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# Employee voice in a semi-rural hospital: impact of resourcing, decision-making and culture

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## Abstract

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## ABSTRACT

The purpose of this paper is to understand current employee voice arrangements within a semi-rural hospital and the implications for the engagement of healthcare professionals. The Job Demands-Resources (JDR) model is used to explore how organisational mechanisms (resourcing, decision-making processes and culture) provide a voice for staff. We adopt a single case study approach using in-depth interviews with healthcare professionals in a semi-rural public hospital in Australia. The study found that the semi-rural context, characterised by high levels of centralised decision-making and resourcing and low levels of confidentiality and anonymity, has limited employee voice and the ability for staff to participate in decisions affecting their work. This lack of voice has consequently had negative effects on engagement levels. We propose that employee voice be viewed as a distinct job resource, manifest through an organisation's resourcing, decision-making processes and culture, to generate a direct and positive effect on employee engagement.

Keywords: employee voice, participation, engagement, resourcing, organisational mechanisms, Job Demands-Resources model

**Key points:**

- Doctors and nurses face varying challenges in their job roles, which is exacerbated in a semi-rural hospital setting.
- The semi-rurality of the hospital and its centralised resourcing approach has placed priority on cost efficiency when establishing resourcing arrangements. Such

bureaucratic processes disregard cultural norms and inhibit the voices of healthcare professionals.

- Healthcare professionals in the semi-rural hospital are limited in voicing work or personal issues affecting work due to the small town mindset, as lower levels of anonymity impact their professional standing within the community.
- Active involvement and participation of healthcare professionals in resource allocation and the decision-making process in hospitals is likely to improve their ability to manage the stressful job demands and long work hours, resulting in better employee engagement, retention and patient care.
- HR departments should use employee voice as a conduit to form a partnership between management and staff to create organisational resourcing and decision-making approaches to better serve its semi-rural hospital needs.
- Decision makers need to encourage employee voice across all occupational groups within hospitals, as it can serve as a job resource to improve employee engagement and especially to combat the job demands specific to a semi-rural hospital setting.

## INTRODUCTION

Engagement levels of healthcare professionals is important as research has found that more engaged employees have a strong positive relationship with patient safety and a safety culture (Collier, Fitzpatrick, Siedlecki and Dolansky, 2016). Higher engagement is also found to help to increase retention levels of medical and nursing professionals (Tullar, Amick III, Brewer, Diamond, Kelder and Mikhail, 2016), given the challenge of recruiting and retaining

healthcare professionals in rural and semi-rural hospital settings (Godwin, Hoang, & Crocombe, 2016).

Healthcare professionals face greater challenges at work than most employees, and this is accentuated when working in rural areas, particularly in the Australian context where geographically dispersion and isolation from the main cities is greater. Such contextual settings are characterised by a shortage of access to equipment and infrastructure, a distinct lack of specialist staff, limited access to professional development, different patient demographics that present higher and varied needs, and professional isolation (Lenthall et al., 2018). In addition, rural healthcare professionals experience social isolation due to limited access to social activities, education services for children, and job opportunities for their partners (Bentein, Garcia, Guerrero, and Herrbach, 2017).

Past research in the Australian health sector has concentrated mostly on nursing staff (see for example, Boswell, et. al., 2017; Lenthall et al., 2018), with a noticeable lack of empirical research that has examined both doctors and nurses. Further, there is a lack of research that examines healthcare professionals and hospitals in semi-rural and regional areas (Buykx et al. 2010). More specifically, limited focus is given to the effects of organisational mechanisms within the healthcare sector on staff participation in decision-making and employee engagement. Thus, this paper aims to explore and analyse the impact of organisational mechanisms (resourcing, decision-making processes and culture) on employee voice and engagement across the various occupations within a semi-rural hospital setting.

O'Neill, Beauvais and Scholl (2001) consider organisational mechanisms to form two parts; organisational structure (e.g. resource allocation, coordination and control of activities) and symbolic management (i.e. organisational culture). They posit that these mechanisms are an important component for organisations who strive to ensure employee efforts towards achieving strategic goals. Our paper follows O'Neill et al's (2001) argument that such

mechanisms have a unique impact on individual behaviour and outcomes. This study explores these two mechanisms through concepts of resourcing, decision making and culture to better understand the current employee voice arrangements within the semi-rural hospital, and consequently how they affect employee engagement levels. The focus of this study is on the extent of use of empowerment-focused HRM (ie. development opportunities, workplace participation, and information sharing opportunities) to generate the perception of voice opportunities (Van De Voorde, Veld and Van Veldhoven 2016).

To this end, the paper will address the following research question "how does the semi-rural context shape employee voice in hospitals?" In doing so, the paper will: 1) explore how organisational resourcing, decision-making and culture impact employee voice in a semi-rural Australian hospital, 2) compare this across key occupational groups (doctors, nurses and middle managers), and 3) explore the impact of employee voice on employee engagement.

**Employee Voice and engagement**

When organisations have systems and protocols that facilitate an inclusive and shared culture, there is a greater chance for enhancing shared governance and employee engagement (Boswell, Opten and Owen, 2017). Employee voice is viewed by the literature as a key factor by which this can be achieved and has become an important HR strategy used to promote high-performance work systems that require high levels of employee-management commitment and involvement (Wilkinson & Fay 2011). Employee voice is a broad concept that takes on various meanings, purposes and names. It has evolved from an earlier institutional focus using concepts such as industrial democracy, involvement and empowerment concerning the level of involvement and participation given to employees at work (Budd, Gollan and Wilkinson, 2010). It has now expanded towards the behavioural and strategic domain, exploring whether or how organisations listen and respond to employees, enabling them to have a say in how things can be improved at work (Mowbray, Wilkinson and Tse 2015; Macleod and Clark 2009).

Morrison (2014) explains voice to be when employees voluntarily communicate their ideas, suggestions and concerns in an informal manner to bring improvement or change to a work-related issue. Other scholars specifically describe it to be when organisations more actively encourage employee voice, using a two-way communication process between management and employees that is designed to involve employees in the organisational decision-making process (Marginson, Edwards, Edwards, Ferner and Tregaskis, 2010).

This paper incorporates both meanings of employee voice. More so, we take it to mean that voice is voluntary and that it can be formal or informal, with contributions that address a vast range of matters, be they work-specific or organisation wide. It is about having the opportunity to be heard and contribute to part of the decision making process. Importantly, this form of employee voice is not based on compliance or control, rather aims to encourage employees to identify with their work and contribute to organisational goals (Conway, Fu, Monks, Alfes, and Bailey, 2016). Consequently, this form of voice is not viewed as a demand. That is, in keeping with Schaufeli and Bakker, (2004), this paper posits that high involvement through voice constitutes a resource, which can create a more engaged workforce and buffer against work demands.

Kahn (1990) describes engagement as the harnessing of organisational members' selves to their work roles, where engaged workers express themselves authentically at work both cognitively, emotionally and physically. He goes on to say that such engaged employees are more likely to have a positive orientation toward the organisation, feel an emotional connection to it, and be productive. This also holds true within the Australian public-health context. Employee engagement within the public hospital context is viewed to be "where people find their work meaningful and are willing to work together for patients, their colleagues and the future success of their organisation" (Queensland Government, 2012, p.7). This includes the

involvement of people at all levels in a positive two-way dialogue and action to deliver the highest quality patient care and create great places to work.

We use the Job Demands-Resources model (JD-R) (Bakker & Demerouti 2007) to explore how resourcing, decision-making processes and culture act as job resources to provide a voice for healthcare professionals' in their workplace. Particular attention is given to the ability of employees to participate in decision making processes and consequently how this impacts employee engagement. The rationale is that HRM policy and practice is expected to influence employees' level of task-based job resources (better job autonomy, job variety and development opportunities) thereby facilitating workplace participation and engagement (Boxall and Macky, 2009). Using similar logic, this paper gives consideration to the notion of organisational mechanisms (resourcing, decision-making processes and culture) and how employee voice is recognised as a 'job resource'.

Currently, the literature gives little recognition to the distinct role that employee voice plays as a job resource within the JD-R model, particularly the relationship between employee voice and engagement. One exception is the study of a large Irish public sector organisation which explored the impact of performance management and employee voice practices on employee wellbeing (Conway et al, 2016). Using the JD-R model, the study found employee voice act as a job resource by enhancing employee engagement and counterbalancing the demands of the performance management system. Similarly, Ng and Feldman (2012) took a conservation of resources perspective and used meta-analytic findings to highlight how voice enable workers to preserve or accumulate resources to enhance their performance. Further, much of the existing JD-R empirical studies seem to be focused around cross-sectional European samples (Brough, Timms, Siu, Kalliath, O'Driscoll and Sit, 2013) and highlight a lack of qualitative empirical studies (Ravenswood, Douglas, & Haar, 2018). This paper aims

to extend the analysis of the JD-R model by exploring voice as a job resource, using an Australian case study.

**Job Demands-Resources Model (JD-R)**

The JD-R model is based on the idea that jobs hold two key characteristics: job demands and job resources. 'Job demands' are the physical, psychological, social, or organisational aspects of the job that require cognitive or emotional effort (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). These demands are therefore associated with certain physiological and/or psychological costs, and such demands are claimed to lead to a reduction in engagement levels and worker wellbeing. Job demands (i.e., physical demands, time pressure, shift work) are associated with exhaustion. Similarly, lacking job resources (i.e., participation in decision making, team climate, social support, performance feedback, role clarity and job control) is associated with disengagement (Schaufeli, & Bakker, 2004).

On the other hand, 'job resources' is a broad term under the JD-R, referring not only to the physical aspects of the job, but also the psychological, social or organisational aspects (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). According to this model, 'job resources' serve a motivational function and help employees cope with the demands of work which lead to positive work outcomes such as engagement. Such resources foster an environment geared to achieving goals and personal development and growth and positively impacts engagement levels (Bakker, Hakanen, Demerouti, & Xanthopoulou, 2007; Demerouti, Bakker, Nachreiner and Schaufeli, 2001; Opie, Dollard, Lenthall, Wakerman, Dunn, Knight, & MacLeod, 2010). Consequently, employee experiences of high forms of employee voice will have a positive impact on employee engagement, as it leads to a perception of fairness in the outcome of decisions made and in the process by which that decision was made. In the current study, we view job resources to include organisational mechanisms (resourcing approach, decision-

making processes and culture) that encourage and support employee voice (participation and involvement in work related or organisational matters).

The focus of this case study is primarily on the job resources aspect of the JD-R model as it best captures notions of employee voice. Job resources have been well documented in the literature as a key influencing factor of engagement. In their review, Bakker, Schaufeli, Leiter, and Taris (2008) identified 16 empirical studies reporting strong positive relations between job resources and work engagement across homogeneous and heterogeneous samples. Other research produced similar findings, identifying resource support and working conditions as factors likely to improve work engagement levels (Attridge, 2009; Hakanen, Schaufeli, & Ahola 2008). Schaufeli and Bakker (2004) found that engagement is exclusively predicted by the 'availability' of job resources. The most powerful of findings were by several longitudinal studies, confirming the positive and predictive capabilities of job resources on employee engagement (Hakanen, Schaufeli, & Ahola, 2008).

However, the JD-R model does not consider the broader contextual or organisational conditions that may also serve to impact employee engagement. For instance, working in a semi-rural hospital presents a unique contextual setting typified by high job demands and an under resourced environment, and further engulfed with the challenges of working in a small remote town. Such healthcare professionals are confronted by additional challenges which have been found to negatively impact emotional demands. Social isolation and the social aspects of work pose further challenges for confidentiality and with maintaining privacy. In this context, employee voice becomes an especially important job resource to enable workers to combat these various demands and provide the right forms of social and organisational support. The JD-R model does not consider contextual factors specific to a semi-rural setting (Bentein, Garcia, Guerrero, and Herrbach, 2017). This study therefore gives due consideration

to organisational mechanisms (resourcing approach, decision-making processes and culture) in a semi-rural hospital.

**Resourcing approach as a mechanism for employee voice**

According to the resource-based view of the organisation (Barney 1991), resources are categorised as tangible or intangible assets that can be possessed or owned by the organisation (Wang 2009). Resourcing theory emphasises the importance of actioning the resources. Resourcing, in this case, is defined as the act which brings potential resources into action as actual resources (Feldman and Worline, 2013). The JD-R model depicts this notion of resourcing and how it can impact employee engagement. Bakker et al. (2007; 2010, cited in Bakker and Demerouti 2014, p.9) claim that an employer's ability to provide employees with job resources not only counters the effects of job demands but also provides an indicator to "…work enjoyment, motivation and engagement". For example, when organisations provide mentoring, guidance on career progression and opportunities and facilities for counselling to manage mental fatigue, it can have a positive impact on the wellbeing and engagement healthcare professionals (Almeida, Fernando, Munoz and Cartwright, 2019).

Actioning resources in a meaningful manner means that organisations give employees the opportunity to contribute to resource allocations or how they perform their work, which can positively influence engagement (Grawitch et al., 2015). On the other hand, when employees do not have the resource control required to perform a task, there is a decrease in job satisfaction levels, and the likelihood of involvement and commitment (Robertson and Cooper, 2011).

Studies of engagement using the JD-R have proven that the relationship between job resources and engagement are consistently positive (Crawford, Lepine and Rich 2010). When the employer provides financial and economic as well as socio-emotional resources (e.g. wellness programs), employees are more likely to respond and repay the organisation through engagement, resulting in a high-quality employment relationship (Cropanzano and Mitchell

2005). According to studies conducted across countries such as Finland, Australia, Belgium and China in different occupational groups such as teaching, health professionals, volunteers and blue-collar and white-collar workers, job resources that enhance learning and autonomy can buffer the impact of job demands, and can potentially motivate staff when job demands are high (Hu, Schaufeli and Taris, 2011).

The public healthcare sector in NSW resembles a distinct culture or microcosm which is resourced centrally by their larger sister hospital. Since 2011, the NSW Health government places regional hospitals within a larger organisational structure. There are currently 15 Local Health Districts: eight that cover the Sydney metropolitan region, and seven that cover rural and regional NSW. The rationale behind this structure was to restore local decision-making and introduce a more efficient management structure. Costs and efficiencies were a key consideration as many medical services require significant investment in infrastructure and highly specialised staff. It was deemed more cost effective to have a "group of hospitals" within each health district to deliver a range of services required by a whole community. The rationale being that one stand-alone hospital would not be able to provide the same breadth and depth of services.

However, according to Duffield (2007), frequent structural changes to Australian hospitals coupled with the need to contain costs have significantly impacted the healthcare workforce, reportedly impacting employee engagement negatively. These cost containment strategies employed in the healthcare industry combined with increased patient throughput have increased workloads for healthcare professionals (Aiken et al., 2013). When considering the unique needs of semi-rural hospitals, particularly to be able to provide both general and specialised care, the placement of resource control away from the semi-rural hospital can have unintended consequences. Such a centralised resourcing and decision making model potentially reduces the opportunity of smaller sister hospitals (i.e. semi-rural hospitals in the

district or group) to offer their services in the most effective way. It also reduces the opportunity for management and staff to voice the needs and concerns of the smaller, rural based hospitals.

**Decision making process as a mechanism for employee voice**

Although the literature supports a positive link between employee involvement/participation and employee engagement (Demerouti, Bakker, de Jong, Janssen, and Schaufeli, 2001; Schaufeli and Bakker, 2003; Schaufeli et al., 2008), specific studies testing the relationship specifically between involvement or employee voice and engagement are scarce. Much of the focus in past research has instead been towards the link between high-involvement work systems (HIWS) and performance (Townsend, Wilkinson and Burgess, 2013). Such studies have found that job satisfaction, commitment and work-life balance is directly and positively associated with direct voice mechanisms and higher involvement, such as regular meetings between management and staff and the existence of semi-autonomous workgroups (Boxall and Macky, 2014). One exception is a report by MacLeod and Clarke (2009), which identified employee voice (participation) as being one of four major enablers of employee engagement. In addition, a study by Scrima, Lorito, Parry and Falgares (2014) demonstrated the importance of job involvement as a personal resource in promoting affective commitment. Having job involvement as a job resource helped to engage workers to control and impact their work environment successfully.

The extent of research evidence concerning employee voice and decision making within the healthcare sector is also limited, with much of the research conducted in large scale hospital settings. The focus of earlier studies being predominantly on how healthcare professionals prevent or address risky behaviours to support safe practices for patient care (Orasanu and Fischer, 2008; Tarrant, Leslie, Bion, and Dixon-Woods, 2017), with little focus on employee attitudes and behaviours or their role in the decision making process.

The importance of voice and decision-making processes in a semi-rural setting is especially significant given the inherent privacy and visibility issues evidenced by healthcare professionals, as they hold multiple roles and relationships in rural communities with less protection and confidentiality afforded to them (Gregory, 2005). Consequently, healthcare professionals may face ethical issues in relation to voice and decision making within these unique semi-rural contexts.

**Organisational culture as a mechanism for employee voice**

Organisational culture is commonly viewed to serve as the social glue amongst organisational members, conveying a sense of identity and commitment to something beyond the individual member (Smircich, 1983). Schein (1985) further notes that organisational culture is like a coping mechanism used by employees to deal with problems of external adaptation and internal integration. In a similar vein, Sims and Lorenzi (1992) sees it as a consensual schema used by individuals to cognitively process and evaluate information in similar ways to help create shared interpretations to guide behaviour.

Culture has been studied from two perspectives; functionalist and interpretivist. This paper adopts the interpretivist approach to culture primarily because it propounds that culture resides not only in the cognition and attitudes of individuals, but in meaning shared by social actors (Allaire and Firsirotu, 1984). More specifically, culture is perceived as emerging from a group's history. In this way, structure, strategy and power relations in the organisation are viewed as manifestations of culture (Allaire and Firsirotu, 1984). Culture in public health organisations emerges from its history, and therefore, its structure and power relations are manifestations of its culture (Bloor and Dawson, 1994). When organisational culture is perceived to be negative(Spooner, 2016), the in-built cultural hindrances, behaviour and values in the workplace can negatively influence employee health, job satisfaction, productivity, commitment and burnout (Smith, Andrusyszyn and Laschinger, 2010).

This paper examines how organisational culture serves as a mechanism to provide semi-rural healthcare professionals with an environment that fosters employee voice, and the extent to which employees are afforded opportunities and abilities to contribute towards organisational goals and job-specific matters, such as resource allocation. Given the high demand and under resourced environment of the semi-rural hospital, organisational culture may potentially be the key to providing employees the opportunities to have a voice and the organisational support required of healthcare professionals. For example, in their study of occupational stress among nurses working in remote areas, Lenthall et. al., (2018) suggested that 'system capacity factors' such as the climate for worker psychological health, flexible/adaptable culture, consultation and preparation, and communication systems, could influence demands and resources. Indeed, remote work, social isolation and lack of support were key factors impacting occupational stress of nurses working in remote areas of Australia (Opie, et al., 2010).

**Organisational mechanisms, employee voice, and engagement using the JD-R model**

Based on the above, we posit that the organisational mechanisms that facilitate employee voice will lead to a more engaged workforce. Similar to Conway, Fu, Monks, Alfes, and Bailey (2016), we argue that employee voice is a job resource that serves to increase employee engagement and also to address job demands, which are elevated due to the additional challenges prevalent in a semi-rural hospital setting.

As per the JD-R, the job demands of healthcare professionals are best combated by the availability of job resources (Demerouti and Bakker, 2011). Such 'job demands' include high workload, low staff-patient ratios, scarce resources, job pressure-high stress environment, while 'job resources' include structures or systems that provide workers with management support, participation in budget and resource allocation, job autonomy, wellness programs, and

training and development programs to suit the needs of the different healthcare professionals (medical professionals versus nurses).

In this paper, the key organisational mechanisms form part of the 'job resources' component of the JD-R model. It therefore follows that employee voice is manifested through organisational mechanisms of resourcing, decision making and culture, and these 'job resources' can influence employee engagement. The paper explores the voice arrangements within a semi-rural hospital and its impact on engagement levels. Particular attention is given to the level of input of healthcare professionals have in matters concerning resource allocation, decision making (especially financial budgeting, and training and development) and organisation culture. This is depicted in Figure 1.

## METHOD

The study uses a single case study approach as it enables greater depth and richness to examine the 'causal links in real-life' phenomena, resulting in an insightful linking of causes and outcomes (Yin 2003).

The data sample is treated as a case study of a public health organisation in a semi-rural town, which would enable future researchers to compare and contrast the findings of this research against other potential case studies (Yin, 2003). Thus, the purpose of this research is particularisation, not of generalisation. There is an emphasis on uniqueness and understanding the case itself. The actual data of this research is specific to the semi-rural public hospital context. In addition to the primary data gathered through in-depth interviews, the case study approach was also strengthened with the use of multiple secondary sources (photos of noticeboards in each ward of the hospital, including thank you cards from patients) to triangulate the interview findings and provide multiple measures of the same phenomenon. This assists to generate theory in a dynamic manner by supporting the facts of a case by more than a single source of evidence (Yin, 2003).

*Contextual setting*

The study was conducted within a semi-rural community in New South Wales, known to experience relative levels of socio economic disadvantage. This is reflective of working class, retirees that typically live within a rural setting, and is in contrast to a city based hospital setting comprised of a larger younger working population (Australian Bureau of Statistics, 2016). One important factor to consider is the unique nature and characteristic of semi-rural hospitals, not only in the services they provide but also the role they play in the wider community. That is, they promote health and wellness of the community via building community capacity and improving healthcare access for the disadvantaged rural populations (Mutamba, van Ginneken, Paintain, Wandiembe and Schellenberg, 2013). Similarly, this applies to the role of healthcare professionals within the broader rural community, who may often be depicted as a respected and upstanding figure amongst the local community. Rural hospitals have unique characteristics including their location and size, and often make a significant contribution to the community as a whole. The hospital is also often the largest employer in the community.

The semi-rural hospital in this study (220 beds) offers a range of services and sits within a larger health district with eight other hospitals, one of which was a major regional referral centre (i.e. the corporate headquarters). At the time of the data collection, the organisational structure typically included the chief executive with 5 executive directors reporting to the chief executive (Tier1 management level). The next hierarchical level included the clinical division co-directors and the speciality directors (Tier 2 management level). The next management level included the professional leads and the hospital hub general managers (Tier 3 management level). The individual hospitals then had their management staff reporting to the hospital hub general managers (Tier 4 management level).

The leadership and organisational structure varies to that of a city based hospital. The administrators in a semi-rural hospital typically have several portfolios. In this case, each

hospital and community centre located within the district has a site manager that provides operational oversight of their facility. However limited financial and human resources has necessitated a different structure. That is, strategic decision-making and financial delegation sits at a central level. Each site manager reports to a district-wide position that manages both the operational and strategic arms within their portfolio, and includes some smaller facilities. This district-wide senior management position reports directly to the Chief Executive. In addition to the operational district position, there are district-wide clinical-leadership positions that provide input into the strategic plan for their respective clinical streams (such as surgical, general medicine or cancer). However, these positions are strategic only, and have no operational role; this is assigned to the facility managers. This type of organisational structure means that budget allocation occurs at a district level, rather than at the hospital (or organisational) level.

*Recruitment of participants*

Senior management at the semi-rural hospital emailed all staff indicating that an independent research team would be conducting a study on employee engagement. A research assistant visited the hospital two weeks before conducting the scheduled day of data collection and placed posters advertising the research project in each of the divisions. Visits to the hospital were made over five days to cover most staffing rosters and promoted participation by providing refreshments. Survey data (n=106) was collected on site using IPads (online survey) which included questions on workplace wellbeing, engagement, intention to quit and job satisfaction. The participants of the survey were approached (after completing the survey) to identify if they were willing to be interviewed. This paper only focuses on the interview data collected during the 5 day data collection visit. A combination of a convenience and purposive sample approach was used, which consisted of 16 interviews (15% of the survey participants) with nurses (including 3 Nursing Unit Managers, who are in charge of the nursing staff in each

unit), doctors and management staff, to gain as many diverse perspectives from all occupations as possible. Typically, each shift a 200 bed hospital is staffed by about 40 doctors and 250 nurses and is run by 2 senior managers, who were clinicians prior to taking leadership positions.

During the research process, researchers remained in 1 division/unit each day and managed to cover 5 divisions/units within the busy hospital in the 5 days of data collection. In each division, typically there were about 3-4 doctors and 25 nurses on duty. Researchers also faced the challenge of gaining consent from participants who were willing to participate in an interview during their busy shift at work. According to Patton, (2002) there are no rules for sample size in qualitative inquiry and the size depends on the purpose of the research, the credibility of the participants and what can be done with available time and resourcing. As such the sample size can depend on the fewest number of interviews needed to have a good understanding of a given phenomenon (Glaser and Strauss, 1967). We maintain that we were able to understand how semi-rural based organisational resourcing, decision making and culture impacted the voice and engagement of some of the elite participants including senior managers, Nursing Unit Managers and the doctors within a small semi-rural hospital within a limited time frame and resourcing capacity.

When a case study approach is used, Creswell (2007) typically recommends conducting between 12-25 interviews with research participants. Glaser and Strauss (1967) notes that most of the data saturation occurs by the twelfth interview. We similarly experienced that theoretical saturation was achieved when the later interviews reconfirmed the previously disclosed challenges, factors that influence their engagement and voice in the semi-rural hospital context. This suggests that the interview sample size was sufficient for the needs in this study and there were no new properties revealed about these themes and thus there is no need for collecting more data (Hood 2007).

The participants included six doctors (four males and two females) including visiting medical officers, staff specialists and doctors in training, clinically trained management staff (male and female) and nursing staff (eight females) ranging from nursing unit managers to registered nurses. The sample is typical of the staffing profile in a hospital setting. For instance, over half of the 450 000 paid health professionals in Australia are nurses, 12% are medical professionals, and 74% of health workers are female (Armstrong et. al., 2007).

*Ethics and data collection*

Ethics approval was received from the local health district and the university to conduct the study. Researchers also ensured that the participation in the interview was entirely voluntary, having the option to withdraw from the study at any time and withdraw any data that has been gathered to that point. The potential participants were informed that no identifiable information was sought and that the interview can take place at their workplace or a venue of their choice, at a time that suits them. Participants were also informed that interviews would be audio-recorded and transcribed (of which participants could request a copy so that they had the opportunity to delete parts, add information, or make changes). The interview was approximately 40 minutes in duration, involved questions around 1) typical workday challenges, 2) factors that positively influence performance in their job and why, 3) factors that influence their job negatively and why 4) support they require from the organisation to be more productive and progress in career, 5) HR practices that deter or motivate and support to do the job, and 6) strategies recommended to promote staff engagement, career development, retention and quality of work life. It was important to note the time constraints for conducting interviews within a small hospital. Typically, the participants (doctors and the nurses) were in the middle of their busy shift and agreed to do the interview whilst managing their patient care duties. The senior managers were constantly required to 'fire fight' operational scenarios and to support and advise various division heads. Consequently, researchers were required to be

flexible and adaptive to the place and timing of the interview, as at times the participant would need to attend to an urgent task before recommencing the interview. Obtaining an agreement to be interviewed within their busy day shift was challenging and depended on various scenarios that were beyond the control of the interviewer and the interview participants. Given these limitations, conducting 16 interviews is a sufficient sample size that is deemed representative of the doctors and the nursing staff at this hospital. The interview was conducted as a friendly informal conversation using a semi-structured interview protocol with the interviewer triggering further questions based on the answers given by the participant.

**DATA ANALYSIS**

This research made use of codes, memo writing and integrative diagrams to analyse the data. Codes help to set up a relationship between the data and the research respondents and to 'capture patterns and themes and cluster them under a "title" that evokes a constellation of impressions and analyses for the researcher' (Lempert, 2007, p.253). The interviewer conducted the first round of coding immediately after the interviews were completed to ensure that the tacit information of the participants and the interviews with each participant was fresh in their mind. With permission from the relevant unit managers, photographs were taken of the notice board announcements (the visions and mission statements, the counselling services available to staff) and the thank you cards from patients. These artefacts were used as a way to triangulate the cultural values and to understand the contextual issues that are being faced by the healthcare professionals in their daily work life. In addition, the interviewer/researcher kept observational notes as part of the interview process to make sense of the contextual issues. Observations provide the ability to explore various aspects of workplaces, examining them in relation to each other and within its total environment (Gummesson 2006). The interviewer/researcher also kept notes of the interactions of the staff within departments and between departments. Observations about how clinicians and administrators treated and

communicated with each other become useful in deciphering the content of the interviews. Subsequent to the interviews, one of the authors manually conducted open coding to identify and describe phenomena in the interview transcripts (Strauss and Corbin, 1990) and then reflected on the results with another researcher who was part of the health district to clarify the meanings and phenomena identified in the interview transcripts.

Next, axial coding was used to identify the connections between various codes and to construct particular themes and categories (Strauss and Corbin, 1990). This was conducted jointly by two of the authors across several days throughout a six month period as part of a reflective dialogue, in order to compare and contrast the individual coding analysis. The interviewer's memos were continuously corroborated with the meanings and information with some of the employees of the hospital, enabling the authors to clarify and make sense of the connections about the contextual and policy-based issues facing the health district. It also enabled us to adopt an interpretivist approach to data analysis as we analysed the data in relation to the health district's history, structure, and power relations, consequently helping to shape the data collection, analysis and interpretation in a way that is open to unexpected meanings (Elliott and Timulak, 2005). For example, the original focus of the research was on levels of engagement of the staff, and less so on employee voice concerns.

The interpretivist approach helped us to use interview data in combination with observational methods (including photographs of the context and observational notes) to interpret the data in a more grounded manner. For example, it helped researchers explore contextual issues and explore more in-depth issues and understanding of factors affecting employee engagement. Consequently, two of the researchers were able to create meaning by validating the coding and analysis by having a constant reflective dialogue with various actors in the organisation at various times during six months. This permitted a constructive critique of the interview data. Being open to reassessment of the interpretations gives power to the

research participants and actors within the research context (Elliot and Timulak, 2005). See Figure 2: Sample coding and themes.

**FINDINGS**

As per the interpretivist approach, when understanding patterns in data and developing themes, we continually reverted to the literature to generate meaning of the data. Based on the review of the literature, this study considered how resource allocation, decision making and culture facilitated or hindered employee voice and engagement. How we made sense of these relationships is discussed below.

*1. Resource allocation and its impact on employee voice and engagement*

Since the semi-rural hospital operated under a centralised resourcing model, most of the clinical support services previously located at the regional hospitals were now operating centrally from the main hospital. For example, the quality manager was moved to a central office, instead of being located on site. The purpose was to pool the expertise centrally and allow for even workload distribution and efficient workload rostering. However, the lack of physical presence of expertise resulted in the unintended expansion of administrative responsibilities of unit managers, such as the nursing-unit managers.

> All of those support services that used to be on site are no longer here. So the NUMs [nursing-unit managers] are the ones to take that over. It is [that] the support systems have been taken away and things gradually being added to a NUM's workload. Interview 7 (Nurse)

Overall the doctors and nurses agreed that the centralised resourcing structure disadvantaged the semi-rural hospitals, resulting in feeling unsupported and unable to maximise the use of their skills at work. Generally, nursing staff were more concerned about the increase in workload and the lack of resourcing available, while doctors were more concerned about the lack of resourcing to support professional development and the non-personalised nature of the training programs.

Unequal resource allocation of the budget for the semi-rural hospitals was one key issue that staff highlighted as a concern. A national case-mix funding model is used to allocate resources in health. For example, in the district which this case study belongs, 60% of the operating budget was allocated to the major regional referral centre/hospital, a further 30% was allocated to the other eight hospitals, and community-based services received the remaining 10%. Frontline staff expressed concerns with this costing model. There was a strong feeling that much of the organisational resources were diverted to the major regional referral centre/hospitals and that the semi-rural hospital resourcing needs were neglected.

> There is a real inequity in the way the resources are managed with everything, whether it is staffing, equipment [or] process. It is so city-centric that the whole rest of the state is impaired by that. I have not seen that anywhere else. Interview 1 (Doctor)

The perceived inequity in resource allocation seemed to be further exacerbated by the fact that the financial targets are also set centrally, with no consideration of current resources in semi-rural hospitals and no input sought by semi-rural hospital staff.

> Targets have been set for this financial year for surgical performance, a 22% increase in targeted activity from last year. [This is determined by] the Ministry of Health and the District based on what we have on our waiting list. But no extra resources to do it, so a 22% increase in activity; you just cannot do it with the same resources. Interview 8 (Managerial role)

The above evidence is consistent with research by Hallberg & Schaufeli (2006) and Schaufeli and Bakker (2004) who state that managers should direct their initiatives by increasing the involvement of employees in the everyday practices of work and budget allocation. The implementation of financial targets without employee consultation within public health departments can negatively impact employee engagement. The effects of this decision-making can also be understood through the concept of participative goal setting and an employee's direct involvement in goal setting (Erez and Arad, 1986, p. 591). Erez and Arad (1986) revealed a link between participative goal setting and its effects on an employee's

performance, goal acceptance and overall satisfaction. This suggests that hospitals should provide employees with opportunities to develop their own goals/targets as this will likely achieve higher levels of commitment and performance.

The centralised model was also used for training purposes, changing the delivery of training to a "one-size fits all" approach for all hospitals in the entire state of NSW. To help reduce costs, training processes were streamlined with a state-wide centralised e-learning platform replacing face to face training. However, this change in training delivery was not received well by staff in the semi-rural hospital, due to the lack of consideration of local requirements. There seemed to be lack of support for ongoing training and education for senior health professionals and lack of replacements to allow senior staff to take time off to participate in ongoing education and training.

> For visiting medical specialists, the first thing you notice is that unless you are prepared for it yourself, in terms of money and time, you are going to struggle. So I think there needs to be some facility in the system to enable and encourage people to go and learn. It is certainly not at the moment. Interview 5 (Doctor)

Participants noted the importance of ongoing training and development and expressed that while the individualised online modules may be cost-effective, they do not deliver the results intended for ongoing staff training and development. Further, the online training approach was found to reduce peer learning and the interactive nature that occurred with face-to-face teaching sessions.

> There is now this huge requirement at a state level to tick boxes to say that everybody has had this mandatory education. And instead of bringing us together as a team, like we did when we used to meet once a year for a one-day update, when we met with different colleagues in different areas/wards, which was a really good thing to do– instead of meeting in that environment, they tell us we have to sit at a computer and go through a whole lot of modules. We do not want that. We want to talk to someone! Interview 15 (Doctor)

This response highlights that training programs within the rural hospital are focused on an administrative, tick-the-box structure restricts employee interaction and the benefits of a

collaborative face-to-face learning environment. This is in contrast with research evidence which suggests that training programs should enable employees to share their experiences and facilitate learning (Purcell, 2012) and that job resources that enhance learning and autonomy can buffer the impact of job demands, and can potentially motivate staff when job demands are high (Hu et al, 2011). The importance of training programs is also highlighted by Anitha (2014) as they can go beyond merely improving employee performance; instead it can develop employee motivation, confidence and engagement.

*2. Decision making processes, culture and its impact on voice and engagement*

The interviewees indicated that the culture of the hospital was quite distinct, but closely resembled hospitals that sit within a larger organisational structure. The majority (over 90%) of the interviewed participants described the district's organisational culture as bureaucratic and concentrated around the major regional referral hospital (i.e. the corporate headquarters). These interviewees felt they had very little flexibility to adapt their practices and policies to suit the needs of their patients. Instead, semi-rural healthcare practitioners were typically handed down solutions from the regional referral hospital, and often deemed irrelevant to the needs of the semi-rural hospitals.

> It is too hard to do anything. There are so many rules and regulations that you cannot actually make any decisions. It is also too top-down, with not enough delegation. To me, it seems everything that should be delegated is not, and everything that should not be delegated is. One of the things that are really difficult as a rural emergency specialist and a rural director is the lack of support. You are completely on your own. All the resources in the world are being pulled into these central city places. Interview 1 (Doctor)

Since the semi-rural hospital facility accounts for a relatively small percentage of the operating budget, the financial focus and decision-making tend to be largely influenced by those hospitals whose services and operations have a greater impact on the overall budget. As a consequence of the bureaucratic approach to communication and decision making,

interviewees expressed a sense of helplessness or lack of voice concerning work issues, particularly regarding input into resourcing, planning and decision-making. This resulted in reduced staff motivation and involvement as employees believed that their efforts would result in failure. Consequently, this caused a level of disengagement by employees. Participants expressed that a lack of voice, an increase in policies, processes and regulations and reduced resources as contributors. This is in contrast to current research evidence which espouses an emphasis on "employee voice that is achieved through increased communication, meetings and consultation amongst employees and managers", to achieve more engaged staff (Purcell, 2012, p.14).

Many of the interviewed participants felt that the regional referral hospital seemed to make all the decisions and have the authority, while those in the semi-rural hospital had little say about issues concerning their work roles and the work context.

> If there is a significant issue in a major teaching hospital, they will get priority over a smaller hospital purely and simply because they speak louder. I think it is a common problem and is difficult to deal with because it means a lot of resources need to be put into regional centres, [which have] constricted budgets. Interview 5 (Doctor)

The lack of input seemed to be aggravated by the fact that they felt that the solutions or policies were pushed from central administration without any understanding of whether these policies and procedures were suited to the semi-rural hospital context. The delivery of unsuitable policies further alienated the participants.

> [What bothers me is] that admin...sit down there and make all the decisions about what goes on in this ward but never come around and see what is going on. It is all about how quickly you can get a patient out of the hospital. – Interview 16 (Nurse)

Generally, the participants exhibited a shared system of meaning-making that their unique regional and semi-rural contextual needs are generally not taken into consideration by the referral centres. Participants also indicated that the central decision-makers make the clinicians feel incompetent and not worthy of contributing their own ideas. This appeared to be

causing a level of disengagement amongst staff. Overall, both nurses and doctors seemed concerned with how the bureaucratic processes not only inhibited their ability to have a say but also made them feel incompetent and undervalued.

> We need to have more say with what happens here. We are directed from the north, who basically have a culture of believing that we are incompetent down here, that we do not know what we are doing. Interview 7 (Nurse)

This finding is consistent with Maslach and Leiter (1997, cited in Cho et al. 2006) who identify six categories known to influence employee engagement; workload, control, reward, community, fairness and values. In this regard, control relates to the level of decision making and autonomy amongst employees. Further, a study of graduate nurses conducted by Cho et al. (2006) revealed that a lack of decision-making and autonomy could result in employees accepting the status quo, and therefore reduce engagement levels.

*3. Voicing concerns over work demands and its impact on engagement*

Nursing staff expressed particular concern about the increasing trend towards having more patients with high dependency than usual in the semi-rural hospital. Currently, the semi-rural hospital uses a ratio of 1 nurse to 5 patients. However, this ratio does not take into account the level of dependency or need of care required by the patient. As a result, on several occasions, nursing staff felt increased pressure to take care of a greater number of high dependency patients without the appropriate adjustment to support.

> The patients are far more high dependency than they used to be. They look at the number of patients per nurse and not at what kind of patient they are. The nurses here are run off their feet. Not all hospital use ratios. This one uses ratios. Currently, it is from 1 to 5. They do not look at how sick they are. It only takes one patient to make you very busy. – Interview 16 (Nurse)

Workload pressure was also raised as an issue by the doctors, who noted the importance of patient safety as well as safety for the doctors. In particular, there seems to be an increased

level of pressure on junior doctors to work long hours, which is likely to result in poor outcomes for their own wellbeing as well as for patient care.

> The expectation that you will work a 12-14 hour day is accepted as normal. I refuse to do a 14-hour day. But not everybody is able to say no. A lot of junior doctors just believe that they have to do it, so they do it. They believe that in order to get career progression they need to satisfy what they are told. They do not cope. They get frustrated, they get angry, they get stressed, they get depressed, and they get alcohol and other drugs. Patient care suffers. But this is not new. – Interview 14 (Doctor)

Silence amongst staff was also an issue as healthcare professionals were too afraid to speak up about their own problems for fear of embarrassment and reputational damage. The results of the interviews also indicated that that healthcare professionals also struggle with managing their own wellbeing when experiencing high workloads. This situation was further exacerbated since working in a semi-rural area meant that their own privacy is harder to maintain. That is, participants felt inhibited in seeking help to cope with their own stress or psychological wellbeing for fear that others in the small rural community would find out about their personal and private matters.

> I think there does need to be more assessment of how people are coping with their stress-related issues. One of the major issues is, at the moment, for the system is that it tends to be very adversarial with how they deal with those issues. People, therefore, are more encouraged, or think they are encouraged, to hide their problems rather than display them because there is nothing in the system that is going to allow a doctor, for instance, to go along to somebody and say 'listen I have a problem here, and I need to be fixed', and that is not helped by the fact that everyone knows everyone else so it can't be kept a secret. I honestly think most medical staff probably know when they are getting into trouble; they just hide it. – Interview 5 (Doctor)

Healthcare professionals are typically deemed an upstanding member in their community, often playing a more significant role in the broader community and relations with community members likely to be more familiar and intimate. Therefore this risk of exposure is likely to deter such healthcare professionals from seeking help to cope with stress or any personal emotional or psychological trauma that they may experience.

Similarly, peers also showed reluctance to acknowledge or offer support to their colleagues who are showing signs of distress, for fear that it will become known to all within the local community.

> We are not encouraged to interfere in their colleagues' lives because once again it seems adversarial. So I think it is a different concept, but I think the only way to get around that one is to get outside the area where they're at. The only real way you could do that, particularly in areas where everyone knows everyone else, would be to have outsiders/external people doing that. That way it would be less likely to become a problem internally. – Interview 5 (Doctor)

That is, in a small rural community, maintaining confidentiality poses a far greater challenge than in urban settings because healthcare professionals work and live in the one same community. The intermixing of personal and professional role boundaries became a constant reality in the lives of this cohort. Rural practitioners' lives were a continuous negotiation and renegotiation of boundaries between the work and personal space, with little opportunity to express their ideas or concerns due to lack of perceived organisational support and psychological safety. Thus, many of the doctors seem to struggle with having limited access to resources to manage their own stress and emotional wellbeing at work. Although general counselling services are offered to all staff members through the employee assistance program, this may not be ideally suited to healthcare professionals situated in a small rural or country town. This poses additional challenges for hospital management, as evidence shows that an employee's health and wellbeing is linked with engagement levels (Robertson, Birch and Cooper, 2012).

## DISCUSSION AND IMPLICATIONS

This study explored how organisational mechanisms impact employee voice and its consequences for engagement, using a case study of a semi-rural hospital in Australia. Focus was on decision making processes, resource allocation and organisational culture as conditions which serve to foster employee voice. The findings indicate that the centralised resourcing

approach of the semi-rural hospital gives primacy to the pursuit of capitalising on efficiencies, with no concerted efforts to achieve organisational goals through a highly involved and engaged workforce. This is largely due to the expectation of senior management to be fiscally responsible.

Evidence from this case study found a lack of opportunity for healthcare professionals to participate in some aspects of their work or the organisation, despite often expressing a desire to be part of the decision making processes. What was deemed most important by participants was having a voice in matters that affect their work, particularly regarding resource allocation, as well as their personal wellbeing. The challenge in balancing their job demands while also looking after their wellbeing was further complicated by the perceived lack of privacy associated with living in a semi-rural town.

The study also found that the centralised resourcing model, where much of the resources are sourced from the larger sister hospital, fails to give due consideration to the specialised services provided by semi-rural hospitals to address patient needs as well as staff needs. This approach to resourcing consequently led to a lack of staff involvement, autonomy and voice in workplace decisions that directly impact their work. Participants expressed the value they place on being given opportunities to voice such needs and concerns helps to combat the various work demands. Indeed, past research has found that lack of employee participation in decision making reduces employee engagement and commitment (Schaufeli and Bakker, 2003; Schaufeli et al., 2008), consequently increasing employee turnover. This further exacerbates the existing problem of staff retention within rural healthcare sector.

Within the context of a semi-rural health facility that sits within a centralised management structure, employee voice may be overlooked or diminished in importance, due to the operational issues facing the health service as a whole. If the semi-rural hospitals are given fiscal responsibilities for their own operations, this is more likely to lead to greater

employee participation and better organisational outcomes. While it could also be argued that that this is likely to increase staff work load (ie. more job demands) rather than alleviate their constant battle for resources and time, participants strongly expressed a preference to be involved during key moments of decision making and resource allocation, as they could see greater benefits and efficiencies be gained if decisions incorporated appropriate input from staff. Therefore, we confirm that employee voice serves to act as a resource to mitigate work demands. This is especially the case in a semi-rural hospital context due its unique setting, patient demographics and consequently the additional challenges its presents to staff and their wellbeing.

This case study also contributes to the voice literature by highlighting it is not sufficient to consider only the working context when analysing variables that shape voice and engagement. The semi-rural context of this hospital identified how the external environment also impacted on staff's ability to demonstrate a voice at work. For example, in a small community where everyone knows each other, concerns about keeping up appearances of professionalism and being an upstanding member within the community outside of work also shape concerns about their ability to voice their concerns while also maintaining their own privacy and confidentiality. The study identified the need to cater to the unique needs of workplaces in rural or remote settings, by providing context-suitable voice mechanisms for staff to better manage their own stress and wellbeing at work. This finding is a unique contribution to the voice and silence literature, providing a new platform and impetus for future research looking at the stigma attached to voicing concerns in rural workplaces.

While the findings of this research are specific to a semi- rural public hospital context, they also have relevance for the broader healthcare sector, and also for larger organisations whose operational structure involves subsidiary firms. The study identified that a perceived inequity in how resources were allocated to the semi-rural subsidiary hospital was the result of

little or no opportunity for staff to have a voice. The findings indicate that staff were more likely to experience greater levels of engagement if they were able to participate in decision-making that affect their day to day practices. These findings are consistent with the JD-R model, which stipulates that employee voice is an important job resource for achieving higher employee engagement levels.

*Implications for theory and future research*

This paper identifies the lack of distinct recognition of 'employee voice' as a 'job resource' within the JD-R model. We propose that employee voice be viewed as a distinct job resource, and in itself has a direct influence on employee engagement. The findings suggest that future research explore the notion of employee voice within the JD-R model in more depth. Firstly, we propose that employee voice is given a more prominent and distinct role within the model, as currently it is subsumed amongst a variety of concepts (such as participation in decision making, team climate, social support, performance feedback, role clarity and job control). Secondly, we suggest that voice be not only considered as a resource under 'job resources' but as an additional component within the JD-R model more broadly. That is, employee voice transcends both aspects of the JD-R model, being 'job resources' and 'job demands'. Indeed employee voice may also serve to mitigate 'job demands' and the negative impact on engagement. We therefore put forward the question "is employee voice only a job resource?"

There is also scope for exploring the above suggestions both qualitatively and quantitatively. Qualitatively, we can extend this current study into other industries and occupations for comparative purposes. From a quantitative approach, future research may focus on developing an instrument to identify and measure employee voice. Further research could also explore the moderating or mediating effect of employee voice using the JD-R.

*Implications for HR policy and practice*

The findings of this paper suggest there is a need to reconsider how an organisation's human resource policies and practices can ensure employee voice is manifested through an organisation's resourcing and decision making mechanisms and culture. Indeed, the current centralised resourcing model assumes away any consideration of employee voice, despite the fact that it could serve management with decision-making to achieve greater efficiency and productivity (Budd, Gollan and Wilkinson, 2010) . Organisational mechanisms that enhances the job resources and fosters a culture that values employee voice is more likely to lead to positive outcomes such as higher employee engagement, better patient safety and improved staff wellbeing (Cropanzano and Mitchell, 2005). Following research by Dundon, Wilkinson, Marchington and Ackers (2004), this paper suggests a move away from a centralised resourcing model, toward the development more localised organisational mechanisms to serve the unique needs of rural and semi-rural hospitals. Voice needs to be expressed through a partnership between management and hospital staff aimed at securing long-term viability and sustainability for all.

The study also highlighted the practical consequences for subsidiary organisations in small towns, particularly in relation to wellbeing issues. This paper suggests that senior managers develop an organisational culture of high trust by providing a form of psychological safety for staff to feel safe and supported to communicate and report concerns for the health and wellbeing of themselves and their colleagues. This is especially within a small community setting, where emotional exhaustion extends beyond the workplace and into the community. In order to generate a sense of support that will mitigate the deleterious effects of emotional exhaustion in a semi-rural environment, management needs to focus on improving organisational culture that will build interpersonal trust within the organisation. This could also be addressed through employee empowerment practices and the development

of pre-emptive interventions and preventative strategies which are in line with the Mentally Healthy Workplace agenda (NSW Government, 2018).

Corrective interventions could focus on developing formal reporting or communication training (Tarrant, Leslie, Bion, and Dixon-Woods, 2017) for the current decision-makers, to raise their awareness of the current issues and challenges confronting semi-rural hospitals. Furthermore, it might be important to facilitate training and development opportunities to develop the skill set of semi-rural healthcare professionals to speak out and speak up (Tarrant et al., 2017), via effective communication strategies such as using graded assertiveness (Okuyama et al., 2014), communicate across hierarchies and boundaries (Brindley and Reynolds, 2011) and optimise semi-rural subsidiary staff engagement within high risk settings (Orasanu and Fischer, 2008).

## CONCLUSION

Australia's public hospitals are constantly struggling to meet patient demand with limited funding. These demands are placing increased pressure on healthcare professionals and their engagement at work. These demands can be combatted by providing employee voice through the appropriate resourcing and decision-making mechanisms and culture. This is especially the case with staff in semi-rural hospitals as they are presented with different and more challenging daily work challenges to larger city based hospitals. Human resource practices need to encourage employee voice within the entire health district, including semi-rural areas.

We propose that the JD-R model gives more recognition to employee voice and explore its role and impact on employee engagement. We question whether the impact of voice transcends any work context, and whether it can be understood as separate to the job resources component under JD-R model. Future research needs to assess whether employee voice is a key influential factor (moderator) of employee engagement. Finally, this case study highlights the practical consequences for larger organisations operating in various locations and in

different contexts. HR policy and practice need to ensure that resourcing, decision-making mechanisms and culture also cater to the unique needs of smaller subsidiaries and use voice to provide the necessary support to healthcare professionals but also act as a conduit to form a genuine partnership between management and hospital staff to reach organisational goals.

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**Figure 1: Organisational mechanisms in a semi-rural Australian hospital using JD-R**

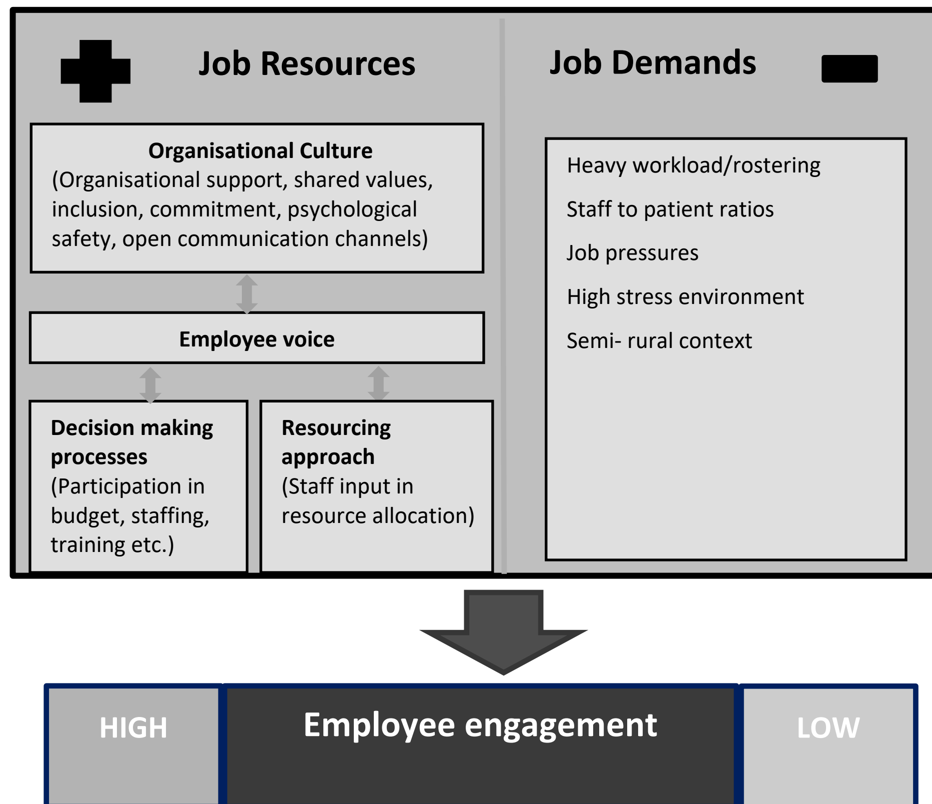

**Figure 2: Sample coding and themes**

| **Theme:** *Resourcing challenges semi-rural healthcare professionals' experience* |
|---|
| **Code** – Centralised resourcing approach imposed on semi-rural hospital (Sample interview quotes from interviewee 1 and 7) |
| **Code** - One-size fits all approach to resourcing (Sample interview quotes from interviewee 5) |
| **Code** – Perceived inequity in resource allocation (Sample interview quotes from interviewee 8) |

| **Theme:** *Lack of semi-rural healthcare professionals' involvement, autonomy and voice in workplace decisions* |
|---|
| **Code** – Head office handing down solutions that are not suited to needs of semi-rural hospital (Sample interview quotes from interviewee 1) |
| **Code** – Lack of authority to make decisions at semi-rural hospital level (Sample interview quotes from interviewee 5) |
| **Code** – Lack of participation in the centralised decision-making process (Sample interview quotes from interviewee 16) |

| **Theme:** *Healthcare professional's inability to voice concerns about workload/ stress and maintain confidentiality in semi-rural settings* |
|---|
| **Code** – Coping with stress (Sample interview quotes from interviewee 14) |
| **Code** – challenges of managing confidentiality in small rural or country town (Sample interview quotes from interviewee 5) |