
<td>182.2</td>
<td>244.8</td>
<td>283</td>
</tr>
<tr>
<td>Workforce unionized</td>
<td>81.2%</td>
<td>18.3%</td>
<td>263</td>
</tr>
<tr>
<td>Workforce reduced</td>
<td>11.2%</td>
<td>9.6%</td>
<td>285</td>
</tr>
<tr>
<td>Workforce reduced by attrition</td>
<td>36.2%</td>
<td>31.1%</td>
<td>265</td>
</tr>
<tr>
<td>Workforce reduced by voluntary severance</td>
<td>29.5%</td>
<td>27.8%</td>
<td>265</td>
</tr>
<tr>
<td>Workforce reduced by layoff</td>
<td>34.3%</td>
<td>31.7%</td>
<td>266</td>
</tr>
</tbody>
</table>

Note: HRM = human resource management.

Scores range from 1 (very low importance) to 6 (very high importance); α = .81.

RESULTS

Table 2 shows the results of regression analysis for change in hospital performance for each of the 18 performance variables. The results of our study address the potential impact that some progressive HRM practices may have on the perception of several key performance variables for hospitals that have undergone significant workforce reductions over a two-year period. In fact, our analysis suggests that the presence of progressive HRM practices may play a larger role in organizational performance than does the size or severity of the overall reduction. In other words, the adoption of certain HRM practices considered to be high involvement, high performance, or progressive may play a key role in mitigating the dysfunctional consequences of large workforce reductions.

Our results suggest that certain progressive HRM practices have a differential impact on perceptions of organizational performance. The 18 performance measures we examined in this study are indicators that roughly represent the four quadrants of a modified balanced scorecard (see Kaplan and Norton 1996; Baker and Pink 1995). This approach captures hospital performance along four key dimensions: (1) the customer perspective, (2) the employee perspective, (3) the operational perspective, and (4) the organizational change and adaptation perspective, allowing a broader conceptualization of organizational performance than the traditional measures do.

Customer perspective. Hospitals that had more progressive HRM practices were more likely to report positive associations with perceptions of patient care quality and patient satisfaction than organizations with less progressive practices, regardless of the size of the workforce reduction undertaken. They were also more likely to report more favorable reputations. Not surprisingly, patient morbidity (sickness acuity) was found not to be associated with either the size of the workforce reduction or the degree of progressiveness (high involvement) of HRM practice.
Employee perspective. We found those hospitals that had adopted less progressive HRM practices to be more likely to report lower employee morale and nurse quality of worklife and higher employee grievances. These effects may well be moderated by the size of the workforce reduction in that large reductions, when coupled with less progressive HRM practices, will worsen employee morale and nurse quality of worklife while increasing employee grievances. Those hospitals in our sample that adopted more progressive HRM practices were also more likely to report perceptions of higher physician job satisfaction. Hospitals that had implemented more progressive HRM practices and had smaller overall workforce reductions reported slightly lower levels of management stress.

Operational perspective. We found hospitals in our sample that had adopted more progressive HRM practices to be more likely to report improved operating efficiency and fiscal health than those hospitals without such practices, regardless of the size of the workforce reduction.

Organizational change and adaptation perspective. We also found hospitals in our sample that had adopted more progressive HRM practices to be more likely to report increased organizational flexibility, organization reputation, community support, and access to services than organizations without such practices, regardless of the size of the workforce reductions.

DISCUSSION AND CONCLUSION

It has long been a management maxim that people are a critical resource and provide an important means by which organizations gain and maintain strategic advantage (Pfeffer 1994). Our research, although preliminary and tentative, adds to the growing empirical evidence that effective management of human resources has an impact on organizational performance, or at least the perception of it, and may play an as-yet-undetermined role in mitigating some of the dysfunctional consequences associated with massive workforce reductions and restructuring. Confidence in the results of this research may be bolstered by the fact that our large sample set is drawn from a single industry in which
industry-specific confounders can be better understood and controlled. However, we caution that the generalizability of our conclusions to other settings is highly tenuous; therefore, our findings would need to be tested in a wider range of organizations and industries.

Several limitations suggest that any conclusions drawn from this research should be viewed with caution. First, our measures of organizational performance reflect the subjective assessments of senior hospital executives. Although some evidence suggests that perceptual assessments of performance are strongly associated with more objective measures, they are still subject to the inherent biases, perceptual distortions, and preferences of the individuals in question. One way to reduce this problem would be to collect human resource and performance information from a variety of different respondents, including employees.

Second, because data collected in this study are from a single source, common method bias may act to distort the findings and blunt its conclusions. For instance, respondents who report favorable perceptions of organizational performance may also tend to report more high-involvement HRM practices. To some extent, we have tried to control for this bias by asking both fact-based and perception-based questions.

Third, there is considerable debate among human resource management scholars concerning what sets of HRM practices should be considered high performing, high involvement, and progressive (Becker and Gerhart 1996). The underlying assumption is that the impact of different HRM practices is additive and positive in nature. Yet, not every practice produces positive performance enhancements for every organization, nor does a combination or “bundle” of these practices always produce performance enhancements for every organization. In fact, some HRM practices when combined may actually work to undermine performance. Most studies examining high-performance or high-involvement HRM systems have varied significantly as to which practices to include. For instance, should employer guarantees of job security be considered a progressive HRM practice because it removes the threat of job loss for individuals and improves their potential commitment to the organization, or should they be considered a regressive practice because it makes the organization less flexible?

Finally, there is a real difference between what managers say they do and what the organization actually does. Managers may believe in good faith that progressive HRM practices are strongly emphasized in their organizations, but in many instances these practices are variously interpreted, intermittently practiced, or partially diffused. In addition, an organization’s operating culture and value system may act to reinforce or undermine these practices (Ulrich and LaFasto 1995). Future researchers need to determine the extent to which these practices are diffused as well as assess the contribution of the organization’s culture as a facilitator or inhibitor of these practices.

Our results suggest that human resource management practices may play an important role in mitigating perceptions of several key performance variables for organizations undergoing planned workforce reductions. The unprecedented downsizing in Canadian hospitals has offered a unique opportunity for researchers to examine the impact of downsizing within a single industry (Baumann et al. 1996; Burke and Greenglass 2000; Havlovic, Bouthillette, and Van der Wal 1998). Although monoindustry studies are important because they allow for the control of industry-specific factors that can confound results, the generalizability of study conclusions to other organizations and industries remains problematic.

Nevertheless, our initial findings seem to suggest that, in the face of severe workforce contractions, perceptions of organizational performance may be strongly influenced by the extent to which progressive HRM practices are emphasized. However, even if performance improvements are real, we are unable to say through this research whether they are lasting. Innovative practices may help at first to mitigate the harmful consequences of downsizing, but these may break down over time because of underlying conflict or the inherent fragile nature of the practices. Much more evaluation needs to be undertaken in this and other industries not only to more fully ascertain which HRM practices can act as effective mitigants to the dysfunctional consequences of profound workforce reduction but, more specifically, to delineate more clearly how they act.

NOTES

With respect to how hospital budgets are consumed by their labor costs, my understanding is that hospital labor costs represent about 70 percent of total hospital costs in Canada. I would imagine that the figure is comparable in the United States.

2. W. F. Cascio, in Learning from Outcomes: Financial Experience of 311 Firms That Have Downsized (from The New Organizational Reality, ed. M. K. Gowling, J. D. Kraft, and J. C. Quick, Washington, D.C.: American Psychological Association, 1998, p. 59), defines a significant downsizing as a permanent workforce reduction that is greater than 3 percent of the total workforce. Because the workforce reductions conducted in Canadian hospitals averaged almost 12 percent (over a two-year period), massive downsizing/structural change may be appropriate terms to describe the scope of change.

REFERENCES