OLSZTYN ECONOMIC JOURNAL
Abbrev.: Olszt. Econ. J., 2014, 9(3)

BEHAVIOR OF HOSPITAL MID-LEVEL MANAGERS IN BUDGETING IMPLEMENTATION – AN EMPIRICAL STUDY

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K e y w o r d s: hospitals, budgeting, managing change, Lewin's model, middle-level managers.

A b s t r a c t

This study examines the introduction of management changes in a hospital based on the Lewin's model. It focuses on the attitudes of a hospital's mid-level managers to a new management-budgeting system. The conclusions are based on empirical research. The article analyzes the change implementation process related to the budgeting system in a hospital with particular consideration of the attitudes and the level of involvement of employees in the performance of new tasks. The analysis showed that the top management of hospitals and the mid-level management do not see the effects of changes related to budgeting in similar ways. This may cause significant hindrances to the process of employees adopting attitudes and behaviors required by the top management. The diversity of opinions in this area may result from: not specifying in detail the targets of budgeting by the top management or not informing the medium-level management of them, a lack of set measures for evaluation of the performance of budget tasks, aiming at achievement of the assumed targets by means of methods not accepted by the employees.

POSTAWA ŚREDNIEJ KADRY KIEROWNICZEJ W PROCESIE WDRAŻANIA BUDŻETOWANIA – STUDIUM PRZYPADKU

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S ł o w a k l u c z o w e: szpitale, budżetowanie, zarządzanie zmianą, model Lewina, średnia kadra kierownicza.

Abstrakt

Celem artykułu była ocena postawy średniej kadry kierowniczej szpitala w procesie wdrażania systemu budżetowania na podstawie modelu Lewina. Stopień zaangażowania pracowników szpitala w realizację nowych zadań związanych z wdrożeniem budżetowania oceniono na podstawie badań ankietowych przeprowadzonych pośród kierowników działów, ordynatorów/koordynatorów oddziałów oraz pielęgniarek oddziałowych. Analiza wyników wykazała, że efekty zmian związanych z budżetowaniem nie są dostrzegane w podobnym zakresie przez dyrekcję szpitali i średnią kadrę kierowniczą. Może to istotnie utrudniać proces identyfikacji pracowników, polegający na przyjęciu postaw i zachowań pożądanych przez naczelne kierownictwo. Zróżnicowanie opinii w tym zakresie może wynikać z: niesprecyzowania celów postawionych przed budżetowaniem przez dyrekcję lub niepoinformowania o nich średniej kadry kierowniczej, braku ustalonych mierników oceny stopnia realizacji zadań budżetowych, dążenia do osiągnięcia założonych celów metodami nieakceptowanymi przez pracowników.

Introduction

Currently, health care institutions are undergoing a period of rapid transformation (SCROGGINS 2006). Particular focus is being placed on quality improvement coupled with a simultaneous decrease in costs (WEST 1998). The skills of adjusting to the new conditions are the basis for the successful implementation of any changes in a business entity. They are particularly important for a health care institution where implementation of new solutions requires an awareness change from both the management and the entire staff. This requires a crucial role to be played by the physicians, with particular focus on the heads of departments who supervise treatments and organize the work in the department. It also requires the engagement of nurses and, above all, the nurse leaders and department managers (ROEMER 1996, EMBERTSON 2006). In the majority of hospitals, each of those groups reacts differently to the changes made in both the area of administration and in the realm of medical procedures (WEST 1998, GROSS et al. 1996). Budgeting as a management tool aims at supporting the management in taking decisions and establishing mechanisms for effective management of the institution. In practice, this is manifested through supporting the performance of the basic management functions, i.e. planning, informing, motivating and controlling. Entities which have implemented a budgeting system use it, first of all, in an administrative manner, for coordination of activities by individual hospital units, planning the demand for material resources and analysis of the planned profitability of the hospital and individual centers of responsibility (CYGAŃSKA 2007). The effectiveness of budgeting depends on its successful implementation. The aim of this article is to analyze and evaluate the change implementation process related to the budgeting system in a hospital, with particular consideration of the attitudes and the level of involvement of employees in the performance of

new tasks. This paper includes an empirical study, conducted between October 2011 and December 2011. The study involved four Polish hospitals within the same region which were identified by the letters *A*, *B*, *C* and *D*. The choice of the sample hospitals was deliberate. They were all institutions in which the managements had consented to the study and had implemented modern management and budgeting systems.

Background

Human resources, along with natural and capital resources, play an important role in the functioning of an organization (*Zarządzanie zasobami ludzkimi*... 2006). This results from the fact that the people determine in which way all the other resources of the institute are used. It should, however, be pointed out that this resource includes not just the people themselves, but also their knowledge, skills, health, attitudes, values and motivations (POCZTOWSKI 2003). The crucial role of the employees in this process makes it vital to select appropriate human resource management methods and instruments. Human resource management is defined as the personnel functions of the organization, whose task is to adjust the characteristics of human resources to an organization, harmonized with the needs of employees under specific external and internal conditions (*Zarządzanie zasobami ludzkimi*... 2006). This notion is also defined as the systematic undertaking of various activities aiming at unifying the organization as it concerns the implemented strategy, existing culture and the dialogue between the managers and employees of the unit (PEI et al. 2004). In the subject literature, two approaches to human resource management are highlighted: the „hard" and the „soft" approach (*Zarządzanie zasobami ludzkimi*... 2006). The „hard" human resource management approach encourages the selection of employees for the organization based primarily on the cost criterion, combined with work quality and productivity. Attention is also drawn to minor participation of the employees in decision making. The „soft" approach, on the other hand, highlights the importance of communication and motivating employees, as well as aiming at balancing the individual needs of the people with the needs of the organization. The modern approach to human resource management that should be reflected in health care institutions requires assuming the perspective of the interests of different internal and external groups in the implementation of actions related to personnel management (POCZTOWSKI 2007). The choice of the appropriate approach to HR management is of particular importance in the process of organizing work at hospitals. This is related to high diversity in the employment

structures at those health care institutions considering education, functions and influence of employees on the quality of services provided.

Three basic groups of personnel can be identified in hospitals:

– medical personnel: doctors, nurses, midwives, medical technicians, rehabilitation personnel;

– technical personnel: attendants, moving personnel, employees of technical departments, service personnel (kitchen, laundry);

– administrative personnel: management staff, employees of accounting, marketing, etc.

While managing the technical and administrative personnel should cause no difficulties, medical personnel management and development of a methodology for evaluation of employees and motivation systems satisfactory to the doctors and nurses as well as the management is not an easy task. This is related to the linear, strongly hierarchic organizational structure of the hospital where, in numerous cases, a „dualism of competences" exists (JASIŃSKA 2003) and also as a result of the specific role of doctors in the institution. Considering their specialist knowledge and skills, as well as the burden of responsibility, they form strong and influential groups. The professional role of the doctor is one of the three classical professional roles (along with architects and lawyers). It is characterized, among others, by higher prestige in the form of public esteem and a higher level of autonomy in a formal organization, a large need for personal autonomy, status awarded by special scientific commissions, an identification with one's own role and not the organization, conduct by own standards and code of ethics, a feeling of mental comfort in a decentralized organization, a need for permanent education and the performance of work of a conceptual and intellectual nature (HENZEL-KORZENIOWSKA 2003). To manage doctors in an effective way, an employer should consider their specific professional role based, in most, cases not on issuing orders but on skillful conduct of negotiations to gain support for the implemented projects. The process of human resource management at hospitals is additionally complicated by the fact that increasingly often medical personnel are employed by health care institutions on the basis of a civil-legal agreement. The civil-legal agreement, commonly referred to as „the contract", specifies the duration and conditions that cannot be unilaterally amended. This causes not only reduced employment of doctors, nurses, midwifes and other persons practicing in medical professions as employees but also changes the methods of managing the health care institutions. The employment of contractors on the basis of civil-legal contracts also leads to limitation of the power in a hierarchical work system (KUBOT 2001). Due to the continual changes in the legal regulations governing the operation of health care institutions and the contracting of health services, these institutions have been

forced to undergo frequent transformations. Organization transformation is a process aiming at creating and implementing programs of changes to react to new needs and continue effective operation in a changing environment (ARMSTRONG 2006). Most of these changes are operational and, as opposed to strategic changes, they focus on internal systemic, procedural or structural regulations with almost immediate effect on the current work of the personnel. The influence of operational changes, however, may be even more important than that of a wide strategic change and, hence, it should be treated with significant care (ARMSTRONG 2006, KASSEAN, JAGOO 2005). Almost any change in the organization involves the resistance of employees (ASH 2000). Among the major reasons for this situation, the following should be mentioned (ARMSTRONG 2006, KASSEAN, JAGOO 2005, WEST 1998, BAULCOMB 2003): shock caused by the novelty, economic concerns, inconvenience, uncertainty, risk to interpersonal relations, risk to status and skills, concerns related to competences. Preventing or mitigating the build-up of resistance to change among the employees should focus on actively involving them in the processes of change and in-depth discussion of the consequences of the new activities. Achievement of durable changes is not easy and their potential depends highly on how the implemented changes influence the personnel and their perceptions of the changes (HAYLLAR 1995). This gives personnel the opportunity to express their own fears and concerns related to the new situation as well as the feeling of real influence on the shape and scope of implemented changes. The subject literature identifies a number of change implementation models, including the Lewin model (LEWIN 1951), the Beckhard model (BECKHARD, HARRIS 1987), the Thurley model and the Quinn model (BRISSON-BANKS 2010). These models describe the activities that should be undertaken before commencement of change implementation, during the process and after completion – focusing on the role of the employees in the activities related to the transformation. In the subject literature, numerous principles of effective change implementation to minimize the risk of project failure are presented. The following changes should be listed among the major changes required (PENC 2007, KASSEAN, JAGOO 2005): dissemination of the opinion on inevitability of changes, creating and popularizing a vision of the future organization development, presenting real benefits to the enterprise and the employees resulting from the projected change, accurate preparation of the preconditions and stages of change implementation, involving authoritative and trusted employees in popularization of the change, creating a work atmosphere favorable for contacts among employees, openness and mutual trust as well as exchange of information, delegation of authority and responsibility, establishing the adequate motivation system.

Methodology of studies

As indicated by the research conducted by WEST (1998), readiness for change may differ between different professional groups. That is why, for the purpose of conducting the analysis of attitudes and behaviors of middle management under conditions of changes related implementation of budgeting survey questionnaire was targeted at the heads of the departments, department head nurses and managers of divisions at the entities *A*, *B*, *C* and *D*. The questionnaire contained questions concerning the following issues:

– evaluation of conditions for implementation of changes related to budgeting in the hospital and influence of the top management and employees on that process,

– attitudes and behaviors of employees of the subject hospitals towards implementation and operation of budgeting,

– effects of the implemented changes,

– threats resulting from the implemented changes.

The number of employees that returned the correctly completed survey questionnaires and their percentage share in the analyzed professional groups is presented in Table 1.

Table 1

Number of employees at the surveyed hospitals

Staff Hospital	Heads of departments (P)		Department head nurses (N)		Managers of divisions (M)		Total	
	n	%	*n*	%	*n*	%	*N*	%
A	8	48.65	14	100	9	95.52	31	81.39
B	6	37.25	16	76.00	6	85.62	28	66.29
C	12	60.00	15	82.35	8	79.52	35	73.86
D	5	29.25	13	76.25	4	100.00	22	68.50
Total	31	–	58	–	27	–	116	–

N, *n* – number of employees,
% – percent of the professional group
Source: own work

The results of the initial surveys were input and grouped in an EXCEL 97 spreadsheet and were then statistically processed using the Statistica PL software package. The questionnaire questions to the middle management were of a closed type. The respondents were asked to present their attitudes to the options of responses within the limits of individual issues by allocating to them the scores from 1 to 5 according to the scale defined as follows:

1 – I strongly disagree,

2 – I disagree,

3 – hard to say,
4 – I agree,
5 – I strongly agree.

The results of studies were tabulated considering the hospital type and the employee groups, which were marked as:

P – Heads of Departments,
N – Department Head Nurses,
M – Division Managers.

Results and discussion

The budgeting system allocates entirely new roles for doctors, department head nurses and division managers. Although they are not burdened with the responsibility for elaborating the budget plans, they are required to implement them. Under conditions of limited funds, they must endeavor to decrease the level of costs in the individual organizational units.

Doctors, who on one hand decide the health and life of the patients by selecting treatment methods and, on the other hand, must consider the economic consequences of their decisions, are in a particularly difficult situation. Possessing a wide range of autonomy in deciding the treatment procedure and observing the Code of Ethics of Medical Professions, in particular article 11 which states: „a doctor should attempt to perform professionally under conditions that assure appropriate quality of care for the patient", they are at the same time required to achieve the financial targets determined by the top management. Thus, considering the independence and authority of doctors in the process of treatment, as well as minimizing the conflict between the roles of the doctor and the manager, has become one of the major challenges for the top management in implementing changes in budgeting in hospitals. Wider research on the role of the middle level managers in managing a hospital was conducted by TIMMRECK (2000). The conflicts appearing between the doctor and the manager can be of two types:

– individual conflicts (internal) appearing when the doctor simultaneously holds a managerial position (hospital manager, department head),

– social conflicts appearing between doctors and managers who are not always doctors.

The change implementation process was evaluated on the basis of the Lewin model, considering three basic stages in overcoming the resistance of employees against the implemented changes:

– „unfreeze"- achieving a situation that the employees consider the implemented change necessary and acceptable for all,

– „move" – the employees should assume new attitudes through the process of identification and internalization.

– „refreeze" – establishing new and required pattern of behaviors (O'NEILL 1990, LEVASSEUR 2001, SCHEIN 1995).

In first stage, a familiar process is to be „unfrozen". The second step („Move") aims at strengthening all changing forces in order for the change to actually take place. The final step reinforces the maintenance of the newly achieved status quo (SUC et al. 2009). Acceptance of implemented changes by the medical personnel is particularly important as numerous studies have indicated a relationship between the satisfaction with the work done and the quality of services provided (KROGSTAD et al. 2006). Table 2 presents an evaluation of the change implementation process related to the budgeting system. It contains the opinions of the medical staff (doctors, nurses) and administrative staff (division managers) of the hospitals.

Table 2

Necessity of implementing budgeting-related changes in hospitals according to mid-level management (from 1 to 5)

The budgeting system is:	Staff Hospital	P	N	M	Total
Needed	*A*	4.45	4.24	4.70	4.37
	B	4.24	4.20	4.35	4.25
	C	4.24	4.18	3.98	4.17
	D	4.59	4.05	4.24	4.18
	total	4.30	4.17	4.38	4.24
Known to all the employees	*A*	3.36	3.53	3.71	3.54
	B	2.62	2.65	3.20	2.84
	C	2.00	2.55	2.65	2.41
	D	3.18	1.93	2.83	2.31
	total	2.65	2.68	3.25	2.79
Accepted by all employees	*A*	3.00	2.47	2.92	2.73
	B	2.44	2.33	2.70	2.51
	C	2.00	2.49	2.12	2.30
	D	3.18	1.93	2.83	2.31
	total	2.53	2.39	2.76	2.50
Implemented effectively	*A*	3.82	3.26	3.49	3.42
	B	2.92	2.61	3.00	2.84
	C	2.83	2.55	2.39	2.62
	D	2.12	2.12	2.47	2.18
	total	2.95	2.65	3.04	2.80

O – heads of departments, P – department head nurses, K – division managers, D – top management
Source: own work.

The mid-level management staff of three entities (*B*, *C* and *D*) felt that this method of management in hospitals is not known to all the employees. Only in entity A is the knowledge of budgeting principles among the employees at the

moderate level. Since in every entity at least one training program in budgeting was provided, it may indicate either the low effectiveness of the training provided or an inappropriate flow of information between mid-level management and subordinate employees.

Lack of knowledge of budgeting principles is linked directly to a lack of acceptance of changes found in all the entities and was the strongest in hospital *C*. Considering the budgeting implementation effectiveness (total average 2.80), measured by knowledge of the system principles and level of its acceptance in the entity, only hospital *A* (which is significantly outstanding from the others) achieved a positive rating. The implementation activities were ranked the worst at hospital *D*. It is worth highlighting that the opinions of mid-level management concerning the level of budgeting system knowledge and acceptance are similar to those of the top management in the hospitals covered by the study. Only in entity A was budgeting considered implemented effectively, which is probably a consequence of entrusting the development and implementation of the system to a consulting company. The analysis conducted showed that the „unfreeze" stage had not been completed successfully. The belief of the mid-level management in the need for implementation of budgeting was not established and requires strengthening. Additionally, insufficient level of knowledge and approval of the implemented changes by employees was recorded. The direct interviews conducted with the mid-level management indicated that the situation was caused by a too small number of training programs provided during change implementation, excessively frequent modifications of the solutions concerning, above all, the principles of cost accounting for the purpose of budgeting and the scope of responsibility of the mid-level management. The unsatisfactory level of the „unfreeze" process effectiveness resulted in the failure in the next stage of „implementing the changes" involving development of the required attitudes among the participants in the budgeting process (Tab. 3).

The attitudes of employees necessary to achieve satisfactory effectiveness of budgeting-related changes have not been fully established in any of the hospitals. Insufficient observation of budget discipline (average 3.65) and poor adherence to the accepted schedules and timelines (average 3.63) indicate that the process of identification as a factor necessary for effective implementation of the changes achieved a very low level of advancement in all the hospitals. This is confirmed by the high level of work autonomy of the medical personnel – which is fully justified in the medical activities of the doctors but not in other work areas. This is indicated, among others, by the fact that in none of the hospitals is the medical staff actually held responsible for unjustified budgets expenses. Lack of identification of the mid-level management with the goals of the top management makes initiation of the internalization process impossible,

Table 3
Attitudes of the budgeting participants in hospitals in the opinion of mid-level management (from 1 to 5)

Item	Staff Hospital	P	N	M	Total
Work of the entire team, openness and partner relations in solving problems	*A*	4.42	3.60	4.64	4.08
	B	4.20	3.41	4.24	3.83
	C	4.01	3.74	3.98	3.85
	D	4.24	2.70	4.59	3.31
	total	4.18	3.39	4.45	3.81
Personal responsibility for performance of tasks	*A*	4.06	4.13	4.51	4.20
	B	3.87	3.92	4.45	4.01
	C	3.53	4.11	4.51	4.00
	D	4.59	3.37	4.59	3.81
	total	3.89	3.90	4.48	4.02
Maintaining budget discipline in managing budget funds	*A*	3.53	3.18	3.85	3.51
	B	3.68	3.48	3.86	3.67
	C	3.41	3.99	3.45	3.74
	D	4.59	3.18	4.59	3.68
	total	3.65	3.55	3.89	3.65
Adherence to accepted schedules and timelines	*A*	3.53	3.50	3.98	3.69
	B	3.56	3.58	3.72	3.60
	C	3.30	3.81	2.92	3.53
	D	4.24	3.37	4.24	3.68
	total	3.53	3.61	3.74	3.63

Source: own work.

which is confirmed by the low level of personal responsibility for performance of budget tasks (average 4.02) and moderate collaboration of the team in solving the problems resulting from the new system (average 3.81). However, as demonstrated by the research of L.J. Stewart, well-organized employee teams are one of the basic factors for achievement of satisfactory financial results from medical activities (STEWART 2002). A significant strengthening of the identification and internalization processes can be achieved through positive effects of implemented changes also being noticed by the mid-level management.

Table 4 presents the opinions of the mid-level and top managements of the hospitals studied concerning the influence of the implemented changes on managing human resources in the hospitals.

According to the respondents, budgeting has a positive influence on improvement of collaboration between individual organizational units (total average 4.31). This is manifested in better work organization of individual laboratories and operation theaters, resulting in more effective use of the available resources. The influence of budgeting on the level of motivation of employees (the average of responses was 4.19) was slightly less perceptible.

Table 4
Effects of the changes implemented in the hospitals according to the opinions of the mid-level management (from 1 to 5)

Effect	Staff Hospital	P	N	M	Total
Improved cooperation of organizational units	*A*	3.89	4.85	4.51	4.53
	B	4.23	4.35	4.22	4.29
	C	4.47	4.11	3.45	4.13
	D	4.24	4.24	4.59	4.30
	total	4.24	4.38	4.24	4.31
Better use of human resources	*A*	4.03	3.45	3.49	3.55
	B	3.54	3.22	3.70	3.41
	C	3.30	3.12	3.98	3.29
	D	3.53	3.18	3.89	3.37
	total	3.53	3.23	3.68	3.40
Improved labor productivity at the hospital	*A*	3.82	3.18	3.18	3.31
	B	3.55	3.16	3.56	3.37
	C	3.41	3.12	3.98	3.32
	D	3.53	3.29	4.24	3.49
	total	3.53	3.18	3.60	3.35
Higher motivation for performance of tasks appointed by the top management	*A*	3.00	4.32	3.98	3.91
	B	4.02	4.36	3.94	4.18
	C	4.47	4.43	3.71	4.35
	D	4.59	4.24	4.24	4.30
	total	4.01	4.35	3.95	4.19
Increasing the responsibility of employees	*A*	4.24	3.71	4.09	3.87
	B	3.70	3.60	3.72	3.67
	C	3.53	3.49	3.18	3.47
	D	3.89	3.56	3.53	3.61
	total	3.71	3.58	3.74	3.65

Source: own work.

No significant diversification of responses was recorded either among the hospitals covered or within the individual groups of employees.

The analysis showed that, according to the management staff, budgeting had a positive influence on human resource management at hospital (the total average of 3.29–3.55). There are no significant differences of opinions in this area between the hospitals and between the groups of employees. Additionally, a small influence of budgeting on the scope of responsibilities of employees was recorded. Perceptible progress in that area has been noted, e.g. a more thorough description of the patient treatment process to obtain funds, using the results of tests ordered by the family doctor before admission to the department instead of repeating them at the hospital, and more effective use of medical equipment.

Conclusion

The analysis showed that mid-level management does not see the effects of changes related to budgeting in a similar way as top management. This may cause significant hindrances to the process of employees adopting attitudes and behaviors required by the top management. The diversity of opinions in this area may result from:

– not specifying in detail the targets of budgeting by the top management or not informing the mid-level management about them,

– lack of set measures for evaluation of the achievement of budget tasks,

– aiming at achievement of the assumed targets by means of methods not accepted by the employees.

Undertaking any changes at a hospital should be based on modification of the behavior of people by focusing on, *inter alia*, their knowledge, skills and expectations. The analysis of attitudes and behaviors of mid-level management under conditions of budgeting implementation conducted according to the Lewin model showed that in none of the analyzed entities had implementation of the three stages of the model been completed successfully. The studies confirmed that entrusting budgeting implementation to a consulting company has a positive influence on implementation of the first stage – „unfreeze", i.e. the preparation of the employees for the changes. It can also be concluded that the attitude of the mid-level management does not depend on the duration of budgeting operations, because no higher level of acceptance or more favorable behavior was observed among the employees of the hospital in which budgeting had been implemented the earliest.

Translated by Jerzy Gozdek

Accepted for print 19.09.2014

References

Armstrong M. 2006. *A Handbook of Human Resource Management Practice*. 10th ed., Kogan.

Ash J.S. 2000. *Managing Change: Analysis of a Hypothetical Case*. Journal of the American Medical Informatics Association, 7(2): 125–134, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC61465/pdf/0070125.pdf.

Baulcomb J.S. 2003. *Management of change through force field analysis*. Journal of Nursing Management, 11: 275–280, http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2834.2003.00401.x/pdf.

Beckhard R., Harris R.T. 1987. *Organizational Transitions: Managing Complex Change*. 2nd ed., Addison-Wesley, Reading, MA.

Brisson-Banks C.V. 2010. *Managing change and transitions: a comparison of different models and their commonalities*. Library Management, 31(4/5): 241–252, http://www.emeraldinsight.com/journals.htm?articleid=1860247.

Cygańska M. 2007. *Ocena i postulowane kierunki zmian w systemie budżetowania kosztów szpitali*. Doctoral dissertation, Faculty of Management, University of Gdansk.

EMBERTSON M.K. 2006. *The Importance of Middle managers in healthcare Organizations*. Journal of Healthcare Management, 51(4): 223–232, http://search.proquest.com/docview/206725015/13A352BF27877C68175/1?accountid=14884.

GROSS R., NIREL N., BOUSSIDAN S., ZMORA I., ELHAYANY A., REGEV S. 1996. *The influence of budget-Holding on Cost containment and work procedures in Primary care clinics*. Soc. Sci. Med., 43(2): 173–186, http://www.sciencedirect.com/science/article/pii/0277953695003592.

HAYLLAR M.R. 1995. *Implementing Management reforms in Honk Kong's Public Hospitals*. Asian Journal of Public Administration, 17(1): 178–226.

HENZEL-KORZENIOWSKA A. 2003. *Zarządzanie zasobami ludzkimi w warunkach względnego chaosu otoczeni*. Zdrowie i Zarządzanie, 1: 128–134.

JASIŃSKA J. 2003. *Znaczenie kultury organizacyjnej w procesie łączenia zakładów opieki zdrowotnej*. Antidotum, 2.

KASSEAN H.K., JAGOO Z.B. 2005. *Managing change in the nursing handover from traditional to bedside handover – a case study from Mauritius*. BMC Nursing, 4(1), http://www.biomedcentral.com/1472-6955/4/1.

KROGSTAD U., HOFOSS D., VEENSTRA M., HJORTDAHL P. 2006. *Predictors of job satisfaction among doctors, nurses and auxiliaries In Norwegian hospitals: relevance for micro unit culture*. Human Resources for Health, 4(3), http://www.human-resources-health.com/content/4/1/3.

KUBOT Z. 2001 *Umowy o świadczenie usług medycznych w aspekcie zarządzania zakładem opieki zdrowotnej,* Prawo i medycyna, 3(10).

LEVASSEUR R.E. 2001. *People Skills: Change management Tools – Lewin's Change Model*. Interfaces, 31(4): 71–73, http://mindfirepress.com/uploads/Lewin_s_change_model_INTERFACES–2001.pdf

LEWIN K. 1951. *Field Theory in Social Science*. New York: Harper and Row. London, p. 343–357.

O'NEILL P.E. 1990. *Transforming Managers for Organizational Change*. Training and Development Journal, 44(87): 87–90.

PEI L., STANTON P., LEGGE D. 2004. *Improving human resource management in Chinese healthcare: identifying the obstacles to change.* Australian Health Review, 27: 124–130, http://search.proquest.com/docview/231777212/13A3536CF2B7F2CB166/1?accountid=14884.

PENC J. 2007. *Nowoczesne kierowanie ludźmi, wywieranie wpływu i współdziałanie w organizacji.* Difin, Warszawa.

POCZTOWSKI A. 2007. *Zarządzanie zasobami ludzkimi. Strategie – procesy – metody*. PWE, Warszawa.

ROEMER L. 1996. *Hospital Middle Managers' Perceptions of Their Work and Competence*. Hospital & Health Services Administration, 41(2): 210–235, http://search.proquest.com/docview/206722035/13A353768AF4E4486AE/1?accountid=14884.

RÓSZKIEWICZ M. 2002. *Metody ilościowe w badaniach marketingowych*. PWN, Warszawa.

SCHEIN E.H. 1995. *Kurt Lewin's Change Theory in the Field and in the Classroom: Notes Toward a Model of Managed Learning,* Working Paper 3821, Systems Practice, http://www2.tech.purdue.edu/Ols/courses/ols582/SWP-3821-32871445.pdf.

SCROGGINS W.A. 2006. *Managing meaning for strategic change: The role of perception and meaning congruence*. JHHSA SUMMER, p. 83–102. http://search.proquest.com/docview/199996025/13A35386CB277E00C4F/1?accountid=14884.

STEWART L.J. 2002. *Management Control Theory and its Application to US Medical Practice.* Research in Healthcare Financial Management, 7(1): 1–19.

SUC J., PROKOSCH H.U., GANSLANDT T. 2009. *Applicability of Lewin's Change Management Model in a Hospital Setting*. Methods Inf. Med., 5: 419–428, http://www.schattauer.de/de/magazine/uebersicht/zeitschriften-a-z/methods/contents/archive/issue/special/manuscript/11795/download.html.

TIMMRECK T.C. 2000. *Use of the Classical Functions of Management by Health Services Midmanagers*. The Health Care Manager, 19(2): 50–67, http://apps.webofknowledge.com/full–record.do?product=MEDLINE&search–mode=GeneralSearch&qid=4&SID=V24NI@994g2D2OmnHaA&page=1&doc=1.

WEST T.D. 1998. *Comparing Change Readiness, Quality Improvement, and Cost Management among Veterans Administration, For-Profit, and Nonprofit Hospitals*. Journal of Health Care Finance, 25(1): 46–58, http://search.proquest.com/docview/235174115/13A353B156321D74569/1?accountid=14884.

Zarządzanie zasobami ludzkimi. Tworzenie kapitału ludzkiego organizacji. 2006. Eds. H. Król, A. Ludwiczyński. PWN SA, Warszawa.