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A Policy Analysis of Human Resource Management Optimization in Chinese Public Hospitals under High-Quality Development

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Abstract

Chinese public hospitals are the institutional core of China's medical and health service system and are now undergoing a policy-driven transition from scale expansion to quality, efficiency, refined governance, and stronger public welfare orientation. Against this background, human resource management (HRM) can no longer be treated as routine personnel administration. It must be redesigned as a strategic governance mechanism that connects talent structure, post management, performance distribution, professional development, employee well-being, digital management, and hospital accountability. This article is positioned as a policy analysis and perspective article rather than an empirical research article. Drawing on China's major public-hospital reform policies, the 2024 national health statistical bulletin, and international literature on HRM in health systems, it examines persistent HRM tensions in Chinese public hospitals and proposes an integrated optimization model. The analysis identifies six major problems: incomplete alignment between workforce structure and hospital strategy, extensive post management, insufficiently balanced performance appraisal, discontinuous talent development, weak institutional support for medical staff, and fragmented digital HRM. To address these problems, the article develops a "policy orientation--organizational mechanism--humanistic support--digital empowerment--outcome evaluation" model and translates it into operable pathways: strategic workforce planning, classified post management, public-welfare-oriented performance appraisal, full-cycle talent cultivation, multi-track career development, institutionalized staff care, and data-supported HR governance. The contribution of the article lies in clarifying the Chinese policy logic of hospital HRM reform and offering a structured framework that can guide hospital managers and policymakers in transforming HRM from administrative execution to strategic governance.

Keywords

Chinese public hospitals; human resource management; high-quality development; performance appraisal; talent team construction; policy analysis

1. Introduction

The high-quality development of Chinese public hospitals is not only a matter of medical technology, hospital buildings, equipment procurement, or disciplinary platforms. It is more fundamentally a question of whether hospitals can organize, motivate, protect, and develop the people who deliver medical services. Doctors, nurses, medical technicians, pharmacists, researchers, administrators, and logistics staff jointly form the operational capacity of hospitals. When this workforce is well planned and fairly managed, hospitals are more likely to improve quality, efficiency, and patient experience. When human resource management remains fragmented or primarily transactional, even a hospital with advanced facilities may face unstable teams, uneven service capacity, and weak internal governance.

China's policy environment has made this issue more urgent. The General Office of the State Council's Opinions on Promoting the High-Quality Development of Public Hospitals set out the overall direction that

public hospitals should shift from scale expansion to quality and efficiency, from extensive management to refined management, and from resource allocation dominated by material inputs to allocation that gives greater weight to talent and technology [1]. The Public Hospital High-Quality Development Promotion Action (2021-2025) further identifies discipline construction, talent teams, and information technology as key supports for improving public hospital services and management [2]. These policy formulations clearly imply that HRM is not a marginal administrative function but a central component of hospital governance.

The external performance-assessment system also reinforces this transformation. China's national performance assessment for tertiary public hospitals is organized around medical quality, operational efficiency, sustainable development, and satisfaction evaluation [3]. These four dimensions are closely linked to HRM. Medical quality depends on staffing, competency, collaboration, and professional responsibility. Operational efficiency is affected by post design, workload distribution, scheduling, and incentive compatibility. Sustainable development requires talent echelons, research and teaching capacity, and leadership reserves. Satisfaction evaluation includes not only patient experience but also the work experience and motivation of medical staff. Therefore, the performance assessment system has created a policy bridge between public welfare goals and internal human resource reform.

The scale of China's hospital system further explains why HRM reform is systemically important. According to the 2024 statistical bulletin on China's health development, health personnel reached 15.78 million nationwide, including 13.02 million health technical personnel. Hospitals employed 9.374 million health personnel, and public hospitals alone employed 7.051 million people. Public hospitals provided 3.77 billion outpatient and emergency visits and 209.596 million inpatient admissions in 2024, accounting for the large majority of hospital service volume [4]. Such a scale means that seemingly internal HRM arrangements, such as staffing structure, performance distribution, training opportunities, and staff support, have system-level implications for service capacity and health system resilience.

International health-system literature supports this interpretation. Human resources for health are widely regarded as a critical policy component, because workforce supply, distribution, competencies, incentives, and working conditions affect the performance of health systems [7,8]. Health-care HRM is also closely related to service quality and organizational outcomes [9]. In hospital settings, HRM practices have been associated with patient mortality and care outcomes in previous studies [10]. These findings do not automatically translate into the Chinese institutional context, but they suggest that hospital HRM should be understood as a governance mechanism rather than a back-office activity.

This article responds to the need for a more explicit and policy-grounded analysis of HRM optimization in Chinese public hospitals. It is positioned as a policy analysis and perspective article, not as a strict empirical research article. It does not present original survey data, interviews, or hospital-level statistical modelling. Instead, it synthesizes official policy documents, public statistical evidence, and relevant international literature to construct an analytical framework for HRM reform under China's high-quality development agenda. The aim is to provide a conceptually clearer and practically usable framework for public hospital managers, health administrators, and scholars concerned with hospital governance.

2. Analytical Approach and Policy Context

2.1 Article positioning and analytical method

Because this article does not use primary empirical materials, it avoids claims that would require statistical verification. Its method is a structured policy and literature analysis. First, major national policy documents related to public hospital development, performance assessment, modern hospital management, salary reform, post management, and talent evaluation were used to identify the institutional requirements placed on public hospitals. Second, recent national health statistics were used to describe the scale and workload background of hospital HRM. Third, international literature on human resources for health, strategic HRM, hospital performance, staffing, burnout, and employee support was used to strengthen the theoretical logic of the proposed framework. The article then organizes these materials into a problem-cause-path-effect structure and proposes an integrated optimization model.

This positioning is important for two reasons. On the one hand, policy analysis can be valuable when a country is implementing major institutional reforms and needs a clearer translation of national policy goals into organizational management tools. On the other hand, the absence of primary data requires caution. The article therefore does not claim to test causal relationships or measure the effectiveness of specific hospital interventions. Instead, it clarifies policy logic, identifies plausible management mechanisms, and proposes a framework that can be further tested in future empirical research.

2.2 Policy logic of high-quality public hospital development

China's public hospital reform has increasingly emphasized public welfare, refined management,

talent and technology, and governance modernization. The 2017 guidance on establishing a modern hospital management system established the institutional direction of improving hospital governance, enhancing management capacity, and balancing social benefit with operational efficiency [5]. This earlier reform provided the governance foundation for later high-quality development policies.

The 2021 Opinions on Promoting the High-Quality Development of Public Hospitals transformed these governance ideas into a more explicit development agenda. In relation to HRM, the policy has several direct implications. First, it calls for strengthening clinical specialty construction and medical technology innovation, which requires high-level discipline leaders, clinical backbones, research teams, and compound management talent. Second, it proposes a shift to refined operational management and data-supported decision-making, which requires hospital managers who understand medicine, operation, economics, information technology, and quality control. Third, it specifically calls for reforming the personnel management system, implementing post management, scientifically drafting post responsibility statements, and treating staff within and outside formal staffing quotas more consistently [1].

The salary reform policy is equally relevant. The 2021 guidance on deepening public-hospital salary reform emphasizes the "two allows" principle, internal distribution autonomy within approved salary totals, salary systems that reflect post responsibilities and knowledge value, and performance links that maintain the public welfare nature of public hospitals [6]. This means that performance distribution should not be reduced to departmental revenue or workload alone. It should reflect technical difficulty, quality, risk, public service responsibilities, teaching and research, cost control, and staff contribution.

The action plan for public hospital high-quality development (2021-2025) further stresses the construction of high-quality talent teams, including urgently needed specialties, public health-clinical compound talent, administrative management talent, operational management talent, information management talent, and economic management talent [2]. The policy implication is that public hospitals must move beyond a narrow medical-specialist view of talent and build a multidisciplinary workforce structure that fits modern hospital governance.

3. Main HRM Problems in Chinese Public Hospitals

3.1 Workforce structure does not fully match strategic needs

A common contradiction in public hospitals is the mismatch between workforce structure and strategic development needs. High-level talent is often

Policy document	Core policy requirements	HRM implications
Opinions on Promoting the High-Quality Development of Public Hospitals (2021)	Shift from scale expansion to quality and efficiency; strengthen specialty construction, innovation, refined management, post management, and salary reform.	HRM must become a strategic governance function aligned with hospital development, service quality, and public welfare.
Public Hospital High-Quality Development Promotion Action (2021-2025)	Build high-level hospital networks, clinical specialty groups, high-quality talent teams, information systems, and management capacity.	Talent planning should include clinicians, nurses, researchers, public health-clinical compound talent, operational managers, and digital governance staff.
National Performance Assessment for Tertiary Public Hospitals (2019)	Assess medical quality, operational efficiency, sustainable development, and patient/staff satisfaction.	Internal HRM and performance systems should link staff incentives to quality, efficiency, sustainability, and staff experience rather than revenue alone.
Guidance on Deepening Public Hospital Salary Reform (2021)	Implement the “two allows”; reflect post responsibility, knowledge value, industry characteristics, and public welfare orientation.	Performance distribution should recognize workload, difficulty, risk, quality, teaching, research, cost control, and long-term contribution.
Guidance on Establishing a Modern Hospital Management System (2017)	Improve governance structure, hospital charters, internal management systems, and scientific decision-making.	HR departments should participate in strategic planning, internal control, governance modernization, and leadership development.

Table 1. Main policy documents and HRM implications for Chinese public hospitals

concentrated in strong departments and platform specialties, while pediatrics, emergency medicine, critical care, infectious diseases, rehabilitation, geriatrics, mental health, pathology, anesthesia, and public health-related positions may be less attractive. At the same time, high-quality development requires a broader talent portfolio. Smart hospital construction requires staff who understand both clinical processes and digital systems. Payment reform requires staff who can connect clinical pathways, cost control, medical insurance rules, and hospital operations. Scientific innovation and achievement transformation require staff with knowledge of medicine, research design, intellectual property, project management, and industry collaboration.

This structural issue is not simply a recruitment problem. It reflects a lag between hospital strategy and workforce planning. When hospitals plan human resources mainly according to historical staffing quotas, immediate vacancies, or departmental bargaining power, they may overlook future service demand, population aging, new disease burdens, regional medical-center construction, and the needs of integrated care. International health workforce projections also warn that health systems face complex imbalances between demand, supply, distribution, and skill mix [13]. Chinese public hospitals therefore need dynamic workforce planning rather than reactive hiring.

3.2 Post management remains insufficiently refined

Many hospitals have introduced post management in form, yet the substantive content of posts is not always updated in line with changes in medical services and hospital governance. Some job descriptions still emphasize academic title, seniority, or administrative category rather than post responsibility, risk, difficulty, workload, and contribution to quality. In clinical departments, workload and risk can differ sharply across positions, but staffing decisions may still be adjusted slowly. In administrative and support departments, the value of work such as medical insurance management, data governance, infection control, medical record quality, operational analysis, and patient service improvement is often difficult to quantify, and therefore may be underestimated.

Policy documents require public hospitals to set posts by category, formulate responsibility statements, and link assessment to post duties [1]. This requires HRM to penetrate the department and post level rather than remain at the personnel-department level. Research on strategic HRM ability in clinical departments of Chinese public hospitals also indicates that department-level HRM capability is a meaningful component of hospital organizational management [11]. In other words, post management is not a clerical exercise; it is a mechanism for aligning organizational strategy, departmental tasks, and employee contribution.

3.3 Performance appraisal remains caught between public welfare and incentive pressure

Performance distribution is one of the most sensitive areas of public hospital HRM. If appraisal gives excessive weight to revenue or service volume, hospitals may deviate from their public welfare orientation and increase internal pressure on departments. If appraisal is overly egalitarian, it cannot recognize differences in workload, technical difficulty, risk, quality, teaching, research, and responsibility. The national performance assessment framework provides a corrective direction by requiring attention to medical quality, operational efficiency, sustainable development, and satisfaction [3]. However, the translation of this external assessment logic into internal departmental and individual appraisal remains uneven.

A high-quality performance system must therefore solve three tensions. The first is the tension between quantity and quality: workload should be recognized but cannot replace quality, safety, appropriateness, and patient experience. The second is the tension between individual contribution and team collaboration: medical services are delivered by teams, and excessive individualization of incentives may weaken multidisciplinary cooperation. The third is the tension between short-term output and long-term capability: teaching, research, talent cultivation, discipline construction, and public health responsibilities may not generate immediate income but are essential to sustainable development. Strategic HRM research in public hospitals suggests that HRM practices should connect employee outcomes and organizational performance rather than operate as isolated personnel techniques [12].

3.4 Talent cultivation lacks continuity across the career cycle

Some hospitals attach more importance to attracting high-level experts than to cultivating internal talent. Talent introduction is necessary, especially for key disciplines and urgent specialties, but it cannot replace a stable internal growth mechanism. Young doctors, nurses, medical technicians, pharmacists, and managers need structured onboarding, mentorship, competency training, clinical exposure, research support, and career guidance. Without such mechanisms, young staff may experience high work pressure without clear development prospects.

A discontinuous cultivation system weakens the talent echelon. It can produce a "middle break" between senior experts and young staff, make departmental succession uncertain, and reduce the hospital's capacity to sustain specialty development. In

the Chinese policy context, high-quality development explicitly requires high-level strategic talent, leading talent, innovation teams, urgently needed nursing professionals, and administrative management talent [1,2]. Therefore, talent cultivation should cover the whole career cycle and all staff categories, not only physicians pursuing academic promotion.

3.5 Medical staff care is not yet sufficiently institutionalized

Medical staff in public hospitals often work under high responsibility, high uncertainty, emotional labor, night shifts, doctor-patient communication pressure, research assessment pressure, and promotion pressure. The 2024 statistical bulletin indicates that public hospital physicians carried a higher daily outpatient workload than the overall hospital average, with 7.2 outpatient visits per physician per day and 2.2 inpatient bed-days in 2024 [4]. Workload alone does not determine burnout, but it is an important background factor when discussing staff well-being and sustainable service capacity.

The international literature consistently shows that burnout among health workers is not merely an individual psychological problem; it is related to workload, organizational support, staffing, recognition, work control, and professional meaning [14-17]. If hospitals address medical staff care only through holiday greetings, short-term commendations, or occasional hardship assistance, the mechanism remains too weak. High-quality development requires staff to maintain professional commitment and service quality over the long term. This cannot be achieved without institutional arrangements for workload control, rest and leave, psychological support, occupational safety, career counseling, childcare or family support where feasible, and fair recognition.

3.6 Digital HRM is fragmented and sometimes increases rather than reduces burden

Digital transformation is a major feature of modern hospital management. Policy documents require the construction of smart hospitals and the integration of electronic medical records, smart services, and smart management [1]. However, HRM digitalization in some hospitals remains fragmented. Personnel records, post appointment, attendance, scheduling, training, professional title evaluation, performance appraisal, and salary distribution may be managed through separate systems with inconsistent standards. When digital tools are implemented mainly for reporting or control, they may increase the documentation burden on frontline staff rather than improve management support.

The core issue is whether digital HRM serves strategic decision-making and employee experience. Data should help hospitals identify overloaded departments, high-turnover posts, training gaps, promotion bottlenecks, performance distortions, and emerging talent needs. It should not become a new

Model element	Core question	Key HRM actions	Expected outcomes
Policy orientation	How should HRM reflect public welfare and high-quality development?	Align HRM with national policies, hospital strategy, performance assessment, and public welfare responsibilities.	Stronger legitimacy, clearer reform direction, reduced revenue-centered bias.
Organizational mechanism	How can policies be translated into daily management?	Strategic workforce planning, classified post management, competency standards, fair performance distribution, full-cycle training.	Better person-post fit, improved internal fairness, stronger talent echelon.
Humanistic support	How can hospitals protect and motivate medical staff?	Workload management, psychological support, occupational safety, flexible scheduling, career counseling, family-friendly support where feasible.	Lower burnout risk, stronger retention, higher professional commitment.
Digital empowerment	How can data improve HRM without increasing burden?	Integrated HR information platforms, workload monitoring, training analytics, turnover warning, data security and privacy governance.	More precise decisions, fewer repetitive administrative tasks, better employee experience.
Outcome evaluation	How should HRM reform be assessed?	Indicators covering medical quality, efficiency, staff satisfaction, patient experience, talent growth, and public welfare performance.	Closed-loop reform, accountable governance, continuous improvement.

Table 2. Integrated HRM optimization model for Chinese public hospitals

layer of mechanical assessment. Digital HRM also raises issues of data accuracy, privacy protection, authorization boundaries, and algorithmic fairness. For public hospitals, digital governance must be guided by public welfare, staff trust, and management improvement.

4. An Integrated HRM Optimization Model for Chinese Public Hospitals

To move beyond a list of separate suggestions, this article proposes an integrated optimization model for Chinese public-hospital HRM. The model has five connected elements: policy orientation, organizational mechanism, humanistic support, digital empowerment, and outcome evaluation. Policy orientation ensures that HRM follows the public welfare and high-quality development direction. Organizational mechanism translates policy goals into workforce planning, post management, performance distribution, and talent development. Humanistic support protects medical staff and sustains professional motivation. Digital empowerment improves precision and evidence-based decision-making. Outcome evaluation connects HRM reform to medical quality, service efficiency, staff experience, patient satisfaction, and sustainable hospital development.

5. Optimization Paths

5.1 Establish strategic and dynamic workforce planning

Public hospitals should make workforce planning a component of hospital strategy rather than a passive response to departmental shortages. Planning should begin with the hospital's functional positioning, regional medical demand, discipline-development priorities, medical alliance responsibilities, public health tasks, and future service models. Based on these factors, hospitals can identify which specialties need expansion, which posts have high risk of shortage, which age groups face succession gaps, and which compound talents should be cultivated in advance.

A practical workforce planning system should include at least five datasets: age and retirement structure, educational and professional-title structure, post distribution, workload and service volume, and turnover or mobility. These data should be updated regularly and linked with recruitment, training, job rotation, and promotion decisions. Planning should also incorporate weak and urgent specialties. Emergency medicine, pediatrics, intensive care, infectious diseases, geriatrics, rehabilitation, mental health, anesthesia, pathology, nursing, pharmacy, and public health-clinical integration should receive special attention when regional needs and hospital functions require them.

5.2 Build classified post management based on responsibility and value

Public hospitals need differentiated post systems for physicians, nurses, medical technicians, pharmacists, researchers, administrators, public health staff, and logistics personnel. A classified post system should not create rigid hierarchies; its purpose is to recognize different forms of work value and ensure that evaluation standards fit job characteristics. For clinicians, key indicators may include medical quality, technical difficulty, patient safety, diagnosis and treatment capability, and participation in multidisciplinary care. For nursing staff, indicators should reflect nursing quality, patient safety, risk level, health education, and patient experience. For medical technicians and pharmacists, technical accuracy, reporting efficiency, rational medication support, and clinical collaboration should be considered. For administrators, service to clinical departments, operational efficiency, coordination ability, problem solving, and policy implementation should be emphasized.

Post responsibility statements should be updated when clinical technology, workflow, policy requirements, or digital systems change. Hospitals should also create mechanisms for departments to participate in post design while preventing departmental self-interest from distorting staffing demands. The HR department should work with medical affairs, nursing, quality control, finance, medical insurance, information, and discipline offices to establish evidence-based post standards. In this way, post management can become a bridge between organizational strategy and individual performance.

5.3 Redesign performance appraisal around public welfare, quality, and long-term contribution

Performance appraisal should be reconstructed from a revenue-centered logic to a multi-dimensional value logic. The external national assessment framework already provides a useful structure: medical quality, operational efficiency, sustainable development, and satisfaction [3]. Internal hospital appraisal should translate these dimensions into department-specific and post-specific indicators. For example, clinical departments should be assessed not only by workload but also by disease difficulty, quality-control indicators, adverse-event prevention, rational medication, average cost control, patient experience, teaching tasks, research contribution, and cooperation with primary care or medical alliances.

Performance distribution should also recognize high-risk, high-intensity, urgent, and public-interest posts. Emergency medicine, intensive care, infection control, pediatrics, obstetrics, nursing, medical record management, and medical insurance administration

may contribute to hospital safety and public welfare even when their work is not fully reflected in income. At the same time, performance appraisal should avoid over-fragmentation. If every small indicator is linked mechanically to income, staff may focus on measurable tasks and neglect holistic patient care. A balanced system should combine quantitative indicators, qualitative peer review, department-level team incentives, and transparent explanation procedures.

The salary reform policy allows public hospitals to design internal distribution models that reflect post responsibility, knowledge value, labor characteristics, and public welfare requirements [6]. This policy space should be used to develop a more stable and trusted distribution system. The principle should be clear: more work and better performance deserve recognition, but "better performance" must include quality, safety, ethics, collaboration, and long-term contribution, not only volume or revenue.

5.4 Create full-cycle talent cultivation and multi-track career development

Talent cultivation should cover the whole career cycle. For newly recruited staff, hospitals should strengthen onboarding in professional norms, patient safety, medical ethics, hospital culture, and basic post competency. For young backbone staff, mentoring, clinical skills training, research-method training, project support, external study opportunities, and cross-department rotation should be provided. For middle-level managers and discipline backbones, training should focus on team building, quality management, budget thinking, medical insurance policy, data interpretation, and communication. For high-level talent, hospitals should provide team resources, platform support, protected research time when possible, and fair mechanisms for achievement transformation.

Multi-track career development is necessary because not all staff should be evaluated by the same academic route. A clinician with excellent technical skill and patient trust should have a recognized clinical track. A nurse with strong specialist-care capability should have a nursing specialist track. A pharmacist contributing to rational medication and clinical pharmacy should have a professional development path. Hospital administrators should also have professionalized promotion channels rather than being treated as auxiliary personnel. Research-oriented staff, teaching-oriented staff, and innovation-transformation staff may require different evaluation standards. This multi-track approach is consistent with policy calls for classified evaluation and reduced overreliance on paper quantity or single academic indicators [1].

5.5 Institutionalize care and support for medical staff

Staff care should become part of hospital governance. First, hospitals should establish workload monitoring and warning mechanisms. When a department remains overloaded for a long period, the response should not be limited to urging staff to work harder; it should include staffing review, process optimization, schedule adjustment, and support from related departments. Second, rest and leave systems should be implemented more strictly, especially for night-shift and high-risk posts. Third, psychological support should be normalized and destigmatized. Confidential counseling, peer-support programs, communication training, and crisis-intervention channels can help staff cope with stress before it becomes burnout.

Fourth, hospitals should provide career-development consultation. Some occupational pressure comes from unclear promotion rules, uncertain expectations, and conflicts between clinical work and research requirements. Transparent rules and individual development guidance can reduce unnecessary anxiety. Fifth, hospitals can provide targeted support for young staff, including housing information, childcare coordination where feasible, and assistance for staff in special hardship. These measures should not be understood as welfare decoration. They are part of a retention strategy and a quality strategy. A hospital that cannot protect its staff will find it difficult to sustain high-quality services.

5.6 Promote digital HRM with data governance and employee experience

Digital HRM should be designed around three goals: reducing repetitive administrative work, supporting scientific decisions, and improving employee experience. Hospitals can integrate personnel files, post appointment, scheduling, attendance, training, performance appraisal, professional-title evaluation, salary distribution, and staff feedback into a unified or interoperable HR information system. This does not mean that all data must be centralized without boundaries. Rather, standards, authority, privacy, and use scenarios should be clarified.

Data analysis can support practical HRM decisions. For example, workload data can reveal persistent departmental overload; training data can show whether programs improve competency; turnover data can identify posts with retention risks; performance data can expose whether indicators unintentionally encourage revenue-oriented behavior; and career-development data can identify talent echelons. However, digital systems should not become instruments for excessive surveillance. Staff should understand how data are used, how errors can be corrected, and how privacy is protected. Digital HRM will succeed only when it improves trust and reduces burden.

Dimension	Main problem	Underlying causes	Optimization path	Expected effect
Workforce structure	Mismatch between talent supply and strategic needs	Reactive hiring; weak forecasting; insufficient compound talent reserves	Dynamic workforce planning; urgent specialty support; compound talent cultivation	Improved service capacity and strategic adaptability
Post management	Unclear responsibility and uneven workload recognition	Overreliance on title/seniority; outdated job descriptions	Classified post standards; post responsibility statements; person-post fit analysis	Fairer evaluation and stronger motivation
Performance distribution	Tension between incentives and public welfare	Revenue-centered indicators; weak quality and long-term indicators	Multi-dimensional appraisal covering quality, efficiency, sustainability, and satisfaction	Better alignment between incentives and high-quality development
Talent cultivation	Fragmented training and weak career continuity	Emphasis on introduction over cultivation; single promotion track	Full-cycle training; mentoring; multi-track career development	Stable talent echelon and stronger professional growth
Staff care	Burnout risk and insufficient institutional support	High workload; emotional labor; unclear support mechanisms	Workload warning, rest protection, psychological support, career counseling	Improved retention, staff satisfaction, and service sustainability
Digital HRM	Fragmented systems and data burden	Data silos; control-oriented digitalization; weak governance rules	Integrated HR data platform; privacy protection; decision-support analytics	More precise governance and better employee experience

Table 3. Problem-cause-optimization path-expected effect framework

6. Safeguard Measures for Implementation

6.1 Strengthen leadership commitment and HR strategic participation

Hospital leaders should reposition the HR department from a transactional office to a strategic partner. HRM reform involves recruitment, staffing, post design, salary distribution, performance appraisal, training, staff care, and digital governance. These issues cannot be solved by the HR department alone. They require joint participation by hospital leadership, clinical departments, nursing departments, finance, medical insurance, quality control, information technology, discipline offices, and labor unions. Leadership commitment is necessary to coordinate conflicting interests and prevent HRM reform from becoming a set of isolated documents.

HR leaders should participate in hospital strategy formulation, annual planning, discipline construction, budget discussion, and quality-improvement programs. Such participation helps ensure that workforce capacity is considered before new disciplines, new campuses, new technologies, or new service models are launched. It also helps hospitals evaluate whether strategic goals are realistic under existing workforce conditions.

6.2 Build fair, transparent, and explainable rules

Fairness is the foundation of HRM credibility. Recruitment, appointment, performance appraisal, promotion, training opportunity allocation, awards, and salary distribution should follow transparent procedures. Staff may not agree with every decision, but they are more likely to accept management when criteria are clear, procedures are open, and results can be explained. Hospitals should establish appeal and feedback channels so that staff can correct factual errors and express reasonable concerns.

Transparency does not mean eliminating managerial discretion. Some aspects of medical work require professional judgment. However, discretion should be bounded by rules and documented reasoning. In this way, hospitals can combine flexibility with fairness and avoid both rigid bureaucracy and arbitrary decision-making.

6.3 Develop department-level HRM capability

Many HRM problems appear at the department level. Scheduling, workload distribution, mentoring, skill training, internal cooperation, and daily staff support are often handled by department directors, head nurses, and administrative coordinators. Therefore,

hospitals should strengthen department-level HRM capability. Department leaders should receive training in performance communication, conflict management, talent echelon building, psychological support awareness, and data interpretation. The HR department can provide templates, data dashboards, consultation, and monitoring, but department leaders must become active participants in HRM.

Department-level HRM should also be connected with accountability. Departments should not only be assessed by business volume or income but also by staff development, training completion, patient safety, staff satisfaction, and compliance with workload and leave rules. This helps transform departments from simple production units into talent-development units.

6.4 Promote pilot programs and evidence accumulation

Because public hospitals differ by level, region, specialty structure, ownership relationship, and financial condition, HRM reform should avoid a one-size-fits-all model. Hospitals can first conduct pilot programs in selected departments or management modules, such as classified post evaluation, nursing specialist career tracks, burnout-risk warning, digital scheduling, or quality-oriented performance distribution. Pilot results should be evaluated through indicators such as staff satisfaction, turnover intention, workload balance, medical quality, patient experience, and administrative burden.

Future empirical research should build on these pilots. Survey studies, interviews, case studies, quasi-experimental designs, and longitudinal data can test whether specific HRM interventions improve staff outcomes and hospital performance. In this sense, the policy framework proposed in this article is not the end of research but a basis for more rigorous empirical inquiry.

7. Discussion: Contribution and Boundary of the Framework

The main contribution of this article is to connect China's public-hospital high-quality development policies with a coherent HRM optimization framework. Previous discussions often listed problems and countermeasures separately, such as improving recruitment, reforming performance appraisal, strengthening training, or caring for medical staff. This article argues that these measures should be understood as mutually connected elements of a broader governance model. Strategic planning without fair performance distribution may not motivate staff. Performance reform without staff care may intensify pressure. Digital management without transparent rules may reduce trust. Talent cultivation without multi-track career channels may fail to retain staff. Therefore, HRM optimization must be integrated rather than fragmented.

The framework also clarifies the Chinese institutional characteristics of public hospital HRM. Public hospitals are not ordinary market organizations. They must maintain public welfare, implement government reform policies, accept performance assessment, undertake public health responsibilities, and respond to patient demand for accessible and high-quality care. At the same time, they need to motivate highly trained professionals and maintain operational sustainability. HRM reform is precisely where these goals intersect.

The limitations of this article should be acknowledged. It does not provide hospital-level empirical evidence, and it does not compare different provinces or hospital types in detail. Some proposed pathways may require financial resources, digital infrastructure, leadership support, or local policy space that not all hospitals possess equally. The framework should therefore be adapted to hospital level, specialty structure, regional demand, and fiscal conditions. Future research can test the model through case studies of representative public hospitals, surveys of staff experience, and quantitative evaluation of performance-reform outcomes.

8. Conclusion

Under the background of high-quality development, human resource management in Chinese public hospitals must shift from routine personnel administration to strategic, refined, people-oriented, and digitally supported governance. This shift is required by national policy, by the scale and workload of China's hospital system, and by the need to sustain professional motivation and service quality.

The optimization of HRM should begin with strategic workforce planning and classified post management, continue through public-welfare-oriented performance appraisal and full-cycle talent development, and be supported by institutionalized staff care and digital decision-making. The ultimate goal is not only to improve internal management efficiency but also to enhance medical quality, patient safety, staff dignity, talent stability, and the sustainable development of public hospitals.

For public hospitals, the most important human resource question is not simply how to recruit more people or how to distribute performance pay. It is how to build an organizational environment in which medical professionals can work safely, grow continuously, cooperate effectively, and contribute to public welfare. Only when HRM is integrated with hospital strategy, policy requirements, and humanistic governance can public hospitals better meet people's demand for high-quality health services.

Declarations

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The authors are responsible for the originality, factual accuracy, reference authenticity, and academic integrity of the manuscript.

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