

## **Human Resource Management Practices and Quality of Health Care Service Delivery at Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya**

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### **Abstract**

*The study focused on the link between Human Resource Management Practices and Quality of Health Care Service Delivery within Teaching and Referral Hospitals in Kenya. Health care is human resource intensive yet few scholars conceptualize it as a function of Human Resource Management Practices. The lack of studies on the link between Human Resource Management (HRM) Practices and health care delivery has resulted in continued industrial unrest by doctors and nurses in Kenya. The objective was to determine the empirical link between recruitment, training, compensation, and performance management practices, and Quality Health Care Service Delivery (QHCS D). The study was underpinned by the Human Capital, Resource Based View, and Person Fit Environment Theories. The population of interest consisted of all the front line clinical and nursing staff at Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) in Kisumu County, Kenya. A cross sectional survey research design was used to capture opinions of a sample of 97 respondents from a target population of 130 clinicians and nurses. Primary data, collected by a self-administered structured questionnaire was summarized using descriptive statistics to establish the mean agreement with statements on Human Resource Management Practices adopted and Quality of Health Care Service Delivery. The findings were presented using tables and regression results obtained with the aid of SPSS v.20. Multiple regression analysis was used to test the significance of the relationship amongst the log<sub>10</sub> of predictor and outcome variable. The log-log regression results indicated a coefficient of determination (R<sup>2</sup>) of 0.222 suggesting that a 22.2% variance in the dependent variable that can be anticipated from the four HRM practices considered in the study. An ANOVA test isolated the log-log regression coefficients for each of the predictor variables in the study, with training and performance management being significant predictors of QHCS D within TRHs. The study provided empirically derived recommendations for HRM practitioners and academics for enhancing QHCS D by adoption of potent HRM practices within TRHs, in Kenya and beyond.*

**Key Words:** *Human Resource Management Practices, Health Care, Quality of Health Care Service Delivery, Quality Management, Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya*

### **1. BACKGROUND TO THE STUDY**

The study investigates the effect of Human Resource Management (HRM) Practices on Quality Health Care Service Delivery (QHCS D) in Teaching and Referral Hospitals (TRHs). HRM is regarded as vital for the successful realization of organizational objectives. For instance, Elarabi and Johari (2014) point out that in hospitals efficient management of HR is essential for the delivery of efficient and effective medical services and to achieve patient satisfaction. It is

argued that adoption of High Performance HRM (HP- HRM) practices in hospitals is associated with significantly lower mortality rates and better financial performance (Sheldon, 1995). Further, the incorporation of HR personnel, within TRH's managerial hierarchy, has been recommended as a strategy to boost the ability of health care professionals to manage HR at Moi TRH (Wanza and Mwakesi, 2014). As Patterson (2010) suggests, more empirical work is needed to isolate the HP-HRM Practices that are most effective.

It is therefore surprising that, within TRHs, QHCSD is yet to be conceptualized as a function of HRM Practices yet these hospitals not only offer specialized primary and tertiary health care services but also are tasked with handling complex cases and training of medical staff. To execute their mandates TRHs have an imperative to not only recruit a sufficiently trained and specialist Health Care Professionals, but to also manage their performance and compensate them adequately. However, few studies are conceptualized to enhance our understanding of the relative importance of the various HRM functions to provision of quality service in the context of TRHs. It may be argued that lack of knowledge of the relative importance of the effects of the various HRM functions in driving quality in healthcare systems may be dysfunctional. The aim of this study is to determine the relative significance of HRM practices that have the potential to enhance the ability of TRHs to achieve their mandates. The focus of the current investigation is on establishing the significance of recruitment, training, compensation and performance management as predictors of QHCSD within TRHs in Kenya. In particular it focuses on the case of Jaramogi Oginga Odinga Teaching and Referral Hospital (JOTRH), which is the most recent TRH in Kenya and whose HRM challenges are yet to be investigated empirically.

HRM challenges in the provision of health care are not just universal, but have also attracted a lot of research attention both locally and globally. Globally, the key HRM issues that have attracted the attention of relate to size, composition, distribution, workforce training issues and the migration of health workers (WHO, 2003). Despite it being acknowledged that the number of health workers available in a country is a key indicator of that country's capacity to deliver quality healthcare, little attention has been focused on the role of HRM in QHCSD by TRHs. Spence and Lewis (2009) argues that since knowledge, skills and motivation of HR determines QHCSD a need exists to examine the question of what kinds of HRM practices can lead to an enhancement in the QHCSD. More work is needed to solve the problem of identifying which HRM practices are significant predictors of QHCSD (Patterson, 2010). So far, the significance of HRM in organizational performance is yet to be proven empirically (Pfeffer, 1998, Huselid and Becker, 1995). Further, researchers are investigating whether claims of evidence of a universal link between HRM and performance are overstated (Huselid and Becker, 1995). In particular, attention has been drawn to the methodological limitations and heterogeneity of the measures for HRM Practices and QHCSD. There is agreement that QHCSD results from the interaction between various actors and depends on the characteristics and behavior of patients and care givers (Martin and Pimhidzai, 2013).

QHCSD is contingent on what happens in clinics, although combinations of several basic elements have to be present in order for quality services to be accessible and produced by health personnel at the frontline (Gayle and Obert, 2013). Although provision of QHCSD is a human resource intensive undertaking yet few studies focus on HRM as a driver of quality in the health care sector. In the context of TRHs in Kenya, empirical studies have focused on the role of financing, infrastructure, materials and equipment and less on that of HRM. For instance, studies done in the context of TRHs within Kenya, such as by Odongo (2014) focussed on assessing the

effect of ISO certification on organizational performance at Moi TRH. Wanza and Mwakesi (2014) focused on factors hindering health professionals from achieving hospital goals at Moi TRH. The study recommended the incorporation of HR personnel, within TRH's managerial hierarchy, to boost the ability of health care professionals to manage HR in the institution. It can be argued that the HR intensive nature of health care service provision justifies an empirical investigation to identify the HRM practices that significantly predict QHCSD as a way to enhance the role of HRM in TRHs.

## **2. STATEMENT OF THE PROBLEM**

TRHs are a health care institution and the human intensive nature of health care service provision requires the adoption of high impact HRM practices. Paradoxically, TRHs faces the challenge of having adequate health workers with the motivation to deliver quality health care. This challenge is further aggravated by the decentralization in management of HR and irregular disbursement of funds (Njuguna, Mwangi and Kamau, 2014; Mwamuye and Nyamu, 2014). The continued lack of focus on the contribution that HRM may have on QHCSD, in Kenya, has resulted in staff dissatisfaction, strikes and desire to withdraw professional services. In particular, it has not been possible to identify the significance of HRM practices as determinants QHCSD. The current study is motivated by the need to establish if the existing HRM capacity can adequately staff TRHs with well compensated and motivated health care professionals for QHCSD. The current focus on the link between HRM practices and QHCSD fills the empirical, contextual, and conceptual gaps in the health care literature on HRM performance link. Previous work does not provide an empirically derived understanding of the significance of HRM in QHCSD. For instance the study by Njuguna, Mwangi and Kamau (2014) focused on implications of the devolved system of HR management in the health care sector on retention of Health Workers in a remote Kenyan district. Other related studies, such as by Mwamuye and Nyamu (2014) focuses on the implementation of devolution in management of health care within Mombasa County, and improving health service delivery in counties. Such studies are not predictive of the effect that HRM Practices may have on QHCSD in the context of TRHs in Kenya. This has made it difficult to make inferences on the best HRM practices to manage in health care professionals in TRHs. The current study fills this empirical gap by establishing the nature of the relationship between HRM practices and QHCSD in TRHs by examining the case of JOOTRH. In addition to filling the above empirical gap, the current study also fills a conceptual gap in our understanding of the link between the HRM practices and QHCSD. Previous studies have had a much restrictive conceptualization of the role of HRM.

For instance, Njuguna, Mwangi and Kamau (2014) conceived of the role of HRM on retention of health care professionals. They did not address the recruitment, training, compensation and performance management issues that have been suggested to influence performance of health care institutions (Arabah (2012), Adwan (2008) and Mukhaimar and Taamenah (2004). This study provides a more comprehensive conceptualization of the role of HRM in enhancing QHCSD, which views performance of health care institutions from a quality point of reference. Further, it fills contextual gaps since differences in employment laws and governance structures make results of previous studies unsuitable for basing HR decisions that target improvement on QHCSD. An indicator used in one country may be unsuitable owing to lack of data and the economic and institutional circumstances of each country (Dunleavy and Carrera, 2013). The current study presents a useful test of the hypothesis that HRM Practices can predict QHCSD in the context of a developing country, likely to be less endowed with the facilities that TRHs

require for QHCSD. To fill the empirical, contextual and conceptual gaps, a need exists for a study that focuses on the link between HRM practices and quality of health care service delivery. The current study focuses on establishing the empirical link between HRM Practices, of recruitment, training, compensation and performance management, and QHCSD at JOOTRH. The key question answered in the current study is: What is the effect of recruitment, training, compensation and performance management practices on QHCSD within TRHs in Kenya?

### **3. OBJECTIVES OF THE STUDY**

The overall objective of this study was to assess the influence of human resource management practices on the Quality of Health Care Service Delivery at Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya.

The specific objectives were to:

- i. To determine the relationship between recruitment practices and quality of health care service delivery at Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya.
- ii. To ascertain the relationship between training practices and quality of health care service delivery at Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya.
- iii. To establish the relationship between compensation practices and quality of health care service delivery at Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya.
- iv. To assess the influence of performance management practices on quality of health care service delivery at Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya.

### **4. THEORETICAL REVIEW**

A theoretical framework provides the basis on which the entire research rests (Sekarah, 1992). A theory generates research since the interlocking connections have to be tested (Drew, 1980). The current study tested the connection between HRM Practices and QHCSD based on the Human Capital, the Resource Based View and, the Person Environment Fit Theories.

#### **4.1 Human Capital Theory**

The Human Capital Theory (HCT) by Baker (1964) considers people as assets and stresses that investment in people by organizations brings worthwhile returns. According to HCT the human capital they bring to work consist of elements like innate abilities, behavior and personal energy. HCT was used as suitable frameworks for unlocking the connection between recruitment, training between HRM practices and QHCSD. The HCT was considered as being relevant to the current study because human resources are one of three principle health system inputs, with the other physical capital and consumables (WHO, 2000). It is an asset that must be handled properly, since performance depend largely upon the knowledge, skills and motivation of clinical and non-clinical staff responsible for public and individual health intervention (WHO, 2000). As Armstrong (2006) suggests, HRM should focus on attracting, retaining and developing human capital because it is individuals that generate, retain and use the knowledge and skills that create intellectual capital. Further, the level of human capital has an influence on firm performance HRM-Performance Link (Baker, 1964). The current study considered HCT a suitable theoretical lens from which to test the connection between HRM practices, of selection, training and HCS D at TRHs given the importance of human capital in the health care sector and the acknowledge role of HR managers in ensuring a sufficient level of HR, HCT. The second theory that

underpinned this study is the Resource Based View, that Armstrong (2006) notes is closely linked to the HCT.

#### **4.2 Resource Based View of the firm**

The Resource Based View (RBV), by Penrose (1959), is considered suitable for analyzing the link between HRM practices and QHCSD. The relevance of RBV in understanding the HRM Practices QHCSD link derives from the recent development of research interest in the internal operation of the organization. RBV and the associated capabilities framework have been viewed as an increasingly important, yet somewhat controversial, approach. A resource-based view of a firm explains its ability to deliver sustainable competitive advantage when resources are managed such that their outcomes cannot be imitated by competitors, which ultimately creates a competitive barrier (Mahoney and Pandian 1992). RBV explains that a firm's sustainable competitive advantage is reached by virtue of unique resources being rare, valuable, inimitable, non-tradable, and non-substitutable, as well as firm-specific (Barney 1999). Varying performance between firms is a result of heterogeneity of assets (Lopez 2005, Helfat and Peteraf 2003) and RBV is focused on the factors that cause these differences to prevail (Grant 1991, Mahoney and Pandian, 1992). Fundamental similarity in these writings is that unique value-creating resources generates a sustainable competitive advantage to the extent that no competitor has the ability to use the same type of resources, either through acquisition or imitation.

Major concern in RBV is focused on the ability of the firm to maintain a combination of resources that cannot be possessed or built up in a similar manner by competitors. Further such writings provide us with the base to understand that the sustainability strength of competitive advantage depends on the ability of competitors to use identical or similar resources that make the same implications on a firm's performance. This ability of a firm to avoid imitation of their resources should be analyzed in depth to understand the sustainability strength of a competitive advantage. The RBV postulates that firms can develop sustained competitive advantage only by creating value in a way that is rare and difficult for competitors to imitate (Barney, 1995). Two reasons explain why it may be difficult to imitate human resource strategies that are deeply embedded in an organization (Barney, 1991; Collis & Montgomery, 1995). First, it is difficult to grasp the precise mechanisms by which the interplay of human resource practices and policies generates value. To imitate a complex system, it is necessary to understand how the elements interact, in particular, whether the effects are additive or multiplicative, or they involve complex nonlinearities. Researchers are a long way from understanding the precise nature of these interactions and without being able to understand how an HR system works, it is not possible to imitate it by, for instance, reverse engineering it. It is even difficult for a competing firm to imitate a valuable HR system by hiring away one or a few top executives because the understanding of the system is an organizational capability that is spread across many, not just a few, people in the firm.

HR systems are path dependent, they consist of policies that are developed over time and cannot be simply purchased in the market by competitors. A competitor can understand that a system is valuable but is precluded from immediate imitation by the time required to fully implement the strategy. Further, there may be limits on management's ability to successfully replicate socially complex elements such as culture and interpersonal relationships. Thus, given the possibility that they are not easy to imitate, human resource strategies may be an especially important source of sustained competitive advantage (Lado & Wilson, 1994; Pfeffer, 1994; Wright & McMahan, 1992). Theoretical work in business strategy has given a boost to the prominence of HR in

generating sustained competitive advantage. Technology and capital can be acquired by most firms anytime, for a price, but it is not easy to acquire a ready pool of highly qualified and motivated employees (Sparrow et al., 2002). Thus, to be differentiated, the companies need to be very careful with the recruitment and selection process. The theory is relevant to this study since researchers in the field of HRM have increasingly relied on RBV of the firm to explain the role of HR practices on firm performance (Wright, Dunford and Snell, 2001). Following successful use of RBV in Strategic HRM the current study adopts RBV as a suitable lens for examining the link between HRM practices and QHCSD.

### **4.3 Person Environment Fit Theory**

Person Environment Fit (P-E fit) Theory, attributed to Kristof (1996), is premised on the notion of how well characteristics of the person and the environment of the organization fit one another. As such a theoretical framework that focuses on the degree to which a person matches with a job or organization is useful in explaining the relationship between HRM practices of recruitment, selection, training, development, remuneration and performance evaluation and QHCSD. The P-E fit theory holds that attitudes and behaviors are caused by the compatibility between individual and environmental characteristics (Cable & Edwards, 2004; Dawis, 2005; Kristof-Brown, Zimmerman & Johnson, 2005). In the literature a distinction is often made between Person-Organization fit (P-O fit) and Person-Job fit (P-J fit). P-O fit refers to the compatibility between a person and the organization, emphasizing the extent to which a person and the organization share similar characteristics and/or meet each other's needs (Kristof, 1996). PO fit is embedded in the broader concept of Person -Environment (PE) fit. While PE fit is defined generically as the compatibility between attributes of the person and the environment (e.g., Pervin, 1989; Schneider, 1987), in PO fit the environmental referent is simply defined as the organization. As such, PO fit addresses the compatibility between people and organizations (Kristof-Brown et al., 2005). Like PE fit, PO fit has been linked to job choice, selection decisions, job satisfaction, performance, organization commitment, turnover, and psychological well-being (Kristof-Brown et al., 2005). Also linked to these QHCSD predictor variables is P-J fit aspect of P-E fit theory. In P-E theory, the environment referent is simply defined as the Job. As such P-J fit measures the compatibility between people and Jobs. As Edwards (1991) explains, P-J fit refers to the match between the abilities of a person and the demands of a job or the desires of a person and the attributes of a job.

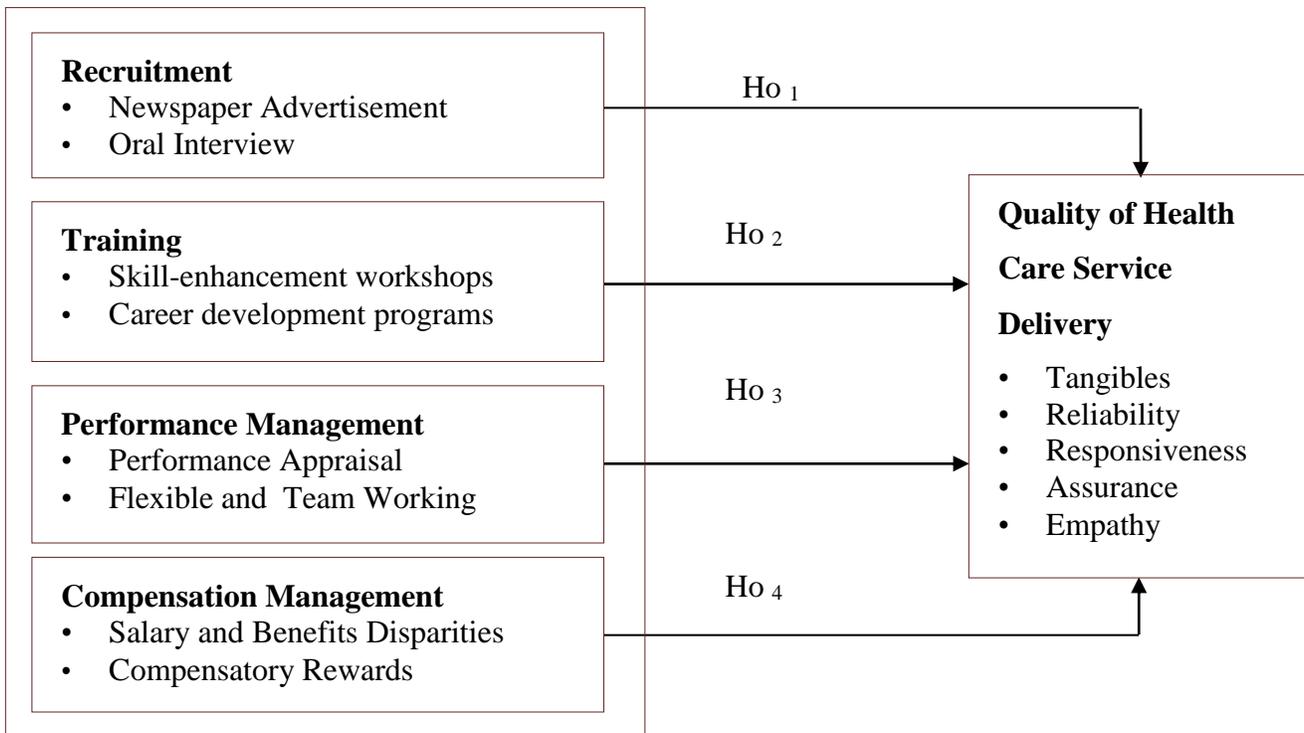
These two dimensions of person-environment fit are simply attempts to explain different sets of attitudes and behaviors that follow from the P-O or P-E fit or misfit. For example, person-organisation fit has been found to influence organisational attraction and organisational citizenship behaviours, while person-job fit has been found to influence job attraction, job satisfaction and intentions to pursue a job offer (Kristof-Brown *et al.*, 2005). This study proposes that P-O fit and P-J fit offers utility in explaining the link between HRM practices and QHCSD. The predictor variables, represent practices that determine the extent of fit between a person and job or an organization. The P-O fit and P-E fit theories offer explanations of people's attitudes and motivations. For instance, P-O fit was found to be correlated with work attitudes such as job satisfaction and organizational commitment (O'Reilly, Chatman & Caldwell, 1991; Vancouver & Schmitt, 1991). Also, P-O fit predicts intention of quit and turnover (Chatman, 1991; O'Reilly et al., 1991; Vancouver et al., 1994), and was related to prosocial behaviors such as organizational citizenship behaviors (O'Reilly & Chatman, 1986), self-reported teamwork (Posner, 1992). The review of the P-J fit literature by Edwards's (1991) identified job

satisfaction, low job stress, motivation, performance, attendance, and retention as outcomes that are positively affected by P-J fit. Although the idea that people should be compatible with their organization may seem simplistic, few studies have considered it a basis for underpinning a study that links recruitment, selection, training, compensation and appraisal and QHCS. The current study proposes that because P-E fit theory offers an explanation of the motivation and attitudes of employees it is a suitable lens from which to understand the link between the four HRM practices, considered in this study, and QHCS within TRHs.

## 5. CONCEPTUAL FRAMEWORK

A conceptual framework relates factors important in solving a research problem (Ngechu, 2006). It provides a diagrammatic summary of the variables investigated based on a review of literature (Oseno, 2012). It. Figure 1 provides the conceptual framework for the current study.

### HRM Practices



**Fig. 1 Conceptual Framework of the study**

The conceptual framework in Figure 1 incorporates HRM variables that have been studied as antecedents of healthcare service delivery recently (Salah Mahmoud Diab, 2012; Al Kudhat Mohammed, 2004; Chan and Mak, 2012). Figure 1 shows that QHCS depends on HRM practices adopted at the TRH to manage the health care professionals tasked with delivery of clinical and nursing services. The framework shows that quality of service delivery in a TRH is a function of HRM practices adopted by their HR department.

## 6. RESEARCH METHODOLOGY

Descriptive research design was considered appropriate, for gathering data on HRM practices and QHCS at a particular point in time, and for describing existing conditions. Descriptive method was adopted to facilitate description of existing phenomena by asking individuals

about their perceptions, attitudes, behaviors and values. The population of interest consisted of all the front line clinical and nursing staff at JOOTRH in Kisumu County, Kenya. From the list of all the 516 staff at JOOTRH, a population of 130 clinical and nursing staff formed the population of interest. Stratified simple sampling technique was used in this study to select a representative sample from the population of interest. Primary data was collected using five research assistants trained prior to the exercise. The researcher supervised the assistants to ensure completeness of the instrument. The questionnaire used a five Point Likert rating scale to ascertain the perception of doctors and nurses of the HRM practices and the perceived level of QHCSD. The questionnaires were administered through the Directors in charge of clinical services and nursing services. The quantitative data was analyzed using descriptive statistics and presented using distribution tables. The study applied multiple regression analysis to the  $\log_{10}$  of the dependent and independent variables.

## 7. DATA ANALYSIS RESULTS

The research applied statistical package for social scientists (SPSS) to develop a log-log level model of the effect of HRM practices on QHCSD. Using SPSS version 20 it was possible to carry out  $\log_{10}$  transformations on the dependent and predictor variables. Table 1 presents the coefficient of determination of the log-log level multiple regression model.

**Table 1: Coefficient of Determination for HRM Practices**

R	R Square	Adjusted R Square	Std. Error of the Estimate
.470a	0.221	0.178	0.07682

*a. Predictors: (Constant), log10Performance Management Practices, log10Rec Practices, log10Training Practices, log10Comp Management Practices*

The R Square value in regression model in Table 1 provides an indication of the explanatory power of the regression model. R square is simply the percentage of variance in the dependent variable explained by the collection of independent variables. The value of 0.221 means that 22.1 % of the variability QHCSD can be explained by the predictor HRM variables considered in the study. The other variables not studied in this research contributed 77.9% of the variability in QHCSD. In the next part of the output, SPSS tests the significance of the correlation coefficient by analysis of variance (ANOVA). The ANOVA report in Table 2 assesses overall significance of the regression model.

**Table 2: ANOVA**

	Sum of Squares	df	Mean Square	F	Sig.
Regression	0.122	4	0.031	5.18	.001a
Residual	0.431	73	0.006		
Total	0.553	77			

*a. Predictors: (Constant), log10PerformanceManagementPractices, log10RecPractices, log10TrainingPractices, log10CompManagementPractices*

*b. Dependent Variable: log10QHCSD*

The column labeled Sig. shows the significance of the statistical test applied to the hypothesis. Numbers in columns labeled Sig. are p values and therefore give results of hypothesis test. The p values refer to a list of collection of independent variables. If the Sig. value shown next to the F-

test value in Table 4.20 were less than .05, we would conclude that the correlation coefficient is significantly different from 0.

In Table 2 the p value is  $0.001 < 0.05$  and therefore we accept the alternative hypothesis that at least one independent variable is a significant predictor of the dependent. That is, we would reject the  $H_0$ , and conclude that there is a significant positive linear relationship between the predictor variables and response variable. In this case, R square = .221 and is significant because Sig. = .001, which is less than .05. With a significant correlation, it now makes sense to examine the regression equation in order to make predictions. Had the correlation not been significant, we would not be able to justify the use of the regression equation.

To determine the significance of the model an analysis of the variance was made using SPSS version 20. From the analysis of variance we cannot tell how significantly each of the independents predicts the dependent variable. This can only be possible after establishing the coefficients of the regression model and the significance of the statistical test. Testing of the null hypothesis was achieved by running SPSS for the parameter coefficients in the multiple regression model relating the predictor variables to the response variable. Table 3 presents the parameter coefficients of the regression model.

**Table 3: Coefficients of HRM Practices**

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	1.377	0.167		8.231	0.000
log10RecPractices	-0.044	0.083	-0.057	-0.529	0.598
log10TrainingPractices	0.167	0.113	0.159	1.47	0.004
log10CompManagementPractices	-0.079	0.063	-0.142	-1.263	0.21
log10PerfromanceManagementPractices	0.33	0.082	0.431	4.044	0.003

*a. Dependent Variable: log10 QHCSD*

Table 3 presents predictor variables coefficients together with p-values. The hypothesis were tested by comparing the decision rule p value of 0.05 with predictor variable p values. The decision rule states that if  $p < 0.05$  reject the null for non-significance and conclude that the independent variable is a significant predictor of the dependent variable. The study hypothesized that:

**H<sub>01</sub>:** There is no significant effect of recruitment practices on QHCSD

**H<sub>02</sub>:** There is no significant effect of training practices on QHCSD

**H<sub>03</sub>:** There is no significant effect of compensation management practices on QHCSD

**H<sub>04</sub>:** There is no significant effect of performance management practices on QHCSD

The results of the test of significance shown in Table 4.20 indicate that the p-value of Recruitment Practices is  $>0.05$  ( $p = .598$ ). We thus accept the first null hypothesis,  $H_{01}$  that that there is no significant relationship between RP and QHCSD. Thus we can conclude that recruitment practices is not a significant predictor of the quality of health care service delivery given the p-value (.598) is greater than the decision p-value  $p < 0.05$ . The result that recruitment practices adopted by JOOTRH do not significantly predict the Quality of health care service provided at JOOTRH does not support previous studies. For instance, Huselid (1995) found that HRM practices such as employee recruitment and selection procedures have a significant impact

on employee turnover and productivity, and on short and long term corporate financial performance. Descriptive work suggests that recruitment may be an important predictor of organizational performance (Rousseau and Wade-Benzoni, 1994; Heneman, Huett, Lavigna and Ogsten, 1995; Huselid, 1995).

Finding of a non-significant and negative relationship between recruitment and QHCSD may come as a surprise to many HR practitioners and theorists alike. However, in the context of TRHs the result is understandable since recruitment is not a function of HR within TRHs. Clinicians and Nurses at JOOTRH were either recruited by the central government or more recently since, 2013, by the County Public Service Board. In the current study, respondents consisted of only permanent staff, who unlike the temporary staff were recruited and posted to JOOTRH by other agencies. In regard to the second hypothesis, the results of the hypothesis test in Table 4.20 indicates that the p-value of training practices ( $p=0.004$ ) is less than the decision p-value ( $p = <0.05$ ) hence we reject the second null hypothesis,  $H_{02}$ , that there is no significant effect of training practices on quality of health care service delivery. Thus we may conclude from the test that training practices is a significant predictor of quality of health care service delivery at JOOTRH.

That training is a significant driver of quality at JOOTRH lends empirical support to earlier studies reporting a positive relationship between training and performance of organizations (Ashar, Ghafour, Munir, and Hafeez, 2013; Raja, Furqan and Muhammad, 2011). The first study report a sense of emotional attachment and commitment to the organizations, and are thus less likely to leave their jobs owing to training being available at all times. In a review of literature on TDP, Raja, Furqan and Muhammad (2011) report that On the Job Training, Training Design and Delivery Style have all been found to be positively related to Organizational Performance. The result that clinicians and nurses perceive of training as a significant predictor may be interpreted in two ways. First, it may be a reflection of the adequacy of pre-service training that these health care providers get before joining the work force. Interpreted in this way then, they view on the job training as being a critical component of their performance, and particularly, in the setting of a teaching and referral hospital where the numbers of those in constant medical and nursing training is large. Thus training, in this context may be viewed to be the order of the day and where it is conducted based on an analysis of needs is perceived to be a driver of quality.

The second interpretation may be that JOOTRH, being deficient in a high profile strategic HRM organization has an effective training strategy targeting quality improvement for its clinical and nursing health care service providers. This is a possible explanation as training practices evident showing that selection for training is based on TNA designed to improve QHCSD (3.10). The third hypothesis tested related to the relationship between compensation management practices and QHCSD at JOOTRH. The p-value of compensation management practices ( $p=.210$ ) is greater than the decision rule p-value ( $p = <0.05$ ) hence we accept the third null hypothesis,  $H_{03}$ , that there is no significant effect of compensation management practices on quality of health care service delivery at JOOTRH. Thus we may conclude from the results of this hypothesis test that compensation management is not a significant predictor of quality of health care service delivery at JOOTRH. The finding that compensation practices do not predict QHCSD at JOOTRH is contrary to findings in previous studies such as by Ozcan and Hornby (2005) in Turkish government hospitals. They found that one of the reasons for poor performance of employees was lack of interest by the managers of head departments in government hospitals to provide better conditions to hospital's staff and develop incentives system. The study recommended the

adoption of incentives system and rewards for staff and nurses who perform well. Further it recommended choosing a group each month as a role model for individuals working in the hospital and pay them special bonuses to encourage other staff who have not been selected.

Finally, the study found that adopting incentive system improved the performance of all individuals working in the hospital dramatically. The empirical finding relating to compensation management not being a significant predictor of quality at JOOTRH is not surprising in the context of health care management in Kenya. Perhaps it is reflective of the fact that remuneration of health care professionals is not decided within the specific hospitals, being a function of the devolved and central government units. It means that staff feel that JOOTRH has no role in managing their compensation, this function being moribund is not perceived to significantly drive quality. The final hypothesis tested related to the effect of performance management on QHCSD at JOOTRH. The results shows that the p-value of performance management practices ( $=.003$ ) is less than the decision rule p-value ( $p < 0.05$ ) hence we reject the hypothesis that there is no significant effect of performance management practices on quality of health care service delivery. Rejecting the null hypothesis means that we accept the alternative hypothesis that it has a significant effect. We concluded from the result of this hypothesis test that performance management practices is a significant predictor of QHCSD. The finding provides empirical support to earlier studies which suggested a positive relationship between performance management practices and performance of an organization such as Musyoka (2015). The study adopted a descriptive and exploratory design to investigate the influence of performance appraisal on performance of health care workers at Mbagathi Hospital in Nairobi. Findings show minimal awareness and use of PA for training and promotion, reward and feedback. It was not embraced to motivate staff to improve service delivery but as a ministry requirement. The study showed that lack of basic training by health service managers explained the poor implementation of PA in the hospital.

## **8. CONCLUSIONS**

The results of the study are a valuable addition to the literature on the link between HRM Practices and QHCSD in TRHs, within Kenya and beyond. This study concludes that QHCSD is linked to HRM practices as specified in the log-log regression model:  $\text{Log}_{10}(\text{QHCSD}) = 1.377 - 0.044(\text{Log}_{10}\text{RP}) + 0.167(\text{Log}_{10}\text{TP}) - 0.079(\text{Log}_{10}\text{CMP}) + 0.330(\text{Log}_{10}\text{PMP}) + e$ . In conclusion the negative coefficients of recruitment and compensation management practices provide empirical evidence that these practices do not drive quality of care in TRHs. Further, training and performance management practices are significant predictors of QHCSD in TRHs. The model shows 1% changes in performance management and training practices lead to increases in QHCSD by 33 and 16.7 percent respectively. Interestingly, the negative coefficients show a 4.4 percent and 7.9 percentage reductions in QHCSD will follow from changes in recruitment and compensation management practices. In conclusion, by revealing the most potent predictors of QHCSD, this study provides an empirical basis for prescribing high impact HRM practices within TRHs in Kenya.

## **9. RECOMMENDATIONS**

Several recommendations to improve QHCSD at JOOTRH from a HRM perspective arise from this work. The first and second recommendations derives from the finding that only 22.1 % of the variability in QHCSD, suggesting HRM deficiency in TRHs. The third and fourth recommendations derive from the coefficients of the log transformed explanatory and target

variables. First, since over 77.9 percent of the variations in QHCSD do not arise from HRM practices, it is recommended that HRM deficiency within TRHs is addressed. This can be done by establishing HRM departments to entrench the role of TRHs in recruitment and compensation of nurses and clinicians. This will address the perennial problems of strikes in the health care sector. The current institutional and regulatory frameworks vests recruitment and remuneration functions on the County Public Service Board and The Salaries and Remuneration Commission respectively. However, TRHs are the users of services provided by these health care professionals, it is key to ensure their management is vested in TRHs. In particular, the HR intensive nature of health care provision suggests the need to involve

Second, the coefficients of the log regression model reveals that since HRM related factors only account for 22.1 percent of the changes in QHCSD, it is recommended that further studies be made to identify non HRM quality drivers in TRHs. In particular, a focus needs to be made on physical factors, such as facilities and equipment, in addition to financing of facilities. Such focus will help identify other drivers of QHCSD in TRHs in Kenya and beyond. Third, since performance management and training practices are the drivers of QHCSD, it is recommended that the HRM function at TRHs enhance these roles. In particular, the strengthening of performance management techniques like performance contracting and of training practices like training needs analysis can increase QHCSD in TRHs. The final recommendation derives from the result that recruitment and compensation management practices are negative predictors of QHCSD in TRHs. To stem the industrial unrest in the health care sector, there is need to further investigate the potential of recruitment and compensation in ensuring and sufficiently motivated health care givers in TRHs. In particular, the non-significance recruitment and compensation practices, point at more work to understand the effect of current practices on labour unrest within TRHs in Kenya. Thus the current study provides answers to the research question posed in the study: What is the effect of Human Resource Management Practices on the Quality of Health Care Service Delivery at JOOTRH? In particular, it provides an empirical link between HRM practices and QHCSD that fills the empirical and conceptual gaps in our knowledge.

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