SA Journal of Human Resource Management
ISSN: (Online) 2071-078X, (Print) 1683-7584

A voice at the table: Exploring strategic human resource development at a South African private hospital group

Authors:
Helen Meyer[1]
Sanjay Khoosal[1]

Affiliations:
[1]Workwell Research Unit, Faculty of Economic and Management Sciences, North-West University, Potchefstroom, South Africa

Corresponding author:
Helen Meyer,
helen.meyer@nwu.ac.za

Dates:
Received: 12 Sept. 2025
Accepted: 10 Feb. 2026
Published: 19 Mar. 2026

How to cite this article:
Meyer, H., & Khoosal, S. (2026). A voice at the table: Exploring strategic human resource development at a South African private hospital group. *SA Journal of Human Resource Management/SA Tydskrif vir Menslikehulpbronbestuur*, *24*(0), a3331. https://doi.org/10.4102/sajhrm.v24i0.3331

Orientation: Although strategic human resource development (SHRD) is widely proposed for organisational effectiveness, its implementation in highly regulated industries, such as healthcare, may be adversely impacted.

Research purpose: Using McCracken and Wallace's SHRD characteristics and Garavan's model, the study investigated how human resource managers (HRMs) in a South African private hospital group understood and implemented SHRD.

Motivation for the study: In healthcare settings where professional hierarchies, centralised governance and regulatory pressures influence human resource development (HRD) practices, the study addressed research calls to capture practitioners' perspectives in such complicated contexts.

Research approach/design and method: A qualitative, interpretive design was employed. Five purposefully selected HRMs were individually interviewed about their SHRD practices. Data were analysed using Braun and Clarke's reflexive thematic analysis process.

Main findings: Human resource developments implemented SHRD, but in a fragmented and inconsistent manner, contradicting the integrated approach proposed by SHRD theory. Strategic human resource development was unevenly implanted in the hospital context, due to contextual constraints.

Practical/managerial implications: The findings suggest contextualised SHRD frameworks, enhanced cross-level partnerships, developing SHRD competencies and local HRD discretion in HRD planning and decision-making.

Contribution/value-add: The study offers a more situated view of SHRD in practice, demonstrating that contextual factors, such as professional power dynamics, regulatory pressures and centralised control, influence implementation in healthcare, rather than merely highlighting implementation gaps.

Keywords: human resource development; strategic human resource development; SHRD characteristics; SHRD model; private hospital group; South Africa; power relationships; regulated environments.

Introduction

Human resource development (HRD) is widely regarded as a key contributor to improving organisational performance and employee development (Irfan et al., 2023). Human resource development extends beyond training and encompasses strategic initiatives such as leadership development, workforce planning and organisational learning, critical for sustaining high-quality service delivery and organisational adaptability (Otoo, 2024; Yorks et al., 2022). Nevertheless, HRD is often critiqued for not aligning with organisational goals and not demonstrating organisational value (Sthapit, 2021; Torraco & Lundgren, 2020). Due to increasing uncertainties, skills shortages and organisational pressures, HRD is expected to contribute directly to organisational goals and long-term stability (Vong et al., 2025).

In response to these demands, strategic human resource development (SHRD) positions HRD as a long-term, strategically aligned and environmentally conscious process (Garavan, 2007; Yim, 2021). Although previously studied (e.g. Alagaraja, 2013a, 2013b; Garavan, 1991; Garavan et al., 2016; Mitsakis, 2017, 2019, 2020; Parameswaran, 2020; Sthapit, 2020; Yim, 2021), most research has been conducted in relatively stable environments. These settings may differ from modern workplaces, marked by persistent labour shortages and rapidly increasing regulation and managerial control (Empowered Systems, 2025; Schinnenburg & Böhmer 2025; Fenton-O'Creevy & Gooderham 2025). Hence, scholars have urged for exploratory practice-based SHRD research that

investigates participants' perspectives in diverse and dynamic contexts (Mitsakis, 2017, 2019; Yim, 2021).

These dynamics are particularly evident in South Africa's healthcare system. Both the public and private sectors are subject to ongoing reforms, such as the National Health Insurance (Department of Health, 2024; Goodman et al., 2024), as well as intense regulatory pressures and ongoing professional shortages (Department of Health, 2020; World Health Organization, 2020). Although South African healthcare is identified as a priority for HRD (Department of Health, 2020; Gumede et al., 2023), research in this context remains sparse. While private healthcare is considered instrumental in effectively implementing National Insurance (Goodman et al., 2024), previous research mainly focused on public healthcare (e.g. Mburu & George, 2017; Pillay, 2010) or strategic human resource management (HRM) (e.g. Sungwa, 2024; Wahitu & Muhama, 2025). Therefore, private hospitals, similarly characterised by hierarchical professional structures, centralised governance and compliance demands, remain unexplored.

This study addresses these gaps by exploring how HRMs understand and implement SHRD in a large South African private hospital group.

Research purpose and objectives

The study explored how HRMs in a private hospital group understand and implement SHRD in their organisational context by:

- Exploring how McCracken and Wallace's (2000) nine SHRD characteristics are reflected, adapted or constrained in HRD practice, as reported by HRMs.
- Analysing the strategic positioning of HRD practices using Garavan's (2007) SHRD model as an analytic framework.

Literature review

Strategic human resource development: Context and political embeddedness

Human resource development is typically portrayed as a strategic level for organisational success; yet organisational structures and power dynamics may influence its practice. While SHRD is designed as a proactive and strategically aligned approach (Garavan, 2007; Yim, 2021), critical HRD scholars argue that HRD is never applied in a vacuum. Instead, it unfolds within organisational politics, professional hierarchies and unequal authority distribution (Bierema & Callahan, 2014; Meyer, 2025; Saks, 2021). This is particularly evident in healthcare, where strong professional boundaries (Currie & Spyridonidis, 2019) may determine how development opportunities are set and resourced.

Subject to stringent regulations and ongoing professional development, nurses are the predominant professional group in South African hospitals and are essential to service delivery (Blaauw et al., 2014; Esterhuizen & Van Rensburg, 2024; Health Systems Trust, 2015). These dynamics may prioritise nursing development over other staff groups, directing HRD decisions before considering SHRD principles.

The broader healthcare system is also highly regulated, resource-constrained and compliance-driven (Department of Health, 2020, 2024; Goodman et al., 2024). Within private hospital groups, centralised governance and efficiency-oriented managerial systems may further restrict HRD autonomy, thereby reinforcing transactional rather than strategic HRD practices. These circumstances suggest that SHRD is not simply a strategic design challenge; it is a negotiated process influenced by power, hierarchy and organisational structures. Such realities raise questions about the extent to which SHRD assumptions hold in settings characterised by tight regulation and strong professional influence.

The characteristics of strategic human resource development

McCracken and Wallace's (2000) nine characteristics remain widely used to investigate the strategic position of HRD (Mitsakis, 2019; Sthapit, 2020; Yim, 2021). These characteristics are not prescriptive benchmarks in this study, but rather analytical lenses. They help identify where SHRD is partially enacted, constrained or reinterpreted, enabling an exploration that is sensitive to context, politics and hierarchy. The characteristics are outlined below according to how they theoretically frame strategic HRD. For conciseness, some characteristics are discussed under one heading.

Integrated strategic alignment and top management support (characteristics 1–2)

Based on SHRD theory, HRD is closely aligned with the organisational mission and strategy, and top management actively supports and promotes HRD (McCracken & Wallace, 2000; Yim, 2021). These presumptions assume that alignment is based on common priorities and that HRD has access to strategic decision-making (Mitsakis, 2017; Sthapit, 2020). However, strategic alignment may be uneven or biased in favour of dominant groups in organisations where professional hierarchies determine organisational agendas.

Shared environmental scanning and human resource development strategies, plans and policies (characteristics 3–4)

Environmental scanning is positioned as a shared responsibility across organisational levels, enabling HRD to anticipate and respond to external changes (Garavan et al., 2016; Yim, 2021). However, head office control and regulatory pressures may overshadow HRD's involvement in environmental scanning and the design or inclusive HRD strategies, policies and plans in compliance-driven and centralised healthcare systems, thereby restricting HRD authority and responsiveness.

Vertical and horizontal strategic partnerships (characteristics 5–6)

Strategic partnerships with line managers and horizontal integration between HRM and HRD are considered fundamental to SHRD. These partnerships are expected to be collaborative, with shared accountability for workforce development (Garavan et al., 2016; Sthapit, 2020; Yim, 2021). However, power imbalances and role ambiguity, particularly in clinically dominated organisations, can make shared ownership difficult to realise in practice.

Expanded human resource development roles and cultural influence (characteristics 7–8)

Strategic human resource development considers human resource development practitioners (HRDPs) as strategic agents who can influence organisational culture, learning and transformation (Garavan et al., 2016; Yim, 2021). However, this HRD role requires legitimacy, authority and senior support to realise, which may be constrained in environments where hierarchy and compliance demands dominate. Consequently, HRD's ability to influence culture may be limited to communicating values rather than transforming culture, thereby reinforcing their operational roles.

Evaluation and cost-effectiveness (characteristic 9)

Strategic human resource development theory emphasises systemic evaluation to demonstrate return on investment (ROI) and organisational impact (McCracken & Wallace, 2000; Yim, 2021). However, in organisations with limited resources, evaluation may narrowly focus on compliance and cost containment, leaving limited opportunity to formally evaluate long-term developmental outcomes.

Taken together, these characteristics provide a structured framework; however, they do not account for how SHRD is negotiated in environments that are resource-constrained, power-laden and professionally diversified contexts, such as healthcare. The study also draws on Garavan's (2007) SHRD model.

Garavan's strategic human resource development model

Garavan's (2007) SHRD model has been refined since its introduction (Garavan, 1991; McCracken & Wallace, 2000) to reflect the interaction between organisational context, HRD strategy and individual development. Even though it was criticised for being too prescriptive (Garavan & Carbery, 2012), the model remains useful for illustrating how SHRD operates across multiple levels, including global, organisational, job and individual (Mitsakis, 2019; Yim, 2021).

Instead of a blueprint, the model was used as an analytical benchmark in the study to support the investigation of how SHRD is applied differently across the organisation and how it is influenced or limited by contextual factors such as centralised decision-making, regulatory requirements and professional hierarchies within the private hospital group.

Research design

Research approach

We used an interpretivist qualitative research approach (Creswell & Creswell, 2018; Schurink et al., 2021b) to explore how HRMs understood and implemented SHRD within a private hospital group. This approach was suitable for exploring how participants made sense of their roles, constraints and organisational context from their perspectives. This qualitative study also responds to a call for practice-based exploratory SHRD research in complex settings.

Research strategy

A framework-guided thematic analysis research strategy, adapted from Braun and Clarke (2006), was employed in this study. McCracken and Wallace's SHRD characteristics and Garavan's SHRD model served as analytical lenses, rather than prescriptive categories. This allowed the analysis to consider not only whether SHRD was present, but how it was interpreted, negotiated, limited and partially enacted in practice.

Research method

The research method comprised the research setting, entrée and researcher role, participant selection and sampling, data collection, recording, analysis and strategies to ensure trustworthiness. Ethics and the reporting style are outlined below.

Research setting

To improve understanding and minimise physical distance (Creswell & Creswell, 2018), interviews were conducted with HRMs at private hospitals (natural settings) where they were employed. All HRMs opted to be interviewed in their offices, with scheduling options based on availability.

Entrée and establishing researcher roles

The researcher obtained permission from the private hospitals to conduct the research. The researcher used an interview schedule with predetermined questions and conducted, organised and transcribed all interviews, using recordings and field notes. Reflexive memos were written throughout to document analytical decisions and consider potential influences arising from the hierarchical context. With supervisory input, the researcher hand-coded the data to identify common themes.

Research participants and sampling methods

Given resource limitations and the countrywide geospatial spread of 54 private hospitals, the researcher focused on Gauteng, the most populous province, with the highest concentration of private hospitals. Consistent with qualitative research that focuses on in-depth exploration rather than generalisation, the study population consisted of five HRMs employed at Gauteng-based private hospitals. Table 1 shows participants' biographical profiles and hospital locations.

TABLE 1: Biographical profile of participants.

Participant code	Gender	Ethnic group	Location of the private hospital
P1	Female	White person	Pretoria
P2	Female	White person	Benoni
P3	Female	Indian person	Vaal Triangle and Johannesburg South
P4	Male	Black African person	Johannesburg Central
P5	Male	Indian person	East Rand

Human resource managers were selected through non-probability purposive sampling, using Nieuwenhuis's (2016) criteria, including data saturation, natural setting, HRD experience, legislative knowledge and fluency in English and the organisation's business language. Human resource managers were selected for their direct involvement in HRM and HRD functions, as well as for developing and implementing HRD plans and solutions at private hospitals, making them well-positioned to share insights on SHRD. All participants provided oral consent to participate in the interview.

Data collection methods

Semi-structured individual interviews were conducted to allow flexibility, probe participants' responses and elicit rich, personal accounts of their SHRD experiences (Geyer, 2021). The researcher also recorded empirical observations and interview interpretations (Creswell & Creswell, 2018). Data saturation was reached upon completion of the fifth interview (Geyer, 2021).

Data recording

Using a tape recorder, participant permission was sought before the interviews and recording (Geyer, 2021). Care was taken not to conceal the recorder, and recordings were limited to those relevant to research questions. The recordings were transcribed verbatim into Microsoft Word and password-protected.

Data analysis

Reflexive thematic analysis (Braun & Clarke, 2006, p. 87) guided the analytic process. Strategic human resource development theory informed our interpretation, without predetermining codes and categories. This analysis process included data familiarisation, initial coding, searching for themes, theme identification and review, defining and naming themes and final reporting.

Strategies employed to ensure data quality and integrity

To ensure trustworthiness, transcripts were validated, codes were consistently defined, and cross-checked against the data (Creswell & Creswell, 2018; Schurink et al., 2021a). We enhanced credibility by returning transcripts for participant verification (member-checking). Coding ensured accurate theme development, supported by intercode checks by peers and supervisors. We achieved transferability through an audit trail, comparison with the study's theoretical framework and quotations that reflect the context. Dependability was achieved by progressively understanding the research setting and acknowledging the changing conditions. Conformability was achieved through continuous reflexivity, using external coders and by comparing findings with existing scholarship. Crystallisation was achieved through rich-thick illustrations (Maree & Van der Westhuizen, 2016).

Reporting style

Findings are presented thematically, consistent with interpretative qualitative writing conventions that emphasise clarity, coherence, contextual sensitivity and meaning-making (Creswell & Creswell, 2018; Schurink et al., 2021a).

Ethical considerations

The study received ethical clearance from the faculty ethical committee (EMS-REC, approval number: EMS16/03/03-01/01). Informed consent, voluntary participation, confidentiality, the use of pseudonyms for anonymity and protection from harm were upheld (Strydom & Roestenburg, 2021).

Results

The findings are presented into two overarching themes reflecting HRMs' experiences of SHRD in practice: (1) experiences with SHRD characteristics and (2) experiences with SHRD models, with related subthemes. Although some characteristics were combined in the literature review, they are presented independently here to show how HRMs experienced them. Selected illustrative quotations are included.

Theme 1: Experiences with strategic human resource development characteristics

Alignment with the organisation's vision, mission and goals

Human resource managers' experiences indicate that strategic alignment was mainly achieved through performance management, training needs analysis (TNA) and individual development plans (IDPs). These tools linked organisational priorities with individual and job-specific needs:

> '… your mission … and your objectives and your strategic things of the company are directly linked to a person's objectives … will be linked back to the organisational goals.' (P1)

> 'Yes, it is aligned … it starts with the IDP, which is driven by EPD [*enhancing performance development*] … to business needs.' (P4)

> '… it's important that you engage with them [*management*] to understand why they want certain training needs. It needs to be beneficial to both the business, them [*management*] and the staff member.' (P5)

Taken together, these accounts suggest that alignment was mainly experienced through compliance-driven processes rather than strategic involvement in organisational decision-making.

Senior management support for human resource development

Although executives considered HRD as strategically important, HRMs perceived this support as selective. Nursing staff had significantly more development opportunities than non-nursing staff:

> '… on the nursing side only …, on a non-nursing side, no. Somehow, emphasis is never paid too much on non-nursing staff.' (P3)

Budget constraints and priorities reinforced the perceived unevenness. Despite management's expectation, these constraints limited HRD's ability to address overall organisational needs:

> '… we complain about the [*training*] budgets … we are told we need to be innovative. But, even with innovation, you need some money.' (P2)

> '… we don't have sufficient funds to cater for non-nursing staff.' (P3)

This subtheme suggests that management's support for HRD was primarily symbolic, resource-dependent and selective in nature, limiting HRD's ability to support development across all occupational groups.

External environment scanning

Although environmental scanning occurred, it narrowly focused on nursing and nursing-related regulatory requirements instead of organisation-wide capacity development:

> '… especially for nursing, where we need to do the new nursing qualifications … we need to look at … what is happening nationally in nursing, new qualifications … of SANC [*South African Nursing Council*].' (P1)

Beyond nursing, scanning and planning were centrally driven at the group level, leaving hospital-based HRMs with limited discretion to identify and address emerging skills needs:

> 'Basically, you don't have to think [*at hospital HRM level*]. Everything is pushed to you [*from head office*] … and that is how we implement it.' (P3)

Centralisation also restricted HRD's ability to address site-specific and non-clinical skills development needs, resulting in limited alignment with wider organisational and national priorities. This also created lost opportunities for HRD to develop internal technical capacity:

> '… we pay a service provider … whereas we have [*technical*] staff that have the skill that we can train to have the formal qualification on air conditioning and they can do it.' (P5)

Strategic partnerships with line managers

Line managers were primarily responsible for employee performance development (EPD) reviews and ongoing performance evaluation. Human resource managers emphasised that HRD effectiveness relied on line management engagement and accountability:

> 'Good relationships with your line managers is very important. They [*line managers*] will know who have talent that need training or the people that's under-performing that needs training …' (P1)

However, in some hospitals, line managers viewed HRD as an HR responsibility rather than a shared one:

> 'Line managers do not understand that it's their responsibility [*to partner with HRM*]. They see it as an HR responsibility.' (P2)

While line management partnership is assumed in SHRD literature, these accounts suggest partial implementation of this characteristic, due to hierarchical relations, role ambiguity and managerial understanding.

Strategic partnerships with corporate human resource development

Most HRMs agreed that HRD support was evident. However, this support was mainly centralised and periodic, limiting site-specific strategic HRD planning. Participants experienced support as advisory instead of embedded:

> '… we get feedback from head office … if we don't get those reminders, not a lot will happen … I think it might really help for a hospital to have that access for a day or two for the specialist [*HRDP*] to look at what we have, where the issues are that we need to address and how we think outside the box.' (P2)

> 'It will be quite beneficial for the training team to meet with the business and come to the hospitals and speak to the top management team … (To) engage on a different level … at a site-specific level, you look at site (private hospital) specific initiatives.' (P5)

Although HRD structures exist, limited on-site presence and periodic engagement restricted the formation of strategic partnerships. The lack of shared planning also reinforced HRM's dependence on central structures.

Expanded roles of training facilitators

Training facilitators' roles were mainly confined to classroom delivery, with little authority to engage strategically. Professional boundaries further constrained their involvement. Especially, clinical facilitators lacked autonomy to engage proactively with workforce planning:

> 'The CFs [*clinical facilitators*] don't have the liberty of being so involved in the business to outline our needs … they do try, but due to their circumstances, I don't think they have the liberty to extend themselves further than what they have done.' (P5)

Occasional collaboration between HRMs, training teams and line managers enabled more responsive initiatives, although such practices were infrequent:

> 'There's a team that sat with us to discuss what [*skills development needs*] we want, the guys that designed the course presented it to them [*staff*].' (P4)

While SHRD theory assumes expanded strategic roles for training facilitators, these accounts suggest that their involvement was constrained in practice by limited authority, organisational structures and professional hierarchies.

Using human resource development to influence organisational culture

Human resource development practices focused on communicating organisational values through orientation and onboarding, instead of shaping or challenging organisational culture through strategic development:

> '… the orientation programme and the on-boarding programme, so new employees definitely are on-boarded quite well, one-on-one with my HR staff and then in orientation… in the departments as well, we have our … values and our way [*of behaving*].' (P1)

The accounts suggest that HRD's cultural influence was limited to organisational entry levels, in the form of transmission rather than transformation, across all professional groups.

Using efficiencies and return on investment to promote human resource development

Human resource managers reported limited use of HRD metrics to assess the ROI. Evaluation was primarily informal, and HRMs expressed uncertainty on how to measure training impact:

> 'I don't think that we've ever sat and said, this is the training we've done for the year, and this was the return on investment.' (P2)

In the absence of ROI metrics, HRD value was primarily demonstrated through cost savings:

> '… if you take ten or more, I can give it to you at almost half the cost.' (P3)

Although SHRD theorises evaluation as important, this subtheme demonstrates the difficulty of applying ROI measurement in practice. Moreover, HRD's value was tied to cost containment rather than evidence of long-term capability development.

Theme 2: Experiences with strategic human resource development models

All HRMs experienced limited familiarity with SHRD models, and only one HRM relayed partial exposure to SHRD models:

> 'I want to link it to a model, and which one would fit the best. I've also read about some of the models, but I can look at the Peterson model.' (P1)

They also expressed uncertainty and limitations in aligning HRD with strategic models:

> 'My [*HRD*] strategy is weak … sixty, seventy percent there.' (P1)

Implementation was also limited by organisational and governance arrangements. Some HRMs reported feeling disempowered by rigid policies, which discouraged innovation:

> 'We are too scared to go outside the policy here … … if you do something wrong, you are referred to the policy …' (P5)

Human resource managers also reported broad generalist workloads that limited time for strategic SHRD:

> 'I'm involved in everything from training and development to strategic leadership, consultation … the very operational transactional processes, staff well-being, and a complete generalist function.' (P5)

Overall, these accounts suggest that SHRD models were experienced as aspirational rather than actionable. Although HRMs expressed a commitment to development, they were constrained by limited authority, time, resources and centralised governance.

Table 2 synthesises the relationship between SHRD theory and the findings, indicating how each SHRD characteristic and the model were implemented in the private hospital context.

TABLE 2: Alignment between strategic human resource development theory and findings.

SHRD framework element	What SHRD proposes	Findings	Nature of enactment
1. Integration with organisational vision, mission and goals	HRD aligns with organisational goals through integrated planning	Alignment mainly through TNA and IDPs	Partial: procedural rather than strategic, driven by compliance
2. Top management support	Senior leaders actively champion HRD across functions	Recognised HRD importance but uneven support, nursing prioritised with limited resourcing for non-clinical staff	Constrained by professional hierarchies: symbolic and selective
3. Environmental scanning	Shared by HRD and top management to identify opportunities and threats	Focused on nursing and compliance; other needs were overlooked; limited hospital-based HRM discretion.	Fragmented: narrow, centralised, limited site-level responsiveness,
4. HRD planning and policy formulation (strategy development)	HRD develops proactive, strategic plans aligned with organisational needs	Standardised top-down planning limits local adaptation	Constrained: centralised, limited HRM discretion to address local skills needs
5. Line management partnership	Shared ownership of employee development, collaborative HRD planning	Partnership inconsistent, some line managers perceived HRD as HR's responsibility	Partial: uneven across sites: dependent on local role clarity and authority
6. HRD partnerships across partnerships (HRM–HRD partnership)	Cross-functional collaboration across stakeholders	Limited cross-functional engagement beyond nursing; corporate HRD's advisory role acknowledged, but periodic	Constrained: uneven, partnership depends on role clarity and authority distribution
7. Expanded roles of trainers and facilitators	HRD acts as a strategic partner and change agent, not only a trainer	HRDPs confined to instructional and administrative roles; lack autonomy and strategic involvement	Minimal: mainly operational roles, organisational hierarchy restricts role expansion.
8. HRD influence on organisational culture	HRD shapes and influences organisational learning culture	Communicate values only (orientation and/or onboarding),	Minimal: surface-level influence; transmissive, not transformative
9. Evaluation and ROI	HRD demonstrates strategic value through evaluation systems	No formal ROI; value is demonstrated through cost savings rather than outcomes	Minimal: financial justification replaces strategic evaluation
10. Use of SHRD models	Models guide strategic integration across global, organisational, job and individual levels	HRMs have limited knowledge, models perceived as abstract; constrained by workload, limited resources, centralisation and difficult to apply in a centralised, resource-constrained context.	Aspirational: recognised conceptually but not applied

SHRD, strategic human resource development; HRD, human resource development; TNA, training needs analysis; IDPs, individual development plans; HR, human resources; HRM, human resource management; HRDP, human resource development practitioners; ROI, return on investment.

Table 2 shows an uneven and contextually determined implementation of SHRD, providing a basis for the discussion that follows.

Discussion

The findings suggest that HRMs at private hospitals applied SHRD characteristics in a fragmented manner, rather than uniformly, contrary to McCracken and Wallace's (2000) recommendations. All HRMs reported a lack of knowledge or experience with SHRD models. McCracken and Garavan (2015) note that without adopting such models, HRD practices often become fragmented, lacking executive support, and are perceived as non-value-adding.

While inconsistent application of SHRD is well-documented (McCracken & Garavan, 2015), this study extends existing knowledge by demonstrating how professional hierarchies, centralised governance and regulatory pressure in private healthcare influence SHRD implementation. The findings reveal that SHRD in healthcare is neither neutral nor evenly distributed, but rather politically embedded.

Integration of strategic human resource development characteristics with organisational mission, vision, values and goals

Human resource managers' experiences reflected strategic integration of HRD practices with the private hospitals' vision, mission and objectives through HRD tools such as TNA and IDPs. This alignment demonstrated HRM's efforts to align organisational goals with job-specific and individual needs. As these mechanisms are mostly compliance-driven, this suggests that alignment was more procedural than strategic in nature. These findings mirror Sthapit's (2020) study, which reported that HRD practices do not consistently align with strategic goals.

Senior management support for human resource development

Although top management acknowledged the importance of HRD, their support appeared selective and largely symbolic. Nursing was prioritised for development, while non-clinical staff received far fewer resources and career development opportunities. This uneven distribution of training priorities and budgets demonstrates how professional hierarchies influence what constitutes 'strategic' HRD in private hospitals. These dynamics extend SHRD theory by illustrating that strategic alignment is not neutral but mediated by entrenched professional power structures. In this context, nursing, due to regulatory demands and clinical dominance, anchors HRD decision-making, while marginalising other occupational groups. Shaari et al. (2019) similarly noted that although top management often verbally endorses HRD, actual support remains inconsistent.

Scanning the environment

Human resource managers confirmed that while the external environment was scanned for regulatory requirements, trends and best practices, this was only evident in formal nursing-related education and training. As scanning was primarily driven from the head office, it functioned more as a compliance mechanism than as a tool for strategic foresight. This top-down approach limited HRM's involvement and ability to respond to site-specific needs or identify broader organisational development opportunities. Similar patterns were noted by Wahitu and Muhama (2025), who found that centralised control can restrict HR's ability to act strategically.

Human resource development strategy, plans and policies

Human resource managers expressed the need for HRD strategies to address human and financial resource constraints. However, the highly centralised and standardised process in private hospitals restricted HRMs from adapting HRD plans to site-level workforce needs. This reinforces earlier findings that HRDs operate within narrow boundaries set by governance structures. As Alagaraja and Egan (2013) noted, HRD strategies are most effective when policies, practices and systems are integrated. However, achieving such alignment remained difficult for HRMs in this context.

Strategic partnerships with line management and human resource developments

Human resource managers believed that line managers should share responsibility for developing staff; however, this expectation was not consistently met. Line managers were often perceived as disengaged from their developmental role, while HRMs themselves felt they lacked the authority to influence this. These findings complicate the SHRD assumption of shared ownership, showing that partnerships depend on clarity of roles and power, both of which are uneven in clinically dominated environments. Yim (2021) similarly found that although line-HR partnerships are considered essential for SHRD, they remain difficult to implement in practice.

This research identified a second layer of partnership, where HRMs depend on corporate HRD for strategic guidance, adding to existing SHRD theory. Though not a formal SHRD characteristic, this vertical dependency reflects the centralised nature of hospitals. Human resource managers' limited direct engagement with corporate HRD, together with limited decision-making authority at the site-level, demonstrates how organisational structure shapes SHRD implementation.

Expanded roles for human resource development practitioners

Contrary to SHRD expectations (Alagaraja, 2013a, 2013b), HRDPs were largely confined to operational and instructional roles. Professional hierarchies and centralised governance

appeared to restrict HRDs' opportunities to function as strategic partners or change agents. Research in Uganda (Wahitu & Muhama, 2025) reveals similar patterns, with HR work remaining transactional and hindering strategic implementation. This contrasts with Yim's (2021) findings in Korean organisations, where HRDPs increasingly assume expanded strategic roles.

Ability to influence organisational culture

Human resource managers reported that HRD contributed to organisational culture mainly through onboarding and orientation, indicating a transmissive rather than a transformative influence. This aligns with the broader compliance-oriented culture, where maintaining standards takes preference over experimenting with new learning approaches. Mitsakis (2017) also found links between SHRD and culture. However, in our study, the influence was limited by hierarchical and regulatory factors.

Evaluation and return on investment

Human resource managers confirmed that they do not use formal ROI tools to measure the impact of HRD, mainly due to tight budgets and operational pressures. As a result, evaluation was mainly used to justify spending rather than to support learning or inform strategic decisions. This limited HRD's potential to develop as strategic partners and strengthened the transactional view. Mitsakis (2017) similarly reported evaluation practices that stopped at programme completion. In contrast, Yim (2021) showed that when cost-effectiveness measures are tied to broader organisational development goals, they can strengthen SHRD. In the hospital context of this study, the strategic use of evaluation was largely absent, which narrowed HRD's contribution to longer-term capacity development.

Experiences with strategic human resource development models

Human resource managers had limited familiarity with and experience in SHRD models, viewing them as abstract and aspirational rather than practical, actionable guidelines. They cited limited authority, time, resources and highly centralised governance as key barriers to applying the models. Similar challenges were reported in Woolworths (UK), where the lack of a transparent strategic approach to HRD hindered implementation (McCracken & Garavan, 2015).

Practical and managerial implications

The findings have several practical implications for HRD practice in healthcare settings. Human resource development leaders should prioritise development initiatives that align with core SHRD competencies and organisational priorities, while recognising how professional hierarchies and centralised governance influence what is possible at the site-level (for example, missed development opportunities for non-nursing technical staff). Consistent leadership support and appropriate resources are essential for applying SHRD holistically across all departments and integrating it with strategic planning and performance evaluation.

Human resource managers and HRDs who proactively engage with senior leadership are better positioned to build credibility and demonstrate the value of HRD initiatives, particularly when supported by clear business cases and appropriate measurement tools. These may help demonstrate broader organisational outcomes, such as workforce capability, employability, career progression, cost-effective service delivery and improved employee experience. Strengthening internal partnerships across HRD, HRM, line managers and training teams remains critical for shifting HRD from a transactional function to one that contributes to longer-term organisational outcomes.

Recommendations

The study highlights the need for targeted development to deepen HRM's understanding of SHRD and strengthen the consistent application of its characteristics. Private hospitals and similar organisations would benefit from implementing formal SHRD frameworks that reflect both organisational goals and regulated requirements.

Repositioning HRMs as strategic partners, rather than administrative role-players, is essential for HRD to contribute meaningfully to organisational sustainability. Human resource development practitioners and HR leadership should adopt or adapt SHRD models that are suited to regulated healthcare environments and utilise these frameworks to secure executive support. Human resource development practitioners must develop the necessary strategic skills of change agents and culture influencers to move beyond transactional and reactive HRD services. To realise SHRD, HRD and HRM partnerships and collaboration require strengthening to enable a deep understanding of business needs. Co-created SHRD strategies should respond to environmental changes, organisational structures, culture, leadership expectations, job demands and career pathways, ensuring alignment with all internal and external stakeholder needs.

Limitations

The study was limited to one private hospital group, which excludes public-sector enterprises and may restrict the transferability of findings. Including HR professionals from other hospital groups nationally may have revealed a broader range of SHRD practices. Participants occupied lower organisational levels than the researcher, which may have influenced their responses due to power imbalances. Future studies could include multilevel perspectives, particularly from senior executives, to deepen insight into how SHRD is shaped and enacted across hierarchical layers.

Conclusion

This study demonstrates that the uneven implementation of SHRD in private healthcare is not merely a result of weak implementation. Instead, SHRD practices are influenced by professional hierarchies, centralised governance and regulatory pressures that privilege certain groups, most notably nursing, over others. In this context, SHRD operates selectively, with limited influence on broader organisational capacity development, particularly for non-clinical staff. The study, therefore, argues for a reconceptualisation of SHRD in healthcare as a politically embedded and uneven process, rather than a universally applicable framework. By demonstrating how context mediates strategic intent, professional power and HRD agency, the study extends SHRD scholarship and highlights specific challenges of enacting SHRD in highly regulated, resource-constrained environments.

Acknowledgements

This article includes content that overlaps with research originally conducted as part of Sanjay Khoosal's master's dissertation titled 'Exploring strategic human resource development at a private hospital group', submitted to the Faculty of Economic and Management Sciences, School for Industrial Psychology and Human Resource Management, North-West University, South Africa in 2019. The dissertation was supervised by Prof. Helen Meyer. Portions of the data, analysis and/or discussion have been extensively revised and updated for journal publication. The original thesis is publicly available at: http://hdl.handle.net/10394/33011. The authors affirm that this submission complies with ethical standards for secondary publication, and appropriate acknowledgement has been made to the original work. The literature has also been updated substantially for currency since the submission of the dissertation.

Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

CRediT authorship contribution

Helen Meyer: Conceptualisation, Formal analysis, Methodology, Project administration, Supervision, Validation, Visualisation, Writing – review & editing. Sanjay Khoosal: Conceptualisation, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Validation, Visualisation, Writing – original draft. All authors reviewed the article, contributed to the discussion of results, approved the final version for submission and publication and take responsibility for the integrity of its findings.

Funding information

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Data availability

The data that support the findings of this study are available from the corresponding author, Helen Meyer, upon reasonable request.

Disclaimer

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