INFLUENCE OF EMPLOYEE RELATIONS PRACTICES ON ORGANISATIONAL PERFORMANCE OF PUBLIC HEALTHCARE SECTOR IN KENYA

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DECLARATION

This Thesis is my original work and has not been presented for a degree in any other University.

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DEDICATION

To my dear husband Mateli, Daughters Nzasu, Syokau, Son Mung'ati and in loving memory of my dear Parents, Velisi and Muthoka, my firm foundation, Rest in Peace.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AMO	Ability, Motivation & Opportunity
DHMB	District Health Management Boards
EEO	Equal Opportunity Employer
ER	Employee relation
ERC	Employee Relation & Communication Survey
FBO	Faith Based Organizations
GDP	Gross Domestic Product
HCW	Health Care Workers
HCW	Healthcare workers
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
HRM	Human Resource Management
ILO	International Labour Organization
KHDS	Kenya Health Demographic Survey
KHPF	Kenya Health Policy Framework
KNBS	Kenya National Bureau of Statistics

MMR Maternal Mortality Ratio

MOH Ministry of Health

NGO Non- Governmental Organization

OECD Organization for Economic Cooperation Development

PHMT Provincial Health Management Team

PMSMT Provincial Medical Services Management Team

RBV Resource Based View

ROK Republic of Kenya

SPSS Statistical Package for the Social Sciences

TI Transparency International

UNAid United Nation Aid

USD United States Dollar

WB World Bank

WHO World Health Organization

DEFINITION OF TERMS

Communication: Communication is the downward, horizontal, or upward exchange of information, ideas, feelings, thoughts and emotions through informal or formal channels that enables managers to achieve their goals (Bell and Martin, 2008). Communication refers to the process by which information is transmitted and understood between two or more people (McShane & Von Glinow, 2005).

Compensation: Compensation is a systematic approach to providing monetary value to employees in exchange for work performed (Cole 2004).

Conflict Resolution: Methods and mechanisms used to help employee relations actors manage differences at the work place (Olakunle, 2008).

Employee Relation: Interdisciplinary field that encompassesthe processes of regulation and control over workplace relations, the organisation of tasks, and the relations between employers and their representatives, and employees and their representatives, and is the sum of economic, social and political interactions in workplaces where employees provide manual and mental labour in exchange for employability, rewards as well as the institutions established for the purpose of governing workplace relations (Gospel & Palmer, 2004)

Practice: Repeated performance or systematic exercise for the purpose of acquiring skill or proficiency (Jung, 2010).

Empowerment: Focus of organization on delegation of authority, encouraging workers to participate in decision making, enabling them to control work processes as required (Katou & , 2007).

Organisational Performance: How successfully an organized group of people with a particular purpose perform a function (Harney & Jordan, 2008).

Quality of Service: The degree to which healthcare services for individuals and population increases the likelihood of desired healthcare outcomes and is consistent with the current professional knowledge (Gooderham, Robert & Hancock, 2008)

Productivity: A ratio of actual output to maximum potential output obtainable from a given input level (Freeman, 2008).

Staff Retention: Ability of an organization to keep employees (Hash, 2012).

Performance: Measurements include effectiveness, efficiency, economy, consistency behaviour and normative measurement, productivity, quality of service, (Richardo & Wade, 2010).

Public Healthcare Sector: All organized measures to prevent disease, promote health, and prolong life among the population as a whole (WB, 2013)

Public sector: Part of the economy concerned with providing various government services. The composition of the public sector varies by country, but in most countries the public sector includes such services as the military, police, public transport and care of public roads, education, along with health care and those working for the government itself, such as elected officials (Hellen, 2015).

ABSTRACT

Organisational performance has received wide attention in literature and research due to its importance since every organization aims to achieve higher performance. Critique of existing literature on Employee Relations Practices reveals that gaps exist on their influence on Organisational Performance in Public Healthcare Sector in Kenya. The main aim of this study was to establish the extent to which various employee relations practices such as conflict resolution, employee empowerment, employee compensation, and employee voice influence organisational performance in public healthcare sector in Kenya. The study targeted hospitals categorized in levels four (4) and five (5) as per the government of Kenya categorization structure. Information was gathered by use of questionnaires which were subjected to pre-test to ensure both validity and reliability of the instruments. The study adopted descriptive research design and used census to gather data from four hundred and fifty (450) Hospital Administrators, Human Resources Managers and Employee representatives from all the 150 hospitals of level 4 & 5 in Public Healthcare Sector in Kenya. The study generated both qualitative and quantitative data which was collected using likert scales and later analyzed descriptively using Measure of Central Tendency and inferentially using Multiple Regression Model. Analyzed data was presented using tables, charts and graphs. All the questionnaires were received as valid. This constituted 100% response rate. The questionnaire was pilot tested on respondents drawn from Public healthcare Sector which was not included in the final research. Reliability of the questions was tested by use of Cronbach's alpha. Normality test was done for dependent variable in order to aid subsequent analysis. Factor analysis was also done to reduce the data to meaningful size and all the items met the required threshold. Correlation analysis was used to test the direction of relationship between the independent variables and dependent variable. Multiple regression was used to test whether conflict resolution practices, employee empowerment practices, employee compensation practices and employee voice practices have any influence on organizational performance. The study established a multiple coefficient correlation of 0.693 (69.3%) between employee relations practices and organizational performance. The study concludes that employee relations practices influence organisational performance of Public Healthcare Sector in Kenya. The study recommends to the management in public healthcare sector to embrace sound employee relations practices such as alternative conflict resolution practices as current union voice does not influence Organisational performance. They should also come up with innovative practice to reinforce sense of self efficacy among healthcare worker. The study also recommends that the Ministry of Health to come up with an elaborate plan to equip all hospitals elevated to levels 4 and 5 as these acts as centers of excellence in Medicare. The study recommends further study on other factors such as technology that influence organisational performance of Public Healthcare Sector other that those covered in the study.

CHAPTER ONE

INTRODUCTION

This study focused on the influence of employee relations practices on organisational performance in the public healthcare sector in Kenya. Chapter one provides background information on the topic under study. The statement of the problem, general and specific objectives of the study were covered under this chapter. Study hypotheses, justification of the study, scope and limitations of the study were also covered.

1.1 Background of the study

The performance of healthcare sector has been a major concern of policy makers of many years. Many countries have recently introduced reforms in healthcare sector with explicit aim of improving performance (Collins, Greens & Hunter, 1999). The Government of Kenya (GOK) has been trying to build a healthcare sector which can effectively provide quality health services to the population of the country. Performance in public healthcare sector in Kenya is critical because it provides 48% of healthcare services in the country that has a population structure of 60% absolute poor, 20% relatively poor and 20% rich and powerful (World Bank, 2013). The sector also provides social-economic growth and eradicates poverty by assuring all population receives high quality service and cost-effective health care (Transparency International, 2011).

Kenya has weak public healthcare sector characterized by lack of funding, inadequate health infrastructure, human resources and other health care inputs exacerbating Health Care Workers (HCW) distribution inequalities, quality of service complains, low productivity and poor health services utilization (WHO, 2013). It is widely recognized that the key to economic development in any country is her human resource (Lederman, 2009). Barney (1991) argues that the people dimension of organisational performance reveals its superior importance to the success of any organization (Vasconcelos, 2011; Pinar & Girard, 2008). Empirical studies have establish that features of Human Resource

Management practices such as training and development, recruitment and selection practices, and employee relations are closely related to constructs of organisational performance such as financial performance, staff retention and productivity (Huselid 1995; Ricardo & Wade, 2010; Goel, 2008).Kenya has one of the highest net emigration rates of HCWs in the world, with 51% leaving the country to work elsewhere (WB, 2013). The contemporary trend in the global public healthcare sector shows that there are widespread cases of HCW strikes, poor quality healthcare services, and high employees' turnover (WB, 2013).

In recent years, Kenya has been experiencing a lot of industrial action by trade unions especially in the Public Healthcare Sector. The Labour Commissioners Annual Report indicates that 82 strikes were recorded in 2010; 23 strikes in 2011, 17 strikes in 2012 and 20 strikes in 2013 majority of which were in Public Healthcare Sector (RoK, 2014). Most of these strikes caused by poor implementation collective bargaining agreements, lack of facilities in the healthcare Centers, delayed payment of salaries in some counties especially following the devolution of public healthcare or inadequate funding by the government (Wamai, 2009; Njau, 2012; RoK, 2012).

The Sector is currently experiencing an attrition rate of healthcare workers of 5% per annum. More than 50% of Kenyan Healthcare Workers practice in Nairobi County, with an estimated 3 million people, 6.8% of the country’s population leaving 93.2 % of the population with inadequate healthcare providers (Muchiri, Chankova, & Kombe, 2009). Such challenges have necessitated the need to establish the influence of conflict resolution mechanism, structural and psychological empowerment, compensation strategies and employee voice on organisational performance in the public healthcare sector in Kenya. Empirical studies have established employee relations practices have a significant relationship on organisational performance (Nishii, 2011). These have necessitated the integration of employee relation practices in the policy formulation to enhance performance given that healthcare services are largely delivered by human resources (Wamai,2009; Suliman, 2005).

The performance of the public healthcare sector in Kenya has been inadequate (WB, 2013). Life expectancy of the population as at 2013 was about 46 years and 51 years for men and women respectively compared to global average of 68 years (KNBS, 2014). Mortality rate was 147 per 1,000 lives which is double the global average. Morbidity and Mortality rates remain high with Kenya being rated 13th high TB burden country in the world (Mohajah, 2014). Globally, the trends in healthcare performance are different, average life expectancy for the Organization for Economic Cooperation & Development (OECD) countries is 80 years; mortality rate is 7.16 per 1,000 persons. Sub-Saharan Africa healthcare is ranked among the lower fifty percent (50%) performing healthcare sectors in the World (TI, 2011; WB 2013).

It is through this realization that the research tries to establish through thorough literature review and field research the influence of Employee Relation Practices on Organisational Performance in Public Healthcare Sector in Kenya.

1.1.1 Employee Relation Practices

Employee Relation (ER) involves the body of work concerned with managing and maintaining employment relationship which involves handling the pay –work bargain, dealing with terms and conditions of employment, providing employees with voice, conflict resolution and employee empowerment. Employee relations contribute to satisfactory organizational performance, motivation, and morale thereby preventing and resolving problems involving individuals that arise out of or affect work situations (Armstrong, 2009). Employee relations practices encompasses the processes of regulation and control over workplace relations, the organization of tasks, and the relations between employers and their representatives, and employees and their representatives, and is the sum of economic, social and political interactions in workplaces where employees provide manual and mental labour in exchange for employability, rewards as well as the institutions established for the purpose of governing workplace relations (Dessler, 2008).

The Human Resource Management (HRM) approach to ER emphasis on: commitment, mutuality, individual contracts, involvement, flexibility, teamwork and harmonization (Armstrong 2009). Commonly used employee relations practices include conflict resolution, employee empowerment, employee compensation, and employee voice. These practices are said to be vital for good governance and economic progress as they make decent work a reality at the workplace by helping to improve working conditions, safety and health, employee retention, employment conditions, employee performance and overall organisational performance (Armstrong, 2009).Generally, the goal of employee relations practices is to increase employee satisfaction and maintain good morale among workers. Happy workers are more productive, and more productivity means a better bottom line for the business (Heathfield, 2010). Providing health care is very demanding and stressful work for HCW who work long hours and many health care facilities operate 24-hours a day, seven days a week. As a result, employment issues often arise when members of management are engaged in other duties or otherwise not present to receive complaints or monitor disputes. This can result in employee relation issues festering and becoming major problems before they can be addressed (Ongori, 2007).

In recent years, reforms in the public healthcare sector in Kenya such as devolution of public healthcare services to the county governments meant to address the issues of efficiency and quality of service has brought about employee relations challenges such as unrest, brain-drain, county migration, increased medical errors, high mortality and low life expectancy rates (MoH, 2014). With increasing widespread cases of workplace conflicts, poor industrial democracy, strikes, poor quality health care services, and high employee turnover in the global public healthcare sector, implementation of employee relations practices is becoming increasingly important for the healthcare organizations (Vasconcelos, 2011). Healthcare workers strikes have become a global phenomenon with increasing incidence in many countries and the potential to impact on the quality of healthcare service delivery (Jones, Gorge, & Hill, 2000; Njiiri, 2012).

New developments and trends in the health and social care sector including social, technological and cultural trends globally have an impact on existing care patterns. Examples include increasing migration of healthcare professionals, the emergence of new healthcare patterns to tackle multiple chronic conditions, the growing use of technologies requiring new skill mixes and compensation pattern, work life balance and flexible working patterns. These changes have an impact on the working conditions and relationship of the healthcare workers, the employer and ultimately the healthcare performance (Henry, 2009).Organizations both globally and locally have adopted Employee relations practices to improve on organisational productivity and quality of service. The study will therefore establish whether the employee relations practices influence organisational performance in public healthcare sector in Kenya.

1.1.2 Organisational Performance in the public sector

The public sector is the part of the economy concerned with providing various government services. The composition of the public sector varies by country, but in most countries the public sector includes such services as the military, police, transit and care of public roads, education, health care and elected officials (Harris, Cortvried, Hyde, 2007). Public sector organizations are generally non-profit making and have little potential for income generation and, generally speaking, no bottom line against which performance can ultimately be measured, however, it is vital that the public sector is able to measure various aspects of performance (Boland &Fowler, 2010). Performance measures, such as productivity, customer service, employee retention, levels of absenteeism, motivation, innovations, and surpluses are commonly used to measure performance in not-for-profit (NGO) making organizations (OECD 1994; Pollitt & Bouckaert, 2000; Power, 1997).

The United States Institute of Medicine (USIM) has defined dimensions of healthcare performance to be quality of service; employee safety; effectiveness; efficiency, staff retention and equity of service (Carayon, 2012).New Public Management (NPM)

attribute a high priority to measuring output and outcomes and aim to base their new policies and management activities on this type of information, ideally meant to make policy implementation more efficient and effective (Leeuw & Van Gils, 1999). Nevertheless, the need for measuring output, outcomes, and performance evaluation activities remains an important element in performance contracting with a view of improving government organizations performance (RoK, 2013).

1.1.3 Performance of Global healthcare Sector

The healthcare sector plays a major socioeconomic role in many countries hence improving the delivery and organization of healthcare service delivery can have major impact not only on patients, but also on the socioeconomic health of countries (Carroll, 1999). Health spending represents a major proportion of the gross domestic product (GDP): 17.6% in 2009 in the United States while in other industrialized countries, health expenditures represent between 8-11% of the GDP (Martin, Lassman, Whittle, Catlin, 2011). Interest in improving healthcare delivery has steadily increased at national and international levels. Primary healthcare Report highlights major problems with healthcare delivery systems across the world: inverse care or inequity between those with the least means and the greatest health problems and those with the most means and lesser health problems; fragmented and fragmenting care related to poor working relationships and working conditions of healthcare providers, lack of holistic approach to health; unsafe care and medical errors related to poorly designed healthcare systems and processes; and misdirected care and lack of resources dedicated to primary prevention and health promotion (WHO, 2008).

Global evidence points to a direct correlation between the size and state of a country's health workforce and its health outcomes (WHO, 2006). The WHO (2006) report says Kenya is one of the 57 countries in the world that face a severe health workforce crisis and is one amongst the 36 within sub-Saharan Africa (HRH, 2014).Mortality rates for mothers and children under 5 years of age remain alarmingly high in sub-Saharan

Africa, Adolescent pregnancy, low contraceptive prevalence (13 percent), and high fertility (estimated at 5.6 children per woman) increase the lifetime risk of maternal death. An African woman's lifetime risk of dying from pregnancy and childbirth-related conditions is 1 in 22, compared with 1 in 8,000 in industrialized countries. These regional figures mask considerable differences between and within countries. For example, the maternal mortality ratio (MMR) – maternal deaths per 100,000 live births – is estimated to be 560 in Ghana and 2,037 in Southern Sudan (United States of America Aid, 2008). The challenge for Africa is to these healthcare performance statistics within a resource-constrained environment, with weak healthcare systems, employee relations crisis, and an HIV/AIDS epidemic. By 2010, sub-Saharan Africa accounted for more than half of all child mortality worldwide (WB, 2013).

In the emerging dynamic Global Village, healthcare sector challenges vary from region to region, health sector around the world have the same objective, that is, mainly to deliver the highest possible quality of care to the maximum number of people at the lowest possible cost (Adayi, 2013). Healthcare workers strikes have become a global phenomenon with increasing incidence in many countries. These have been reported in highly developed countries such as USA (Henry, 2009; Richo, 1964; Tjosvold, 1998), UK (Butler, 1973); New Zealand (Ikeda, Veludo, & Campomar, 2005); Germany and France (Henry, 2009,Brewer, Mitchell, & Weber, 2002); middle income countries such as Israel (Duke, 1999; Jung, 2003), India (Pondy, 1992), Czech Republic (Kumar & Steenkamp,1995), and South Africa (Robinson, Roy, Clifford, 1974; Parker, 1974;). Also in less developed countries such as Nigeria (Knippen & Green 1999), Malawi (Fowler & Floyd, 1975) and Zambia (Adomi & Anie, 2005).

The reasons given by HCWs for embarking on strikes may be classified under themes as follows: Failure by employers to honor collective bargaining agreements for improved wages and conditions of service; 'Disempowered' doctors and HCWs who feel unable to provide the best possible care for their patients because of inadequate facilities, drugs, and lack of support by employers especially in decision making, unresolved disputes,

lack of voice on the employee issues to help smoothen the employment relationship (Okene, 2009).While Healthcare workers strikes occur globally, the impact of strikes are more severely felt in less developed countries because of the poorer socio-economic circumstances and embedded infrastructural deficiencies. Such countries are generally confronted by issues of employment relations such as poor wages and working conditions (Edwards & Walton, 2000), poor organisational ethics (Pawlak, 1998; Robbins, 1974), and lack of viable alternative means of voice and resolving conflicts (Chima, 2007; Mackline, 2003). One thing that is obvious in the employer-employee relations is the issue of compensation, poor compensation practices are a constant source of frustration and can result is declines in productivity (Adayi, 2013).Stafford, (2011) aptly observed that compensation constitute a significant part of the overall cost of operations, observing that in some organizations it constitute over 50% of the operating costs.

It is a fairly common practice in the health sector for facilities to have internal conflict resolution practices in place whether or not the employees are represented by a union (Chima, 2007). Conflict resolution in Healthcare sector means working, co-operating, and behaving in a normal and orderly way. The goals and objectives of conflict management are to: ensure that employers and employee recognize each other's rights and obligations; promote constructive cooperation between the parties concerned at all levels; maintain discipline in industry; secure settlement of disputes and grievances by negotiation, mediation, and voluntary arbitration; in order to eliminate all forms of coercion, violence in employee relations; avoid work stoppages; facilitate the free growth of trade unions; respect for the human personality; while management personnel set high standards. Maintenance of a workplace where conflicts are managed is a prerequisite for the attainment of maximum productivity of the healthcare workers and that of the healthcare sector as a whole (Henry, 2009).

As the performance of healthcare sector has increasingly become an issue around the world, hospitals have increasingly had to pay serious attention to employee relations

practices. Minimizing the incidence and impact of Healthcare Workers strikes and migration requires an ethical approach from all stakeholders, and recognition that all parties have an equal moral obligation to serve the best interests of the organization and the society at large (Chima, 2007). It has been observed, especially in advanced capitalist societies like the United States, that there is an ongoing shift in doctors practice options from self-employment as owners of their own practices to doctors becoming employees of healthcare organizations in a managed healthcare environment.

According to Charles, et al (2013), one can anticipate that in the near future there could be more wage negotiations and collective bargaining between doctors as employees and the employing healthcare organizations. This will be similar to the practice in systems where medicine is centralized or socialized, and where HCWs are mostly public service employees on flexible work patterns (Sears, 2010; Crues, 2011). The World Health Organization (WHO) proposes four sets of reforms for addressing healthcare performance problems: work pattern reforms, service delivery reforms, public policy reforms, and leadership reforms. The Employee relations practices have a major role to play in service delivery reforms that improve health services around people's needs and expectations (WB, 2013).

1.1.4 Performance of Public healthcare sector in Kenya

Kenya's public health care sector is structured in a step-wise manner so that complicated cases are referred to a higher level hospital. Gaps in the system are filled by private and church run units. Hospitals in Kenya are structured in levels, with complicated cases being referred to a higher level. The structure thus consists of Dispensaries (level 1); Health centers (level 2); Sub-district hospitals (level 3); District hospital and private hospitals (level 4); Provincial hospitals (level 5) and National & referral hospitals (Level 6).There are about 10,021 healthcare facilities in Kenya representing the quantity of health infrastructure investment with 5000 being public healthcare facilities. The players in the health sector are the Government, which manages public health institutions,

private investors, faith-based organization (FBOs), and non-governmental organizations (NGOs). Forty eight per cent (48%) of the health facilities are run by the Government, Thirty Five (35%) per cent are managed by the private sector fifteen (15%) per cent by FBOs and NGOs two per cent (2%).

Kenya has Nine(9) provincial hospitals which are the regional centres of excellence and act as referral point for the lower level hospitals (MoH, 2015).Under the country's new devolution strategy, provincial hospitals are responsible for delivering health services and implementing health programs hence considered to be the central element of the public health system in Kenya (Wamai, 2009). Management responsibilities are split between the Provincial Health Management Team (PHMT)) and the Provincial Medical Services Management Team (PMSMT). Under the split-ministry structure, the Ministry of Medical Services (MOMS) is responsible for service delivery levels 4-6. The MOMS personnel includes specialist doctors, medical services officers, health records officers, nursing officers, pharmacists, and health administration officers at both provincial and district levels (RoK 2009).

According to World Health Statistics Report, Kenya's total expenditure on health as a percentage of Gross Domestic Product (GDP) was 4.6% in 2011 (29 USD per capita on health services, several dollars below the 34 USD). The Government of Kenya covers about 38.7% of the overall expenditures on health, while private expenditures account for 61.3% of overall spending (WHO, 2013). The performance of the Kenya health system is looked into with respect to equity, productivity, access, quality of service, employee retention and sustainability (ROK, 2010). These performance criteria, while broad in scope and not equally applicable to all the components of a health system, provide information on the major health system issues and can inform benchmarking of health system strengthening activities (Njau, 2012; Wamai, 2008).

Kenya Demographic Health Survey (KDHS) results on health statistics in Kenya including life expectancy, infant mortality, and maternal mortality show long-term

decline (KNBS 2014). Mortality rate is 147 deaths per 1000populations, Life expectancy stands at 46 years for men and 51 years for women (WHO, 2013). It is worth noting that these trends are different globally. In china, Life expectancy at birth in 2010 was 74.8; access to healthcare in terms of hospital beds per 10,000 populations is 4.55 and 2.06 number of physicians per 1000 population while mortality rate is 7.16 per 1000 population. In Sweden, Life expectancy at birth in 2011 was 82; access to healthcare in terms of hospital beds per 10,000 populations is 27 and 70 number of physicians per 1,000 populations while mortality rate is 10 per 1,000 populations. Ghana's life expectancy is 62 years and mortality rate is 273 per 1000; Access to healthcare in East Mediterranean is 4 health workers per 1000 population; 18.9 in Europe; 24.8 in America; 2.3 in Africa and 9.3 in the World (WHO, 2013). The challenge facing Kenya is to reverse this declining trend to comparable statistics with global trends (RoK 2015).

Kenyan public healthcare sector is facing an employee relations crisis (Kabene, Orchard, Howard, Soriano & Leduc, 2006). The migration of trained health workers from the public sector to higher paying positions in the private sector, or away from Kenya altogether, has made retaining qualified health personnel a persistent challenge. Kenya has one of the highest net immigration rates for HCWs in the world, with 51% leaving the country to work elsewhere (WB, 2013) and an annual attrition rate of HCW of 5%. The presence of inadequate HCWs in Kenya has made it difficult for the government to carry out adequate disease surveillance, maintain accurate statistics regarding disease outbreaks, and provide quality service to her population (RoK, 2014).More than 50% of Kenyan HCWs practice in Nairobi, with an estimated 3 million people, represents 6.8% of the country's population leaving 93.2% of the population in other counties with inadequate HCWs to provide quality healthcare service (Waiganjo, 2012).

Kenya has recently experienced unrest by HCWs in various counties due to delayed salary payments, poorly implemented collective bargaining agreements and lack of facilities in county public hospitals (Njau, 2012). Devolution of Public healthcare services to the counties means a complete change in the Human Resource for Health

(HRH) structure and its management with a clear strategic roadmap of human resource for health (HRH) interventions for improved health service delivery (HRH,2014). Kenya is the first call port for referral healthcare services in East African Region, however, the Public healthcare sector has been faced with high HCW migration with those employed in the sector opting to migrate, private-practice or employed by the Private healthcare sector for better compensations, empowerment in decision making and healthcare delivery facilities, clear voice channels and elaborate conflict resolution mechanisms (Njau, 2012; Kamuri, 2010). Healthcare is largely delivered by human resource and maintaining a harmonious employee-employer relationship is key to improved service delivery (Wamai, 2009).

1.2 Statement of the Problem

Organizational Performance of Public Healthcare Sector in Kenya is critical given that the country has a population structure of 60% absolute poor, 20% relatively poor and 20% rich and powerful (WB, 2013). The sector also provides social-economic growth and eradicates poverty by assuring all population receives high quality service and cost-effective healthcare (RoK, 2013). However, Kenya is ranked among the lower fifty percent (50%) underperforming healthcare sectors globally with high mortality rate, low life expectancy and poor quality service (TI, 2011; WB 2013). Kenya Demographic Health Survey (KDHS) on healthcare statistics in Kenya show long-term decline (KNBS, 2014). Mortality rate currently stands at 147 deaths per 1,000 population, Life expectancy stands at 46 years for men and 51 years for women (WHO, 2013). It is worth noting that these trends are different globally where average life expectancy in OECD countries is 80 years and mortality rate of 7.6 per 1000 population (WB, 2013).

Kenya has one of the highest net emigration rates for HCWs in the world, with 51% leaving the country to work elsewhere and an annual attrition rate of HCW of 5% (WB, 2013). More than 50% of Kenyan HCWs practice in Nairobi, with an estimated 3 million people, representing 6.8% of the country's population leaving 93.2% of the

population in other counties with inadequate HCWs to provide quality healthcare service (Waiganjo, 2012).

Kenyan public healthcare sector is experiencing voice challenges among those delivering healthcare in the counties (Njiiri, 2012). The sector is characterized by heavy unionization which has led to rampant industrial unrest. The Labour Commissioners Annual Report (RoK 2013) indicates that 82 strikes were recorded in 2010; 23 strikes in 2011, and 17 strikes in 2012, majority of which were in Public Healthcare Sector.

Poor compensation practices and delayed payment of salaries, employee-employer conflicts and poor or lack of infrastructure remain a constant source of frustration in Public Healthcare sector in Kenya (Ngui, 2014).The inability of public healthcare sector to reverse the declining healthcare outcomes constitute most pressing concerns raised by patients, communities and government regionally and internationally (Wang, Yi, Lawler, & Zhang, 2011; Muema, 2012). The study therefore seeks to establish influence of employee relations practices on organisational performance of public healthcare sector in Kenya.

1.3 Objectives of the Study

1.3.1 General Objective

The aim of this thesis was to examine the influence of employee relation practices on organisational performance of public healthcare sector in Kenya.

1.3.2 Specific Objectives

1. To examine the influence of conflict resolution on organisational performance of public healthcare sector in Kenya.
2. To determine the influence of employee empowerment on organisational performance of public healthcare sector in Kenya.

3. To establish the influence of employee compensation on organisational performance of public healthcare sector in Kenya.
4. To examine the influence of employee voice on organisational performance of public healthcare sector in Kenya.

1.4 Study Hypotheses

H_{01} Conflict resolution has no significant influence on organisational performance of public healthcare sector in Kenya.

H_{02} Employee empowerment has no significant influence on organisational performance of public healthcare sector in Kenya.

H_{03} Employee compensation has no significant influence on organisational performance of public healthcare sector in Kenya.

H_{04} Employee voice has no significant influence on organisational performance of public healthcare sector in Kenya.

1.5 Justification of the study

This study sought to bring out the influence of various employee relations practices on organisational performance of public healthcare sector in Kenya. Availability of high performing public Healthcare sector is central to the attainment of Kenya's Vision2030 whose main pillars are economic, social and political. This study shall help the government of Kenya in formulating effective Public Healthcare policies, plans and strategies for a sustainable socio-economic growth towards achievement of Vision 2030. This Study shall guide the administrators and human resource practitioners in public healthcare institutions who would want to improve their organisational performance. The study shall also contribute to the body of Human Resource knowledge by providing new knowledge in the field of employee relation especially around conflict resolution,

empowerment, compensation and employee voice. The study shall assist other researcher on conceptualizing employee relations practices. The research findings will form part of reference to other researchers and form a basis for further research in the area of employee relations and organisational performance. It will also assist students undertaking courses in employee relations theory and practice.

1.6 Scope of the Study

The study was conducted in Public Healthcare sector Level four (4) and five (5) Hospitals in Kenya. These are the district and county public hospitals which are the regional centers of excellence that provide intensive care and life support, specialist consultations and serves as referral hospitals for all the other Lower level Hospitals such as District & Sub-district Hospitals, Dispensaries and Healthcare centers; also private hospitals (MoH, 2015).This research relied on the sector for vital information as well as information from secondary source. The research attempted to understand issues surrounding employee relations practices in view of conflict resolution, employee empowerment, employee compensation and employee voice and their influence on organisational performance in public healthcare sector and took a duration of four months to complete.

1.7 Limitations of the study

Limitations are factors that impacted on the outcome of the study, but which have not been taken into account (Mugenda, 2008). Some Respondents' were unwilling to divulge information and be truthful with information due to its sensitivity. The researcher provided written assurance to the respondents that the information given will be treated with utmost confidentiality and will only be used for academic purpose only. The respondents were not required to give their names and this meant the respondents were anonymous. Most of the Hospitals are located in very remote areas with poor infrastructure. The researcher opted to use a motor cycle to transport the research

assistants to this area. The researcher also posted questionnaires to some of the country hospitals which were far to reach.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews empirical literature and theoretical foundations of employee relations practices and the postulated variables. It reviews the meaning of the concept from the perspectives of various scholars regionally and globally. The chapter also highlights the gaps in the existing literature whose investigations is the subject of the current study. The chapter has seven sections. The first section is the introduction section. The second section is the theoretical frameworks which cover the theories and models of selected employee relations practices such as conflict resolution, employee empowerment, employee compensation, employee voice and organisational performance. The third section is the conceptual framework and the fourth section covers secondary research. The fifth, sixth and seventh sections cover empirical studies, critic and research gaps respectively.

2.2 Theoretical Framework

This section discusses the theories and models about conflict resolution, employee empowerment, employee compensation, employee communication being the selected employee relations practices and organisational performance leading to the conceptual framework on which this study will be anchored. A theory is a contemplative rational type of abstract or generalized thinking, or the results of such thinking, and provides a yard stick for evaluating practice, though it in turn may be adjusted by findings from practice that show the theory to be in adequate (Halvorson, 2012). A model is s graphical or symbolic representation or simplified version of a concept, phenomenon, structure, system, or an aspect of the real world (Business Dictionary, 2013). Theories and models provide guidelines to the researcher in pointing out the area which is most

fruitful to conduct research; summarize known facts; increase the meaningfulness of the research; and helps in prediction (Cauvery, 2010).

2.2.1 Thomas-Kilmann Model of conflict resolution

The Thomas-Kilmann model was designed by Kenneth Thomas and Ralph Kilmann, to illustrate the options we have when resolving conflicts. The model has two dimensions, the vertical axis, concerned with conflict responses based on the attempt to get what we want. This is the assertiveness options; the horizontal axis, is concerned with responses based on helping others get what they want, the Cooperativeness options. According to Thomas & Kilmann, (1974) conflict can be managed using five management practices. These are accommodating, avoiding, competing, collaborating or compromising.

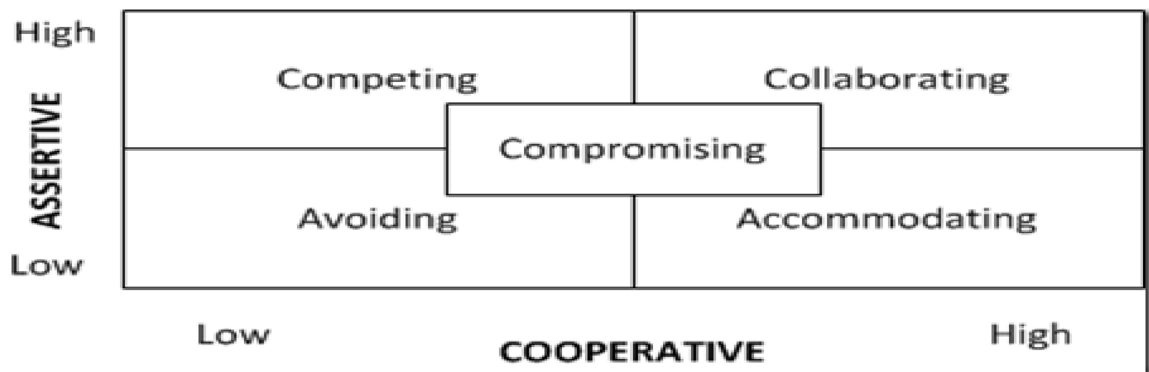

Figure 2.1:Conflict Resolution Model

Source: TKI Model (Thomas, Kilmann, 1974)

Accommodating requires you to cooperate to a high-degree and at your own expense, and actually work against your own goals, objectives, and desired outcomes. This behavior is appropriate when people realize that they are in the wrong or when an issue is more important to one side than the other. A manager using this style subjugates his/her own goals, objectives, and desired outcomes to allow other individuals to achieve their goals and outcomes. This conflict resolution style is important for preserving future

relations between the parties. Avoiding means you aren't helping the other party reach their goals, and you aren't assertively pursuing your own. This works when the issue is trivial or when you have no chance of winning, the issue would be very costly or when the atmosphere is emotionally charged and you need to create some space. It takes the form of diplomatically sidestepping an issue, postponing an issue until a better time or simply withdrawing from a threatening situation. Collaborating is where employer partners or pairs up with the other party to achieve both of your goals.

This is how you break free of the "win-lose" and seek the "win-win." This conflict resolution option means being willing to believe that when two parties are at loggerheads, it is possible for both sides to come out with what they want and develop conflict resolution skills based on mutual respect, willingness to listen to others, and creativity in finding solutions to conflicts. This practice of conflict resolution is appropriate when the concerns are complex and a creative or novel synthesis of ideas is required. Competing is the "win-lose" approach where you stand up for your rights, defending a position which you believe is correct, or simply trying to beat the other side This approach is appropriate for emergencies when time is of the essence, or when you need quick, decisive action, and people are aware of and support the approach (Kilmann, 1974).

Compromising is the "lose-lose" scenario where neither party really achieves what they want and is appropriate for scenarios where you need a temporary solution, or where both sides have equally important goals. The trap is to fall into compromising as an easy way out, when collaborating would produce a better solution. Both sides get something but not everything. It might mean splitting the difference between the two positions, some give and take, or seeking a quick solution in the middle ground. Compromise can also be referred to as bargaining or trading. It generally produces suboptimal results. This behavior is used when the goals of both sides are of equal importance, when both sides have equal power, or when it is necessary to find a temporary, timely solution. It should not be used when there is a complex problem requiring a problem-solving

approach. In the majority of conflict cases, the outcomes are unsatisfactory and lead to fall-outs, disharmony, and distractions from the real purposes of work. The cost in lost productivity and human pain is considerable (Thomas, Thomas & Schummahut, 2007).

2.2.2 Conger and Kanungo model of Employee Empowerment

Conger and Kanungo (1988) define empowerment as a process of enhancing feelings of self-efficacy among organisational members through the identification of conditions that foster powerlessness and through their removal by both formal organisational practices and informal techniques of providing self-efficacy. Conger and Kanungo (1988) argued that relational elements, such as delegation of authority, engaging employees in decision making and sharing information and resources, are conditions that may support and enable the empowerment process. In the process, they include diagnosis of organisational conditions that are responsible for feelings of powerlessness, techniques to remove some of the conditions leading to powerlessness, providing subordinates with self-efficacy information, subordinates' feeling of being empowered, and behavioral effects of empowerment (Conger & Kanungo, 1988).

Situational approach concerns passing authority from higher- level management to employees by engaging them in decision making. The psychological approach put less emphasis on delegation of decision making. This approach analysis empowerment as different psychological cognitions that contribute to improved intrinsic motivation. Spretizer's (1995) psychological empowerment consists of four cognitions that are individual's orientation towards his or her work role, aptitude, impact, significance and autonomy. Liden, Wayne, and Sparrowe, (2000) presented two main viewpoints that empowerment can be derived from literature as micro view point that is empowerment as a specific form of intrinsic motivation of employees and macro point of view is considering the various organisational empowering structures and polices.

Joyce *et al*. (2007) illustrious four dimensions of empowerment, are significance considered as the importance of work, objective or task relative to an employee's own ideals and values; aptitudes considered as the individuals capability to perform task activities skillfully; autonomy that is perception of self-determination of work, behaviors and processes and impact considered the employee perceives being able to influence strategic administrative or operating outcomes at work. The model emphasizes that when the right behaviors are instilled in individuals, it leads to right organisational behaviors which eventually impacts on organisational performance. The behavioral outcomes are of special significance to organisational performance (Kay *et al.,* 2008).

Empowerment processes may allow leaders to lessen the emotional impact of demoralizing organisational changes or to mobilize organisational members in the face of difficult competitive challenges. These processes may enable leaders to set higher performance goals, and they may help employees to accept these goals. These empowerment practices help employees to persist despite difficult situations thereby increasing their performance and that of the organization (Greiner, 1972).

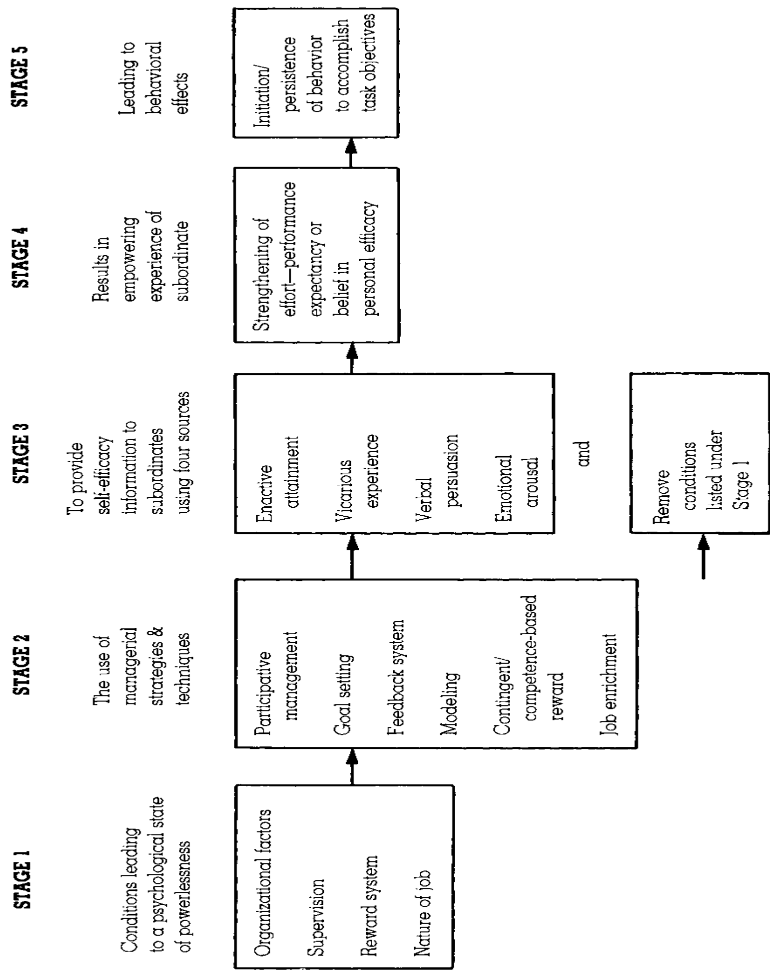

Figure 2.2: Five stages in the empowerment process

Source: *Conger and Kanungo (1988)*

According to Block, (1987) when organizations engage in participation programs, they establish formal systems that empower organisational members through the sharing of information, formal power and authority. This is elaborated in the table 2.1 below.

Table 2.1: Empowerment Constructs

Definition of Empowerment Constructs	
Construct Name	**Definition**
Fostering Self Efficacy	Increasing a member's belief in their capabilities to perform responsibilities.
Setting a Context for Action	Increasing a member's understanding of how responsibilities fit into the mission and goals of the organization.
Structuring the Task	Setting the boundaries for members to carry out responsibilities and decision making.
Creating a Sense of Ownership	Increasing the degree to which members understand they are in charge of how the work gets done.
Coaching for Performance	Actively supporting members as they work to achieve their goals.

Source: MacNeil (2007)

2.2.3 Kanter Model of employee Structural empowerment

Rosabeth Moss Kanter's model of organizational structural empowerment offers a framework for creating meaningful work environments for professional nurses (Kanter 1977, 1993) argues that situational aspects of the workplace such as access to information, support, resources, and the opportunity to learn and grow influence employee attitudes and behaviors to a greater extent. These attitudes and behaviors of the workforce eventually contribute to the overall purpose of the organization (Henry, 2009).Rosabeth (1983) noted that jobs that are central to the overall purpose of the organization are highly visible within the organization, constructed in such a way that there is a lot of discretion or flexibility in how work is accomplished, and contains high

degrees of formal power. Informal power results from positive relationships with superiors, peers, and subordinates within the work setting that lead to effective alliances.

According to the model, employees with access to these power tools are more motivated at work and also experience greater job satisfaction and commitment to the organization. Kanter (1977, 1983) argued that organisational communication systems, network forming arrangements, access to resources, and job design could contribute to employee powerlessness. She noted primarily that people whose formal role gives them the right to command but who lack informal political influence, access to resources, outside status, sponsorship, or mobility prospects, are rendered powerless in the organizations. Kanter theory argues that compensation systems that emphasize innovativeness and high incentive values foster a greater sense of self-efficacy (Kanter, 1979). Kenters theory of empowerment focuses on the structures within the organization rather than individuals own qualities (Bradbury-Jones, Sambrook & Irvine, 2007).

Kanter believes that leader's power will grow by sharing the power through empowering others and as a result, leaders will realize increased organisational performance (Fox, 1998). According to Kanter, there are six conditions required for empowerment to take place these include: opportunity for advancement, access to information, access to support, access to resources, formal power and informal power (Wagner et al, 2010).

2.2.4 Human Resource Management theory

This theory starts from the belief that organisational tensions can be completely resolved by nurturing a psychological contract based on cooperation and collaboration. The employee relations choices in this instance are predicated on the belief that the forces uniting managers and employees are far stronger than the forces dividing them (Stone, 1998; Blyton & Turnbull, 1992). It is the task of management to facilitate these unifying forces by establishing workplace conditions that encourage autonomous individuals, whether employees or management, to work collaboratively for the common good

(Guest, 1989). Health care organizations taking this approach are expected to regard workplace relations holistically, whereby collaboration between management and employees is encouraged in resolving internal tensions by breaking down workplace social classes and promoting a collective understanding that the interests of all are better served by working together and avoiding conflict (Bandura, 1988). Collaborative management practices in the form of workplace teams, problem solving teams, as well as performance related pay are activities that are thought to give content to this approach (Thomas & Schummahut, 2007).

Guest (1995) developed four approaches to human resource management: Traditional collectivism –use of Industrial Relations (IR) with no emphasis to Human Resource Management (HRM); New Realism – Use of IR and HRM in tandem with priority given to both; Individualized HRM – HRM substitutes traditional IR approach and The black Hole – Which uses neither HRM nor IR (non-unionized organizations).Assuming the causal premises of the theory are correct, changing the existing Employee Relations (ER) practices to align with those that nurture cooperation may offer a way to improve the workplace satisfaction of workers hence improved organisational performance (Guest, 2001).This study will use the understanding espoused in this theory to determine employee relations practices relevant to employee voice, compensation and conflict resolution and their influence to organisational performance.

2.2.5 Human Relations theory

The main focus of the human relations movement is on the human and social dimensions of work (Mayo, 1933). Elton Mayo and Abraham Maslow in their Hawthorne studies found that efficiency enhanced independent of the level of lighting. The studies accomplished that the employees were more reactive to social situations than to management controls. Abraham Maslow (1943) a major theorists of the human relations movement identified the different five levels of needs; physiological, safety, love, self-esteems, and self-actualization needs. He suggested that human needs are organized in

any order and that employees are motivated by unsatisfied needs though higher needs could motivate only after lower needs are satisfied. This helped managers understand the employee empowerment. Herzberg (1959) alienated employee motivation into two main factors, motivation factors and hygiene factors. Motivation factors are related to job satisfaction and different from hygiene factor which are related to dissatisfaction. He highlights that employee participation through quality circles has positive effect on organisational performance.

According to Human relations theory by key proponents, (Mayo 1933; Maslow, 1943) adopted the unitarism approach to employee relations implies that a system of management, maximize output by meeting social and psychological needs of employees in the workplace resulting into worker morale maximized, motivated employees and highly productive workforce. Addison and Belfield (2004) and Kaufman (2005) in their studies established that if workers are denied autonomy on the job, or are reduced to acting as mere extensions of the machinery they operate, or are given work that inhibits their capacity to create and think, it is argued that they will invariably find ways to subvert the methods of control that enforce these conditions (Freeman, 1976).

The principal task of management on this conception is to manipulate workplace relations in ways that enable employees to feel personal satisfaction with being involved with the organization. To this end, public healthcare sector operating on this basis are expected to recognize the right of employees to have a say in how they are governed (Hirsch, 2004). In whatever form, managerial approach to employee relations is seeks to reduce internal tensions by developing the sense of workplace satisfaction felt by employees through practices that involve them in the organization and regulation of work. Most importantly, the goal of human relations theory is to make workers feel like they belong to something bigger than themselves, and thus the worker’s work is important to the overall effort of the organization (Kaufman, 2005).

2.2.6 Human Capital theory

According to the human capital theory people possess skills, knowledge, and abilities that provide economic value to firms (Youndt *et al.,* 1996). The theory argues that organizations with valuable knowledge, skills and abilities will present better performance levels, and therefore it has also fostered many universalistic conclusions. An alignment of organisational strategy and employee relations strategy will improve organisational performance and competitiveness. The more likely it is that the firm will invest in human capital and that these investments will lead to higher individual productivity and firm performance (Youndt *et al.,* 1996). People have a crucial value for organisational strategies and certain practices can foster and develop this value, leading to superior performance (Gonzalo & Romero, 2005).

The "universalistic" perspective alleges that certain practices are always better than others and all organizations should adopt such practices on every occasion (Hsi-An, Yun-Hwa & Chu-Chun, 2006; Daud, 2006). According to the theory employee relations practices contribute to worker motivation (and thereby increased productivity) as well as increased efficiency (Ichniowski, Shaw, & Prennushi, 1992). Firms should however create a high degree of internal consistency, or fit, among their ER practices. The universalistic perspective has been criticised for failing to consider the context in which these practices are used. It does not study either the synergic interdependence or the integration of practices, and the contribution of these practices to performance is analyzed only from an additive point of view (Pfeffer, 1994; Osterman, 1994; Becker & Gerhart, 1996). Thus this view denies that the different elements that build the system could be combined in different patterns of practices that could be equally efficient for the organization (Gonzalo Sanchez-Gardey & Romero- Fernandez, 2005).

Table 2.2: Mile's Models of Participate Leadership

	Human Relations	Human Resources
Worker Needs	Workers need to belong, be liked, and be respected.	While workers need to belong, be liked, and be respected, workers also want to creatively and effectively contribute to worthwhile goals.
Worker Desires	Workers really desire to feel as though they are a useful part of the organization.	Workers really desire to exercise initiative, responsibility, and creativity, so management should allow for these.
Outcomes	If worker needs and desires are filled, they will willingly cooperate and comply with management.	Management should tap into worker capabilities and avoiding wasting untapped resources.
Job Satisfaction	When employee needs and desires are met, they'll be more satisfied.	When employees feel that they have self-direction and control and are able to freely use their creativity, experience, and insight they will be more satisfied.
Productivity	Job satisfaction and reduced resistance to formal authority will lead to more productive workers.	When employees feel that they have self-direction and control and are able to freely use their creativity, experience, and insight they will be more productive.
Management Goal	Managers should strive to ensure that all employees feel like they are part of the team.	Managers should help employees discover hidden talents and ensure that all workers are able to fully use their range of talents to help accomplish organisational goals.
Decision Making	Management should allow employees to offer input on routine decisions and be willing to discuss these decisions, but management should keep important decisions to them.	Management should allow and encourage employees to freely participate in the decision making process with all types of decisions. In fact, the more important the decision is, the more the manager should seek out his employee resources in the decision making process.
Information Sharing	Information sharing is a useful tool when helping employees feels like they are part of the group.	Information sharing is vital for effective decision making and should include the full range of creativity, experience, and insight from employees.
Teamwork	Management should allow teams to exercise moderate amounts of self-direction and control.	Management should encourage teamwork and continually look for greater areas where teams can exercise more control.

2.2.7 Equity theory

The theory presupposes that during a social exchange, a person identifies the amount of input gained from a relationship compared to the output, as well as how much effort another person's puts forth. Based on Adam (1965) theory, Huseman, Hatfield and Miles (1987) further suggest that if an employee thinks there is an inequity between two social groups or individuals, the employee is likely to be distressed or dissatisfied because the input and the output are not equal. Inputs encompass the quality and quantity of the employee's contributions to his or her work. Examples of inputs include: time, effort, hard work, commitment, ability, adaptability, flexibility, tolerance, determination, enthusiasm, personal sacrifice, trust in superiors, support from co-workers and colleagues and skills. Output (outcomes) on the other hand is the positive and negative consequences that an employee perceives a participant has incurred as a consequence of his relationship with another. Examples of outputs include job security, esteem, salary, employee benefits, expenses, recognition, reputation, responsibilities, and sense of achievement, praise, thanks, and stimuli and so on.

The major concern in equity theory is about compensations and therefore the cause of concern of equity or inequity in most cases in organizations. In any position in the organization, an employee wants to feel that their contributions and work performance are being rewarded with their pay. If an employee feels underpaid, he would be dissatisfied and therefore becomes hostile towards the organization and co-workers which may ultimately result to lack of motivation and low performance. Since equity is all about perception, employees form perceptions on what constitute a fair (balance or trade) of inputs and outputs by comparing their situation with other 'referents' in the market place as they see it (Ball, 2014).

According to Adams (1985), when a person becomes aware of inequity, it causes a reaction in them, potentially some form of tension that is 'proportional to the magnitude of inequity present'. It is because of this tension that an individual might react in a way

that reduces the tension in him. Equity theory further identifies four mechanisms for organisational performance (dissatisfaction) as follows: Employees seek to maximize their outcomes (rewards minus outcomes); Groups can maximize collective rewards by developing accepted systems for equitably apportioning rewards and costs among members; When employees find themselves participating in inequitable relationships, they become dissatisfied or distressed. The theory explains that in this situation, both the person who gets 'too much' and the person who gets 'too little' feel dissatisfied.

The employee who gets too much may feel ashamed or guilt and the employee who gets too little may feel angry or humiliated; and Employees who perceive that they are in an inequitable relationship attempts to eliminate their dissatisfaction by restoring equity. This could be done by either distorting inputs, outputs, or leaving the organization. Thus the theory has wide-reaching implications for employee morale, efficiency, performance, productivity and turnover. Schultz and Schultz (2010) further extended equity theory to include the behavioural responses patterns to situations of equity or inequity. These response patterns are: benevolent (satisfied when they are under paid compared with co-workers), equity sensitive (believe everyone should be fairly rewarded) and entitled (employees believe that everything they receive is their just due).

2.2.8 Expectancy theory

The expectancy theory was proposed by Victor Vroom of Yale School of Management in 1964. The theory stresses and focuses on outcomes and states that the intensity of a tendency to perform in a particular manner is dependent on the intensity of an expectation that the performance will be followed by a definite outcome and on the appeal of the outcome to the individual. The Expectancy theory states that employee's motivation is an outcome of how much an individual wants a reward (Valence), the assessment that the likelihood that the effort will lead to expected performance (Expectancy) and the belief that the performance will lead to reward (Instrumentality). Expectancy is influenced by factors such as possession of appropriate skills for

performing the job, availability of right resources, availability of crucial information and getting the required support for completing the job (Wright & Niishi, 2007). Instrumentality is affected by factors such as believe in people, who receives what outcome and clarity of relationship between performance and outcomes. Implication of the Expectancy Theory in this study is that managers can correlate the preferred outcomes to the aimed performance levels and that employees must be compensated for their exceptional performance.

2.2.9 Social Exchange Theory

Social exchange theory (SET) posits that all human relationships are formed by the use of a subjective cost-benefit analysis and the comparison of alternatives. The theory has roots in economics, psychology and sociology. Social exchange theory is reliant on voluntary actions rather than formal contracts (Zhang, *et al.,* 2008; Aryee *et al.,* 2002). According to this theory, individuals regulate their interactions with other individuals based on a self-interest analysis of the costs and benefits of such an interaction. SET argues that when workplace relationships are effective, then the organization benefits. Thus people calculate the overall worth of a particular relationship by subtracting its costs from the rewards it provides. Outcome is defined to be the difference between the benefits and the costs: Worth = Rewards – Costs

People seek to maximize their benefits and minimize their costs when exchanging resources with others (Molm, 2001). Individuals engage in an interaction with the expectation of reciprocity (Gouldner, 1960). These benefits need not be tangible and include things such as material or financial gains, social status, and emotional comforts. Costs generally consist of sacrifices of time, money, or lost opportunities. Social Exchange theory (Blau, 1964) has a long pedigree of use in both industrial and employment relationship. This theory recognises that the basis reason for an individual to enter into a relationship is the compensation he expects to gain. It also involves a host

of unspecified and unvoiced expectations and obligations thus if costs rise, workers tend to have expectations that the benefits will increase accordingly.

Similarly, if conditions in the environment force a change in the organization, the employer expects employees are obliged to accommodate themselves to this. Should either party feel that the other is failing to owner his part of the implied bargain, this will lead predictably to similar behaviour in return (Dundon & Rollinson, 2004). Social exchange theory is used as a framework for predicting the effects of management practice on worker attitudes and performance (Stafford, 2008). Positive social exchanges can result in mutual benefits to both the employing organization and the workforce (Allen, Dawson, Wheatley, & White, 2008; Zhang, Tsui, Song, Li, & Jia, 2008). An organization can utilize high-commitment HRM strategy to make employees perceive organisational support and commit to their organization. According to empirical findings, the practices of high-commitment HRM can affect employee motivation and a positive relationship exists between supportive Employee relations Practices and organisational performance (Allen *et al*. 2008; Wang, Yi, Lawler, & Zhang, 2011).

2. 3 Conceptual Framework

Conceptual framework is hypothesized model portraying the relationship between variables diagrammatically that helps in quickly seeing the proposed relationship and establish the significance of the proposed relationship (Mugenda, 2008). Based on the literature reviewed, this study will develop its conceptual framework based on four variables; conflict resolution, employee empowerment, employee compensation and employee voice which are believed to influence organisational performance in public healthcare sector. The organization’s quality of service, efficiency, employee retention absenteeism will be used as a measure of performance. Demographic characteristics of the healthcare workers such as gender, age, and occupation, will be held constant.

The relationship between the variables is as shown in figure 2.5

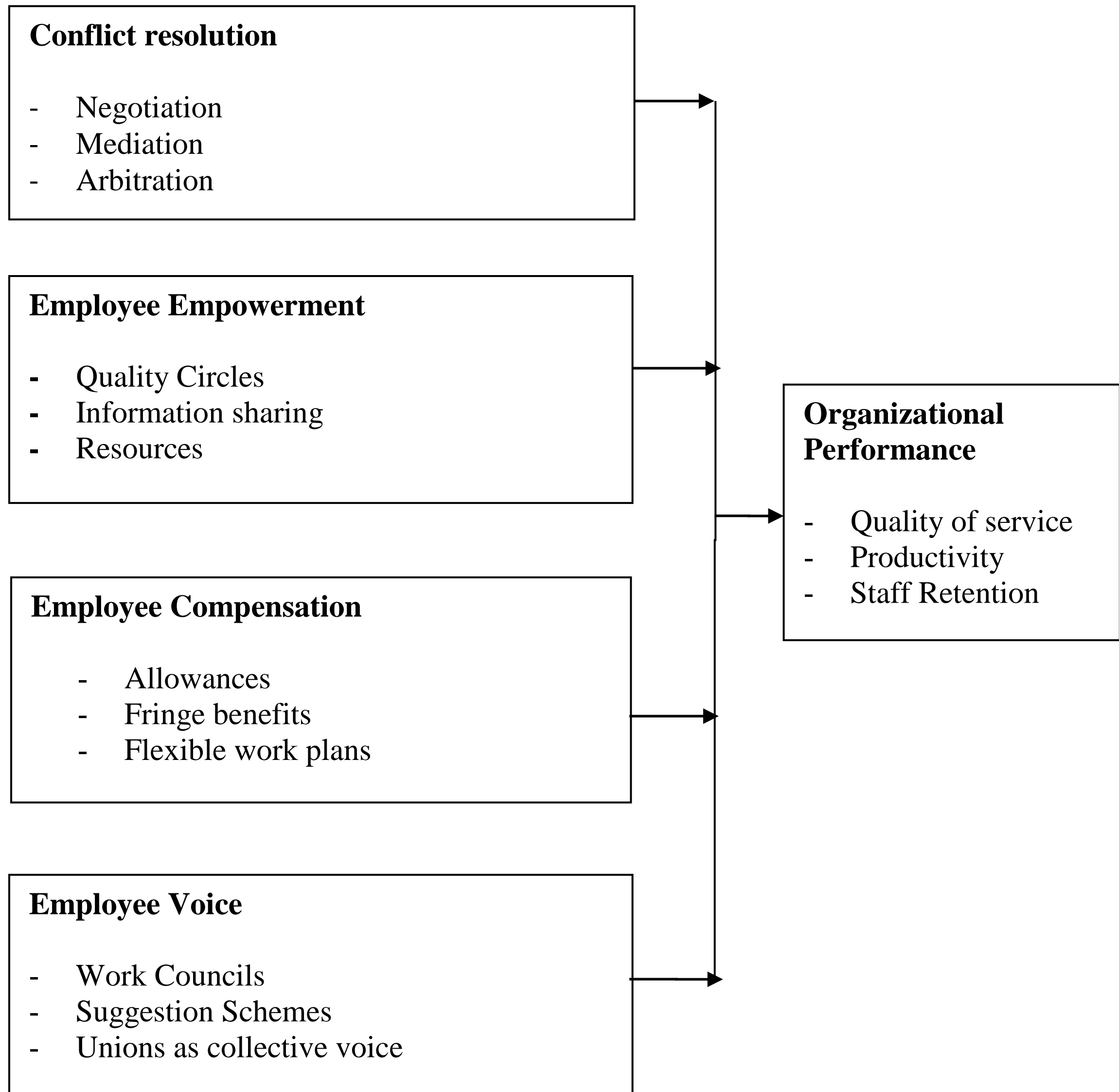

Figure 2.3: Conceptual relationships of variables

2.3.1 Employee Relations practices

Employee relations (ER) as a discipline initially emerged to address workplace problems such as unemployment and power imbalances between employees and employers by focusing on the practices of workplace institutions and organisational behaviors (Kaufman, 2004). It is a multidisciplinary field that studies the employment relationship dealing with both unionized and non-unionized workers (Salamon, 2000). ER encompasses ‘the processes of regulation and control over workplace relations, the organization of tasks, and the relations between employers and their representatives, and employees and their representatives, and is the sum of economic, social and political interactions in workplaces where employees provide manual and mental labour in exchange for employability, compensation as well as the institutions established for the purpose of governing workplace relations (Gospel & Palmer, 2004).

However, according to Kaufman (2004) to a large degree, most scholars regard trade unionism, collective bargaining and labor-management relations, and the national labor policy and labor law within which they are embedded, as the core subjects of the field of employee relations. To achieve this, group dynamics, policy making by consultation, diffusion of authority, delegation, employee voice mechanisms, employee compensation, and conflict management have to be ushered in. Employee relations practices are seen as strategic in terms of managing business risk: both the downside risk of non-compliance with an expanded body of employment law, and the upside risk of failing to deliver maximum business performance (Wamai, 2009). A key assumption is the extent to which the employment relationship necessarily includes conflicts of interests between employers and employees, and the form of such conflicts (Barry & Wilkinson, 2011). When managers treat employees fairly and with respect, it plays a big role in enhancing employees’ motivation and commitment which in turn improves organisational performance (Torrington & Hall, 2006).

Organizations can use collective bargaining to improve employee performance by incorporating compensation for employees who have a good record of performance, resolving conflicts collectively and establishing a mechanism for conflict management and maintenance (Slaikeu, 1996).If workers perceive unfairness, they will sense relative deprivation and feel the wage-effort bargain has been breached; and they will then respond with absenteeism, exit, reduced effort, or direct conflict which in turn adversely affects their performance and that of the organization (Snape & Chan 2000; Elton, 2007; Bertone, Marshall, & Zuhair 2008; Peetz & Preston 2009). Workers on collective agreements received higher wages than workers on registered individual contracts which positively affect their motivation and productivity (Wooden 2000; Baarth, Raaum, & Naylor 1998, Peetz & Preston 2009). Organizations that have adopted employee relations practices that promote information sharing, delegation of authority and availability of resource have higher productivity than other similar organizations; whereas businesses that maintain more traditional labor management relations have lower productivity (Black & Lynch, 2001). However, Hancock (2012), analyzing performance growth across industries as well as nationally, found no evidence of any effect on organisational performance from collective bargaining which encompasses employee compensation. Sloan (2011); and Pearson (2007), found out that collective bargaining had an effect on organisational performance, perhaps removing most of the remaining inefficiencies in the Employee Relations system (Salamon, 2000). Huselid (1995) used several human resource management practices in his study such as personnel selection, performance appraisal, compensation, structural empowerment, grievance procedures, information sharing, attitude assessment, employee participation, employee training and promotion criteria and found that these practices have an economically and statistically significant impact on both intermediate organisational outcomes (staff turnover and productivity) and long term measure of corporate financial performance.

Employee relations practices have been linked with organisational performance in various industries. Teseema and Soeters (2006) their research in Eritrea Civil Service

studied eight Human resource practices including recruitment and selection, placement, training, compensation, employee evaluation, promotion, employee empowerment and pension and other fridge benefits security and their relationship with perceived employee performance in the banking sector and found a positive relationship. Studies by Bowen and Ostroff (2004), Rimanoczy and Pearson (2010), Rees and Johari (2010) and Nishii (2011) shows that Employee Relations practices are linked to employee performance and by extension, organisational performance. Organizations where employee relations are strained are always surcharged with industrial unrest leading either to strikes or lockouts adversely affecting efficiency, productivity, low-grade production and quality of service, negligence in the execution of work, absenteeism among the workers, high rate of labour turnover and overall poor organisational performance (Armstrong, 2006).

According to Chaudhry *et al*. (2011) employee relations practices impart a significant role to enhance performance of organizations indirectly. In their study, they found that performance of employee depends upon job satisfaction, compensation structure, reward plans, promotions, motivation, environment, training, staffing and succession planning. Early models of Beer (1984) and guest (1989) provided a conceptual foundation of the link between employee relation practices and performance. Resource based view (RBV) theory provided base that high performance work practices directly affect organisational performance (Youndt *et al.* 1996; Guest, 1997, Fey *et al*., 2000, Paauwe *et al.,* 2013). Bloom *et al*. (2010) has indicated that modern ER practices have large effects on productivity and profitability.

A positive relationship was found between sound employee relation practices and productivity at workplace where unions are actively voice for workers and organizations have recognized (Wooden, 2000). Employee compensation practices were associated with higher levels of self-claimed productivity (Fry, Jarvis, & Loundes, 2002). Another study from the 1990s showed that the intensity of collaboration between management and workers (through unions) had a positive effect on workplace performance (Alexander & Green 1992). Tuitoek (2008) studied performance appraisal among media

houses in Kenya and found that performance appraisals are used to enhance performance and career progression. Kiboi (2006) conducted a study of management perception of performance contracting in state corporations in Kenya. Oresi (2005) studied on employee performance management practices for the court registry staff in Kenya. All these studies found significant relationship between employee relation practices and firm performance.

Bloom and Van Reenen (2007) explained in their research that ER management is highly correlated with organisational performance and a significant correlation is apparent with measures of performance such as profitability, quality of service, efficiency, sales growth and firm survival. Overall, studies globally suggest that workplaces with good employee relations and high employee empowerment have higher performance (Addison, & Belfield 2004; Hirsch 2004; Freeman, 1976; Kaufman 2005). Companies with sound employee relations practices provide best quality services; enjoy high level productivity and high level of customer retention and comparatively good rate of employee retention (Allan, Dungan, & Peetz, 2010).Employee relation practices have therefore become a very important tool globally and for any organization seeking to improve organisational performance. Organizations implement employee relation practices to polish skills of its employees and resolve conflicts at the workplace which ultimately lead to better organisational performance (Allan, Dungan, & Peetz 2010).

These practices includes compensation decisions such as raises, promotions and bonuses, as well as the workplace conflict resolution, company communication and employee development programs, such as college tuition reimbursement. Recognizing employees' accomplishments and contributions is a major part of employee relations, as is respecting the demands of employees' home and family lives (Michael (2005). According to Budd and Bhave (2008) good employee relation practices is the basis of higher production with minimum cost and higher profits. It also results in increased efficiency of workers which in turn impact positively on organisational performance.

Effective employee relations practices have become essential in enabling the delivery of healthcare services to the public thereby influencing the performance of the sector.

Available literature indicates that ER practices are positively related to organisational and employee performance. For instance, Shahzad *et al.* (2008) in their study titled "impact of HR practices on perceived performance of university teachers in Pakistan reported a positive significant relationship between compensation practices, promotion practices and employee performance. Huselid (1995) used eleven practices in his study which are personnel selection, performance appraisal, incentive compensation, job design, grievance procedures, information sharing, attitude assessment, labor-management participation, recruitment efforts, employee training and promotion criteria and found a significant relationship between compensation and employees outcome.

A lot of research has been done linking performance in healthcare and human resource management practices. Wamai, (2009) identified that quality assurance in healthcare depends more on the human resource as opposed to quality system; Bowen & Ostroff, (2004), Rees and Johari (2010) and Nishii (2011) shows that human resource practices such as training and development, recruitment and Employee relations are linked to employee performance and by extension, organisational performance. Aspden (2007) linked quality of health care to human resource practices. Rathert and Mary, (2007) established a link between the care patients receive and the working conditions under which their caregivers provide this care. (McLoughlin, 2012) found out that skills and knowledge in the personnel contribute to healthcare outcomes. Muchiri *et al.* (2006) researched on the unequal distribution of human resources and finances in healthcare in Kenya and how it impacts on access to healthcare. Although many researchers have looked at the relationship between Human Resource Management practices and hospital performance with regard to employee productivity and financial performance, their studies are limited to developed countries and to private hospitals (Khatibi, Asgharian, Saleki, & Manafi, 2012).

Suliman, (2005) recommends that unless the problems of poor decision making, inadequate resources, lack of effective management skills and lack of autonomy of the workforce are addressed, the performance of public health care sector will not be realized in Kenya. However, scanty literature has been done to determine the influence of employee relation practices such as conflict resolution, employee empowerment, and employee compensation and employee voice on organisational performance in public healthcare globally and in Kenya which is the greatest motivation to this research.

2.3.2 Conflict Resolution

Conflict resolution refers to one of the employee relations practices used to help employee relations actors to communicate more clearly, negotiate effectively, develop and evaluate solutions, or resolve disputes. Olakunle (2008) identified six different levels of conflict: interpersonal, intragroup, intergroup, intrapersonal, intra-organisational and inter-organisational levels. The effective management of these conflicts will go a long way to enhance the performance of the organization in meeting to its overall mandate (Njau, 2012; Rivers, 2005).Conflict resolution offers a private and voluntary option beyond the industrial courts Where there is employment relationship one inevitably finds labour conflicts and the need to resolve them efficiently, effectively and equitably for the benefit of all the parties involved and the economy at large (Olakunle, 2008).

The Health care delivery occurs within complex system of institutional environment, multidisciplinary professionals, technology, financial, legal regulations and patient, family and community based needs (Ramsay, 2001). Care giving teams are expected to represent the multiple disciplines on which patients depend for health service. Each member of the team brings specific knowledge and skill to care planning and delivery they often represent differing perspectives on what that care should include and how it should be administered These differences result into conflicts that adversely affect

productivity, morale, staff retention, quality of service and certainly staff contribution that impede effectiveness of care (Ramsay, 2001).

Conflict among the professionals can also create negative interpersonal relationships that reduce the quality of service and hinder the ability to obtain meaningful outcomes (Miles, 2002). A key objective of every organization is to avoid and manage these conflicts. Effective resolution of employment conflicts is an integral component of a successful employee relations system which effectively contributes to organisational performance (Buchele & Christiansen, 1999).

According to Robinson & Judge (2009) conflict may have both positive as well as negative consequences within the organization, the submission above blend with the fact that, conflict can never be totally eliminated within organizations but can be efficiently managed in order to move organizations to greater height and performance level. Darling & Walker (2007) stated that, even when conflict is a natural phenomenon in social relations it can nevertheless be managed within organizations.

Negotiation mechanism is the most informal employee relations practice of conflict resolution where parties to the contract and their designated negotiators resolve the dispute on the best terms for the party that he or she represents. In a successful negotiation, the parties and their negotiators reach a resolution of the dispute based on the parties' interests creating high level of motivation among the parties and impacting on productivity. Mediation is a collaboration problem solving process that assists in managing workplace conflict through a structured process such as a disciplinary process or grievance procedure and results to a win-win outcome (Slaikeu, 1996).

In this process, the parties select a neutral person, the mediator, to help them arrive at a settlement of the conflict. The mediator spends a majority of the time meeting privately with each party and does not have authority to bind the parties, but can only help the parties resolve their conflict by agreement (Beer & Steif, 1997). Settlement in both

negotiation and mediation practices may be based upon compromises, promises of performance, and agreements to continue to do business in the future (Christopher, Nita & Yawanarajah, 2005).Arbitration is an employee relation practices where the parties select a neutral person, the arbitrator, who acts as a private judge, conducts a hearing, similar to a trial in court, and issues a decision, known as an "award," that binds the parties. Though arbitration is similar to litigation in court, it is private, the parties can choose an arbitrator that has particular expertise in the subject matter of the dispute, and the scheduling of the arbitration proceeding is not dependent on delays usually associated with a court's docket (Njau, 2012).

Organisational conflicts not only affect productivity through labor loss alone but when there are incessant work stoppages, machines and other fixed and variable capitals are not fully utilized it reduces the level of output and increasing average cost (Humphrey, 1991). According to Rivers (2005), the hidden costs of unresolved conflicts in organizations are enormous and finding effective ways to manage and resolve organisational conflicts can have a significant impact on productivity and therefore, may enhance performance. Effective conflict resolution systems can contribute to an effective high-performance workplace by improving employee motivation, morale, and productivity (Milkovich & Newman, 2008; Furlong, 2005). In addition to taking a personal toll on employees, conflict also has adverse effects on the workplace. See table 2.4 below:

Table 2.4: Managing Workplace Conflict

Managed Conflicts	Out of Control Conflict
Strengthens relationships and builds teamwork	Damages relationships and discourages cooperation
Encourages open communication and cooperative problem-solving	Results in defensiveness and hidden agendas
Resolves disagreements quickly and increases productivity	Wastes time, money and human resources
Deals with real issues and concentrates on win-win resolution	Focuses on fault-finding and blaming
Makes allies and diffuses anger	Creates enemies and hard feelings
Airs all sides of an issue in a positive, supportive environment	Is frustrating, stress producing and energy draining
Calms and focuses toward results	Is often loud, hostile and chaotic

Source: Rivers, 2005

The table above focuses on providing information on how to manage any conflicts that may occur so that the results from "out-of-control" conflict do not damage working relationships and effectiveness in organizations. When managed correctly, conflict produces the following results: new ideas for changing organizations, solving of continuous problems, chance for workers to expand their capabilities and increase productivity, and the introduction of creativity into thoughts about organisational problems (Bowditch & Buono, 2007). Negative conflict can lead to decreased productivity, increased stress among employees, hampered organizational performance,

high staff turnover rates, absenteeism at its worst, violence, and death (Fiore, 2007; Bowditch & Buono, 2007; Maiese, 2007).

Researchers have noted numerous studies of conflict resolutions bringing positive results (Rahim, 2011; Simons & Peterson, 2000); however, other studies have demonstrated the opposite results (De Dreu & Weingart, 2003; Tepper, Moss, & Duffy, 2011).Parker (1974) argued that if conflicts arise and are not managed properly, it will lead to delays of work, disinterest and lack of action and in extreme cases it might lead to complete breakdown of the group. Avoidance of the situation that causes the conflict is an example of an interpersonal approach that means the conflict has not been resolved (Robert & Jane, 1969). Another way of coping with conflict is through cooperating (Arbitration), emphasizing the areas of agreement and common goals and de-emphasizing disagreements.

A third way according to (Robinson *et al*, 1974) is competing pushing one's own view on others; this, of course, will cause overt or covert resistance. A traditional way of coping with conflict is to compromise (Mediation), agreeing in part with the other person's view or demand. Derr, (1975) stated that there are three major conflict management approaches from which intervener can draw to formulate an approach appropriate for resolving a dispute; Collaboration, Bargaining and Power play. The appropriate use of these employee relations practices on conflict resolution depends on the individual and organisational state (Ford, 2007).The conflict management systems build the spirit of teamwork, motivation, productivity and cooperation among the employees of the organization (Adomi &Anie, 2005).

2.3.4 Employee empowerment

Employee empowerment is defined as the focus of organization on delegation of authority, encouraging workers to participate in decision making, share resources, share information, enabling them to control work processes as required (Pfeffer, Hatano, &

Santalainen, 1995).There are two main dimensions in defining empowerment: psychological dimension and structural dimension. Psychological empowerment dimension definitions fall into intrinsic motivation that creates discretion and self-efficiency (Patah *et al.,* 2009). Instances for the psychological approaches definitions, Conger & Kanungo (1988) define empowerment as a procedure of improving self-efficiency perception among the employees through problem solving groups (Quality circle) and information sharing.

Brymer, (1991) defines psychological empowerment as a process of decentralizing decision making in an organization, whereby managers give more discretion and autonomy to the employees directly or through their teams. Structural dimension of empowerment explain empowerment as management action from perspective of organization's policies resources and structures (Kanter, 1993). He claimed that empowerment is a state in the organization that influence employee's work related behavior and presented structural factors that influence empowerment in organization thus involving empowerment activities in information accessibility for the employees; supporting employee job responsibility and availability and accessibility of needed resources to perform a job (Kanter, 1993).

Samat, Ramayah and Saad (2006) explored the relationship between employee empowerment and quality of service as well as market orientation and concluded that employee empowerment has significant effect on both compared with other practices of total quality management (TQM) examined in service organizations in Malaysia (Perak, Kedah, Penang & Perlis, 2011).Shulagna, (2009) believe that, that if power and influence in the decision-making widely concentrated at the top hampers flexibility and timely action at the lower levels. Boon, Arumugam, Safa, and Bakar (2007) argue that employee empowerment is the most important employee relations practice that significantly overall organization performance. Jung and Hong (2008) conducted a study to explore the link between organization performance, and found out that employee empowerment plays a significant role on organization performance.

The same critical role of employee empowerment appears in job satisfaction and innovation performance in small and medium sized enterprises (SMEs) (OECD, 2005). Leadership and/or supervision practices that are identified as empowering include expressing confidence in subordinates accompanied by high performance expectations (Burke, 1986; Conger, 1986), fostering opportunities for subordinates to participate in decision making through teams (Block, 1987; Burke, 1986; Conger, 1986; Kanter, 1979), providing autonomy from bureaucratic constraint (Block, 1987; Kanter, 1979) and setting inspirational and/or meaningful goals (Block, 1987; Burke, 1986).

Several studies of nurses have linked structural empowerment to factors identified as important for retaining nurses, including job satisfaction (Laschinger, Almost, & Tuer-Hodes, 2003; Whyte, 1995), participation in organisational decision making (Kutzcher, Sabiston, Laschinger, & Nish, 1997), job autonomy or control over practice (Laschinger & Havens, 1996), and organisational commitment (Laschinger *et al*., 2000; Wilson & Laschinger, 1994). Work settings that are structurally empowering are more likely to have management practices that increase employees' feelings of respect and trust in management thereby increasing organisational productivity (Heather Spence, & Joan, 2005).OECD (2005) found that employee empowerment is one of the four major factors that are critical to success of organizations.

Zhang *et al.* (2008) reported that employee empowerment has a significant role in achieving and enhancing quality of service in organizations. Howes (2010), Handin (2000), Cuthie (2010) and Werbler & Harris (2009) stated that best employee relations practices for improving organisational performance and having motivated employees include among others conflict resolution, commensurate compensation, and structural empowerment among others. Seibert, Silver and Randolph (2004) found significant and positive relationships between empowerment climate and work-unit performance, but not individual performance. They also found psychological empowerment positively and significantly related to individual performance. In a related study, Chen *et al.*(2007) found that, while individual psychological empowerment significantly predicted

individual performance, neither empowering leadership climate nor team empowerment were significantly related to team performance.

Dewettinck *et al*. (2006) concluded that whilst psychological empowerment has a significant and considerable relationship with employee affective outcomes, empowerment only marginally explains the variance in employee performance. Petter *et al.* (2002) explained the different dimensions of employee empowerment and integrated power, decision making, information sharing, autonomy, initiative and creativity, knowledge and skills development, and responsibility, this seven elements model employee empowerment having a considerable overlap between the elements. Petter *et al.* (2002) interviewed street level official working in the welfare office to study dissimilar feature of employee empowerment, and reported that quality circles was one of the important dimensions of empowerment. Ryan and Deci, (2006) identified the benefits of autonomous against controlled directive and accomplished that when intrinsic empowerment is destabilized, there are well documented costs in terms of performance.

The empirical research studies on employee empowerment showed that a strong correlation exists between employee empowerment and employee performance and by extension, organisational performance ((Lashley, 1999; Ongori, 2007). Empowerment helps employees to be helpful with knowledge and inner motivation (Kondalkar, 2009). Employee empowerment has made non-managerial staff able to take autonomous decisions without seeking advice from their boss. The nature of these self-willed decisions depends on the degree of authority and power with which an organization invests in its employees (Seyedjavadin *et al.,* 2009).

The empirical researches emphasize that from a managerial point of view employee empowerment can be seen as a business tool: worker participation as a means to reduce transaction costs associated with the employee-organization relations and, consequently, improving performance (Colling, 2003; Gollan, 2006, 2010; Kaufman & Taras, 2000;

Kaufman & Levine, 2000; Kaufman, 1999). Liu & Fang (2006) revealed that power-sharing significantly predicted team member's performance through the team members' extrinsic and intrinsic motivation. Taken together, there appears to be a strong theoretical support for the role of empowerment in engendering performance in the work place.

2.3.5 Employee Compensation

Compensation is one of the employee relations practices in healthcare sector which is defined as a systematic approach to providing monetary and non-monetary value to employees in exchange for work performed (Cole, 2004). Compensation is a tool used by management for a variety of purposes to further the existence of the company such as recruit and retain qualified staff, increase and maintain the morale of staff, reward and encourage peak performance, achieve internal and external equity, reduce turnover and encourage company loyalty, modify through negotiations practices of unions (Graham & Bennett, 1998). Employee compensation plays such a key role because it is the heart of the employment relationship, being of critical importance to both employees and employers. Employee compensation practices differ across employment organizations and on several dimensions (Gerhart, Milkovich & Murray, 1992).

Components of compensations practices in organizations include fixed pay – monthly rate of pay irrespective of number of hours worked and are subject to annual increment; Allowances include house allowance, dearness allowance, house allowance, risk allowance, hardship allowance, non-practice allowance, transport allowance; Incentives-performance based pay, bonuses, commission, profit sharing; and fridge benefits – provident fund, health insurance, pension scheme, uniform, canteen, gratuity, medical care, group insurance, entertainment allowance and paid holiday (Gerhart, Minkoff & Olsen, 1994). According to Armstrong, (2009) compensation practices help in attracting a quality workforce, maintaining the satisfaction of existing employees, keeping quality employees from leaving and motivating them for higher productivity.

Frye (2004) examined the relationship between equity based compensation and firm performance and found positive relationship between the two. Allowances positively and substantially affect performance of workers and effectively of the organization if combined with innovative work practices like, flexible work plans, employee participation in problem-solving teams, training, extensive screening and employment security (Ichniowski *et al.,* 1997). Significantly, positive correlation has been reported between compensation practices and perceived employee performance (Taseema & Soeters 2006). Adams, (198) found that gainsharing plans on average were associated with net gains per employee but not organisational effectiveness. According to Kalumba and K'Obonyo (2012) employee compensation practices including financial bonuses and allowances, or the opportunity for professional development influenced organisational financial performance in the banking Sector in Kenya.

According to Barney and Hesterly, (2008), an organizations employee compensation policy and practice is important in implementing organisational strategy. A company that adopts a compensation policy that is consistent and reinforces its strategies is more likely to implement those strategies than a firm that adopts compensation policies that are inconsistent with its strategies (Armstrong, 2006). According to Rudman (2003) paying for performance is a big issue in contemporary human resources management; organizations have long believed that productivity improve when pay is linked to performance and payment by results systems and allowances are developed to support this belief. Studies have found a positive relationship between performance-related pay and performance (Huselid, 1995; Dotty, 1996; Goel, 2008).

Boselie, Paauwe and Richardson (2002) proved in their research that Organizations with employee relations system enjoys relatively better employee performance (organisational performance) whereas organizations that adopts control human resource systems are far behind in achieving better level of employee performance. Their research explored Systems including selection process, benefits and incentives, motivation, training, skills enhancement programs, decentralization, empowerment of employees,

conflict handling, and job designs. Guest (2004) developed a theoretical framework to show how employee relations policies can affect human resources and organisational outcomes. He saw retention as a vital outcome, concerned with the goals linking employees with firm performance as the goal of quality is important to ensure the high quality of products and services and high cost effectiveness. He concluded that compensation policy plays an importance role in ER and contribute to improved strategic integration, employee commitment, flexibility and quality of service, high problem solving activity, high cost effectiveness, and low staff turnover, reduced absences and fewer grievances.

Ulrich (2007) noted that working environment characterized with poor employee relations influences application of poor leadership styles that negatively affects realization of organization performance. Horton (2007) noted that an organization with effective reward systems like transactional and relational rewards improves the level of employee motivation and this supports realization of increased organization performance. Howes, (2010), Cuthie, (2010) and Werbler & Harris, (2009) stated that best Practices for improving Employee performance for high organisational performance requires meaningful , rewards, fridge Benefits, Good working conditions, and Quality of Life. Frye (2004) further argued that for human capital intensive institutions, compensation plays a crucial role in attracting and retaining highly skilled employees. Healthcare is largely delivered by highly skilled workforce and as the healthcare sector is a human capital institution, compensation practices can be of great help in retaining highly skilled and competent employees.

2.3.6 Employee Voice

One of the major employee relations practices in healthcare sector is Employee voice. This is any formal mechanism for two-way communication between management and workers either through the union or non-union forms and combinations thereof. Union voice is always a representative collective type while non-union voice can take on both

representative such as independent works councils, joint consultative committees and direct forms such as team briefings and suggestion schemes (Metcalf, 2003).In the last two decades the initiatives that have been taken to improve the employees' performance focuses mainly on enhancing the means of joint consultation, which appeals to both employers who are looking for better business outcomes and employees who are looking for recognition of employee rights (Chartered Institute of Personnel Development, 2007). Common forms of employee voice include union collective voice, Works Councils, Joint Consultative Committees, and Suggestion schemes (CIPD, 2007).

Most researchers share the common view point that for a business to be successful, the importance of employee voice cannot be neglected; as argued by Dundon *et al*. (2004) that employee voice recognition could positively affect their quality of service and productivity, and on the other hand it could help to deflect the problems, which otherwise might explode. Employee turnover rate is believed to be directly related to the opportunities they have to voice their issues. The more opportunities employees have to voice their dissatisfaction and changing the disgruntling work situations, the more they will be interested in staying with the organization(Boxall & Purcell, 2003).According to Boxall and Purcell, (2003), the main focus for representation of employee voice has been on the union collective bargaining and joint consultative committees. Voicing employee issues are more effective in some situations as they help strengthen worker communities and provide a direct means of communication between them and management; but findings by Freeman and Medoff (1984) argued that union plays a vital role in minimizing turnover rate as they provide employees with the voice mechanisms through which they can rectify the work related problems and can negotiate higher compensation packages.

The centrality of voice in employee relations practices has drawn management and behavioural scholars into the research domain on voice, and has elevated the importance understanding voice-performance linkages for individuals and organizations (Boxall & Purcell, 2003). Declining union membership has renewed interest in the fundamental

importance of voice (Budd, 2004) while also prompting inquiries into what forms of voice employees want (Freeman & Rogers, 2006; Freeman, Boxall & Haynes, 2007) and what public policy reforms are necessary to support broad forms of voice (Befort & Budd, 2009), the rise of non-union voice mechanisms has sparked debates over the functioning and legitimacy of alternative forms of voice (Gollan, 2006). There are two widely known forms of voice; Joint Consultative Committees (JCC) and Works Councils (WC). JCCs are considered as the mean of providing formal information sharing mechanisms among management and employee tiers through their representatives (Pettinger, 1999). Pettinger (1999) argued that in presence of joint consultative committees ideas are exchanged, viewed and implemented according to their practicality and benefits to both business and workers simultaneously. Hence, it can be rightly said that joint consultation not only takes employer's perspective in to account but also works for the employee's welfare through proper representation of their views (Brewster, Wood, Croucher & Brookes, 2007). Works Councils on the other hand are formally constituted by the organizations and representatives are chosen from all the business departments for representing employee's views and concerns in the same way as shareholders' interests, financial and operational management issues are addressed; they are constituted for representing employee's interests in an effective manner as the need arises (Pettinger, 1999).

Brewster et al., (2007) defined works councils as collective representative bodies for employee participation at organisational levels with specific informational, consultative and codetermination rights. Works councils provide a wide range of benefits to both employees and employers through creating improved systems for information flow, working for increasing trust and cooperation, spreading the use of best practices and promoting industrial up-gradation (Brewster *et al*., 2007). Croucher &Brewster (1998) added that due to the support of legal bodies WCs are more effective than trade unions in dealing with issues related to flexible work practices. There is no doubt about the importance of WCs and JCCs in the current business environment, but there are few potential problems which need to be taken care of in order to maintain the integrity of

WCs and JCCs. Critics of works councils argued that they are the employers-initiated structures, based on their own terms so they cannot be effective in voicing employee's concerns and issues, and are most likely to secure management position on certain issues (Gollan, 2001).

Jaja & Okpu (2013) defined suggestion scheme as formalized mechanism which encourages employees to contribute constructive ideas for improving the organization in which they work. Employee suggestion schemes are employee relation practices used to capture employee ideas on areas that are often not within their control (Milner, Kinnell & Usherwood, 1995). Lloyd (1996) was able to demonstrate through his research of British Gas how the use of suggestion schemes can encourage employees not only to think more creatively, but also to share their ideas for the benefit of the organization as it makes them more committed and motivated, especially if they receive the appropriate reward and recognition for their ideas, and see them implemented and actually improving the organization. Landau (2009) posit that employees will be more committed if their suggestions facilitate improvement or change in the organization. Similarly Lloyd (1996) believe that when organizations encourage employees to think more creatively and share their ideas for the benefit of the firm by the use of employee suggestion scheme, it will make employees more committed and involved in the organization and less will think of leaving the organization.

According to Martin (2008) when management encourages employees to participate in organization processes and changes through the use of suggestion schemes, it will increase employee productivity to the organization and the urge to stay and see through their ideas implementation. Armstrong (2006) states that there four specific purposes for employee voice these are to articulate individual dissatisfaction with management or the organization; serves as an expression of collective organization to management; contributes to management decision making, particularly regarding work organization, quality of service and productivity; and last, employee voice demonstrates the mutuality of the employer-employee relationship.

2.3.7 Organisational Performance of public Healthcare sector

In the '50s organisational performance was defined as the extent to which organizations, viewed as a social system fulfilled their objectives (Georgopoulos & Tannenbaum, 1957). Later organizations begun to explore new ways to evaluate their performance so performance was defined as an organization's ability to exploit its environment for accessing and using the limited resources (Yuchtman & Seashore, 1967). The 80s and 90s were marked by the realization that the identification of organisational objectives is more complex than initially considered. Thus, organisational theories that followed supported the idea of an organization that achieves its performance objectives based onthe constraints imposed by the limited resources (Lusthaus & Adrien, 1998). In this context, productivity became one of the many indicators of performance.

Lebans and Euske (2006) define performance as a set of financial and nonfinancial indicators which offer information on the degree of achievement of objectives and results. Performance is dynamic, requiring judgment and interpretation. Organisational performance comprises the actual output or results of an organization as measured against its intended outputs (or goals and objectives). According to Richard *et al.* (2009) organisational performance encompasses three specific areas of firm outcomes: (a) financial performance (profits, return on assets, return on investment, productivity); (b) product market performance (sales, market share, etc.); and (c) shareholder return (total shareholder return, economic value added; employee retention). Organisational performance has its basic source from the theory resource based view, according to this theory the organisational performance is taken as an entity which is having resources and competence, a firm can achieve its competitive benefit by using its resources effectively and then can boost its performance (Jung, 2010) . It refers to whether the managers are performing various functions of the company capably to get their goals and objectives achieved (Kim, 2005).

Organisational performance positively correlates to employee relations practices (Armstrong, 2011). West *et al.* (2002) conducted research in 61 UK hospitals obtained information on HR strategy, policy and procedures from chief executives and HR Directors and mortality rates and identified an association between certain ER practices and lower mortality rates. Guest and King (2004) identified three propositions on the linkage between ER and organisational performance : a) ER practices can make a direct impact on employee characteristics such as engagement, commitment, motivation and skill; b) if employees have these characteristics it is probable that organisational performance in terms of productivity, intention to stay and the delivery of high quality customer service will improve; and c) if such aspects of organisational performance improve, the financial results achieved by the organization will improve.

Managers have tended to be judged on their performance in one of the three principal ways: in terms of business outcomes (turnover, profits, return on investment, productivity, customer care, ability to retain staff, absenteeism and so forth) an approach especially favored for middle management levels; in terms of how they have performed generally in carrying out their responsibilities, as stated or implied in their job descriptions, and where performance is assessed as much on the individual managers input into the job as on any outcomes he or she has achieved (Cole, 2005).

Grant (1998) defines organisational performance as the firm's capabilities of undertaking a particular productive activity. Timely and accurate funding data will always be a priority. This perspective takes a view on how the organization must and should appear to shareholders. In healthcare sector, organisational performance is measure in terms of quality of healthcare, efficiency, and other healthcare outcomes (Korir, 2006). Performance has been used synonymously with profitability, productivity, efficiency, effectiveness, quality and competitiveness (Bohlander & Snell, 2007) organisational performance comprises the actual output or results of an organization measured against its intended outputs (organisational goals and objectives). Armstrong (2006) defines performance management as a systematic process for improving

organisational performance by developing the performance of individuals and teams. Armstrong and Baron (2004) view performance management as a discipline of acting upon intelligence and reported information in planning ahead and in managing service operations both directly and through partnerships with other service delivery agents. They describe it as a process which contributes to the effective management of individuals and teams in order to achieve high levels of organisational performance (Armstrong, 2009).

According to Richard *et al*. (2009) organisational performance encompasses three specific areas of firm outcomes: financial performance (profits, return on assets, return on investment); product market performance (sales, market share) and shareholder return (total shareholder return, economic value added). Organisation performance has been the most important issues for every organisation be it profit or non-profit one (Ojo, 2009).

It has been very important for mangers to know what practices influence organisational performance in order for them to take appropriate steps to initiate them (Barney, 2008). According to Javier (2007), performance is equivalent to the famous 3Es (economy, efficiency and effectiveness) of a certain programme or activity. However, according to Daft, (2009), organisational performance is the organization's ability to attain its goals by using resources in an efficient and effective manner. Richardo and Wade (2010) defined organisational performance as the ability of the organization to achieve its goals and objectives. Organization performance is determined by a broad range of factors, some can be evaluated quantitatively, while others require a qualitative analytical approach (Saari, 2006). A number of factors affect performance major among these are the complementary factors of production as well as technology / innovations, institutional back-up, workers motivation, the quality of labour, and environment (Anyawu, 2003). Ruch and Hershauer (1974) provide a framework that separate the factors affecting individual productivity into five distinct, but interacting, sets of variables: individual physical characteristics (size, strength, stamina); psychological

variables (individual attitudes and beliefs); sociological variables (factors that come into play when individuals interact in groups of various sizes); technological variables (tools, equipment, materials); and system variables (policies, management style, communication systems (Daft, (2009).

Hospitals in public healthcare sector are institutions providing healthcare services to the wider population (Sobolev, Sánchez, & Kuramoto, 2012). Performance indicators in hospitals are classified into four groups: indicators based on the use and level, indicators based on the dimensions of performance, financial indicators, and indicators related to resources and health outcomes (Akpinar & Tas, 2012). Organizations are always striving to maintain positive employee relations especially during such trying times of economic downturn. Employers feel especially strong pressure to retain top talent in order to meet and exceed business demands (Barry & Wilkinson, 2011). A very effective way to foster positive employee relations is to provide rewards and recognition for employee suggestions and performance. A rewards program has the potential to positively affect employee relations so long as the process is made explicit and employees understand why or why not they are being rewarded (ERC, 2010).

According to Barry and Wilkinson, (2011) healthcare organizations are not factories; they are highly knowledge-intensive and service-oriented entities and thus require management of employment relationships premised on the commitment of employees to achieving the highest level of quality of patient care. These organizations need to move away from controlling employees to involving them in decision making. One of the important questions in business has been why some organizations succeeded while other failed. Organization performance has been the most important issues for every organization be it profit or non-profit one. It has been very important for mangers to know which factors influence an organizations performance in order for them to take appropriate steps to initiate them.

Researchers among themselves have different opinions and definitions of performance, which remains to be a contentious issue among organisational researchers (Barney& Hestler, 2008). According to Javier (2007), performance is equivalent to economy, efficiency and effectiveness of a certain programme or activity. However, according to Daft (2009), organisational performance is the ability to attain its goals by using resources in an efficient and effective manner. Richardo and Wade (2010) defined organisational performance as the ability of the organization to achieve its goals and objectives. In result oriented evaluation, productivity measures were typically considered. Richardo and Wade (2010) argued that performance measures could include result-oriented behavior (criterion-based) and relative (normative) measures, education and training, concepts and instruments, including management development and leadership training which were the necessary building skills and attitudes of performance management. Hence, from the above, the term performance should be broader based on which include effectiveness, efficiency, economy, consistency behavior and normative measurement (Richardo & Wade, 2010).

2.4 Empirical Review

The empirical literature reviewed could not find studies directly concerned with the influence of employee relations practices in public healthcare sector in Kenya. The literature reviewed indicates that features of employee relations practices are closely related to organisational performance such as financial performance and productivity (Ricardo & Wade, 2010; Goel, 2008). A study by Brenda, Bram, Lars, Marcel, Robert and Sandra, (2014) on effects of HR practices on organisational performance in the Dutch healthcare sector established that HR practices directly affect organisational financial performance. The study confirmed the basic notion that HRM and performance within the health care sector are linked. However the study found a limitation that same mix of HR practices will work for all organizations and recommended inclusion of HR strategy in research design. The study was done in the Netherlands with features of social health insurance scheme in healthcare financing and a mix of Private and Public

sector. The study concluded that HRM makes a difference especially on organisational outcomes. They proposed replica of the same study in an institution with a different kinds of healthcare systems and in a different region.

Zhu *et al*. (2013) conducted study on conflict management between employees from different department: contribution of organisational identification in China and found out that there is a relationship between conflict resolution practice used and organisational outcomes. However, there was no significant relationship between gender, conflict resolution practice and organisational outcome. He used descriptive research design and collected data using cross-sectional design may have inflated the causal relationship between the dependent and independent variables. He recommends study in another region or country and with inclusion of all employees' as well as secondary data.

A study by Ott and Dijk (2005) on effects of ER on client satisfaction in nursing and care for the elderly, with special interest on personal development plan, additional job-related training, job performance review during the past two years, regular departmental meetings and a recruitment protocol in case of a labour-shortage; predictable work schedules and leadership style of the manager which is transparent and supportive. The findings showed that regular departmental meetings and supportive leadership affect job performance; however, the study found that the correlations between the other variables and client satisfaction were generally insignificant. Study done by Chaudhry, Sohail and Riaz (2013) on impact of ER practices on employee performance in hospitality industry indicated that there was a significant relationship between healthcare outcomes and compensation practices, shared decision making and conflict resolution. A study entitled "Human resource management and performance in healthcare organizations", by Harris *et al.* (2007) compared the evidence from a range of reviews concerned with the links between human resource management (HRM) and performance. The study found that relationships have been found between a range of HRM practices, policies systems and performance. The study concluded that trust and power sharing may allow for increasing

tailoring of HR practices to suit organisational circumstances and goals. In their review of health care studies, Harris *et al*. (2007) concluded that practices such as compensation and empowerment are often related to patient oriented performance outcomes. They also noted the importance of conducting additional research on the ‘black box’ issue.

Arbab, Mahmood, Ayoub, and Hussain (2011) looked at whether prestige, learning environment, promotions at upper levels, career growth, and power to take decisions and ownership, facilities, ease of communication, retirement plans, and compensation enhanced the employee performance in hospitality industry and concluded that significant correlation existed. Smith (2010) stated that Nigeria service organizations who are focusing on workforce development, are moving towards a more competitive and productive workforce. Successful companies, who invest in skills development process of employees and recognize efforts of employees, improved their profits and financial figures far more than others do.

Rees and Johari (2010) and Nishii (2011) shows that human resource practices such as training and development, recruitment and industrial relations are linked to employee performance and by extension, organisational performance. Aspden (2007) linked quality of health care to human errors. Rathert and Mary, 2007 established a link between the care patients receive and the working conditions under which their caregivers provide this care. Njau, (2012) researched on human resource challenges facing Kenyatta National Hospital (KNH) in Kenya with special reference to information sharing, financial resource allocation, diverse work force management, dispute management and understaffing and the relationship with specialized quality healthcare outcomes. The study found out that employee recognition, involvement, arbitration of disputes and employee benefits were important factors that affect the delivery of quality service at KNH.

Baraza, (2008) studied adoption of Best Practices in Human Resources Management Among Hotels in Kenya, and found out that a set of proper information sharing and

worker involvement mechanism were indispensable in any work setting. Kalumba and K'Obonyo (2012) in their study on the influence of human resource management practices on financial performance of commercial banks in Kenya found a significant relationship between organisational financial performance and recognition, bonuses and incentivized pay. Baloch et al. (2010), in their study on human resource management practices and employee performance in the banking sector, found a positive correlation between compensation practices and performance of bankers in the North-West Frontier Province (NWFP), Pakistan. They therefore, cautioned that the management of private and public sector banks should pay particular attention to compensation practices in order to increase the performance of their employees.

Shahzad *et al*. (2008), Tessema and Soeters (2006), Huselid (1995) and Frye (2004) examined the relationship between compensation and firm performance and found a positive relationship between the two. Frye (2004) further argued that for human capital intensive institutions, compensation plays a crucial role in attracting and retaining highly skilled employees. As the health sector is a human capital institution, compensation practices can be of great help in retaining highly skilled and competent employees. On the basis of the foregoing discussion, it is worth-noting that compensation practices are correlated with the performance of employees. However, there is the need to test and establish the relationship between compensation practices and organisational performance.

Sloan (2011) and Pearson (2007), conducted a survey filed by HR directors included questions on ten main areas of HRM: trust strategy and HRM, recruitment and selection, training, harmonization, job security, compensation and flexibility, job design and team working, staff empowerment and decision-making, and appraisal. Analysis was conducted, exploring the link between each area and the overall patient mortality index was influence by HRM practices. A further analysis was conducted to determine which practices had the strongest links with patient mortality and found out that performance appraisal was strongest compared to training and development and employee relations.

McLoughlin, (2012) found out that skills and knowledge in the personnel contribute to healthcare outcomes. Although many researchers have looked at the relationship between Human Resource Management practices and hospital performance with regard to employee productivity and financial performance, their studies are limited to developed countries and to private hospitals (Khatibi, Asgharian, Saleki, & Manafi, 2012). Muchiri and James (2006) researched on the unequal distribution of human resources and finances in healthcare in Kenya and how it impacts on access to healthcare. A study by McDermott and Keating (2011) entitled "Managing professionals: exploring the role of the hospital HR function", whose objective was to examine the role of the HR function in the management of professional and non-professional staff in the acute hospital sector found out that in two of the three cases the human resource (HR) function predominantly provides services to non-professional workforce groups. However, the effective and strategic management of professionals is undertaken in the third case, without a professional HR function. The study suggests that HRM as "the management of people and work" was being practiced, if not by the HR function. As a result, a focus on formal HRM structures in hospital organizations is insufficient to capture the manner in which people and particularly strategically valuable workforce groups and work are managed and influence organisational outcomes. Werbler and Harris (2009) researched that employees are ready to make an extra effort if they are satisfied with strategic decisions of their organizations and communication procedures that affect their efficiency and motivation level.

Ngui (2014) studied the effect of human resource management Strategies on the performance of commercial Banks in Kenya using descriptive research design. The objective of the study was to find out whether recruitment and selection practices, training and development practices, reward and compensation strategies and employee relations practices had any effect on organisational performance in the Commercial Banks in Kenya. He found out that there is a positive correlation between employee relations practices such as reward and compensation; communication and employee empowerment. These practices had an effect on profitability, growth and market share in

Kenya's commercial banks. Demographic characteristics such as age, gender and academic qualifications had significant effect on organisational performance. He suggested further study in different economic sectors and compare performance of public and private sector.

Kibe, (2014) carried a research on effects of Communication Strategies on Organisational Performance: A Case Study of Kenya Ports Authority (KPA). The objectives of the study was to identify the effect of internal communication practices such as multi channeled-communication, two-way communication and results-driven communication had significant effect on the performance of Kenya Ports Authority (KPA) and recommended further study using different communication variables. However, this research was a case study and the findings could not be generalized to the whole industry or applied in same industry but are only applicable to KPA. Tuitoek (2008) studied performance appraisal among media houses in Kenya and found that performance appraisals are used to enhance performance and career progression. Kiboi, (2006) conducted a study of management perception of performance contracting in state corporations. Oresi (2005) studied on employees performance management practices for the court registry staff and found a significant relationship between employee relation practices and firm performance. This is a consistent with findings from a similar study by Chenevert and Trembly (2009) who found that good employee relations ppractices such as employee voice and dispute resolution mechanisms have a positive effect on performance. Torrington and Hall (2006) found out that organizations can use collective bargaining to improve employee performance by incorporating compensation for employees who have a good record of performance, resolving conflicts collectively and establishing a mechanism for conflict management and maintenance. A study by Allan, Dungan, and Peetz, (2010) established that the intensity of collaboration between management and workers (through unions) had a positive effect on workplace performance. Overall, studies internationally suggest that workplaces with good employee relations and high employee participation and involvement have higher performance (Addison, John, & Belfield 2004; Hirsch 2004; Kaufman 2005).

2.5 Critique of literature reviewed

The Literature reviewed indicates that features of employee relation practices are related closely to the organisational performance. Card (2001), Charlwood (2007), Gittleman and Pierce (2007) and Armstrong (2010) argue that human resource management practices can improve productivity by increasing employee skills and abilities; promoting positive attitudes; increasing motivation and providing employees with expanded responsibilities so that they can make full use of their skills and abilities. Ahmad & Schroeder (2003), and Hilder and Grindle (1997) found a positive correlation between promotion opportunities and motivation of employees to give out their best. Tessema and Soeters (2006), and Shahzad *et al.,* (2008) as well as Baloch *et al*. (2010) all found a positive relationship between promotion practices and perceived employee performance. Truss (2001) affirmed that financially successful companies like Hewlett-Packard 'promote and develop from within. Park *et al*. (2003) are of the view that synergetic systems of HR practices including merit-based promotion decisions brings about a higher performance of an organization.

Darling and Walker, (2007) in their study on effect of organisational conflict management practices found out that these practices supports the goals for the group and improves the group's performance. Miles (2012) found out that poorly managed conflicts create negative interpersonal relationships that reduce the quality of service, and hinder ability to obtain meaningful outcomes. Researchers have noted numerous studies of conflict resolutions bringing positive results (Rahim, 2011; Simons & Peterson, 2000); however, other studies have demonstrated the opposite results (De Dreu & Weingart, 2003; Jehn, 1995; Jehn & Mannix, 2001; Tepper, Moss, & Duffy, 2011).

Samat, Ramayah, and Saad (2006) explored the relationship between employee empowerment, service quality and market orientation and concluded that it had significant effect on quality of service. Bowen and Lawler (1995) found out that employees influence in decision making process through collaboration had influence on

organisational performance; however, if pushed further down the hierarchy, it could cause chaos. Liu and Fang (2006) revealed that power sharing significantly predicted team performance. Porterfield, (1999) in his research found out that the respondents were not certain about when and where empowerment was influencing organisational outcomes. Chen, *et.al.* (2007) found that leadership empowerment and team empowerment were not significantly related to organisational performance. Peter *et al*. (2002) looked and different empowerment dimensions such as power, decision making, creativity, skill, and creativity and found out that decision making was the most important dimension of empowerment but unfortunately he did not link it with performance.

Frye (2004) examined the relationship between performance based pay and organisational performance and found a positive relationship between the two. Teseema & Soeters (2006) studied the relationship between compensation practices and perceived employee performance and found positive correlation. Goel, (2008); Huselid, (1995) and Dotty (1996) found a significant relationship between organisational outcomes and performance related pay. Kalumba and K'Obonyo (2012) found a significant relationship between organisational financial performance and recognition, bonuses and incentivized pay. Barrington, (2006) found out that application compensation practices and training programs did not have significant influence on organisational performance. Hellweg & Phillips (1982) reviewed literature analyzing communication and concluded that there is a link between employee communication and performance. Goris, Vaught, Pettit (2000) and found that lateral communication was a week predictor of job performance and overall organisational performance.

2.6 Summary of literature reviewed

From the literature reviewed, conflict resolution, employee empowerment, employee compensation and employee voice practices viewed in different dimensions have influence on organisational performance in different sectors. However, some researchers

have contradicting findings coupled with different scope of this study, underlies the importance this research. The research has proposed to adopt various theories and models including Thomas Kilmann model; Scientific Management model, Industrial Relations theory, Human Relations theory and Employee relations theory to analyze conflict resolution practices; Conger & Kanungo Model, legal conception perspective and theory X and Theory Y to analyze employee empowerment practices; AMO model, Human Capital theory, RBV Model, Equity theory and Social exchange theory to analyze employee compensation ; Kanter Model and Social Exchange theory to analyze employee voice practices. Negotiation, Mediation and arbitration practices are identified as conflict resolution practices; Quality circles, information sharing and resources as employee empowerment practices; Allowances, Fridge benefits and flexible work plans as employee compensation practices and works council, suggestion schemes, and union as collective voice practices as forms of employee voice. Empirical evidence that is specific to Kenyan case using variables under review was limited and available data was not adequate in addressing the problem of organisational performance in Public Healthcare sector.

2.7 Research Gaps

The available literature indicates a serious lack of empirical studies designed to specifically explain the influence of employee relation practices on organisational performance (Katou, 2008). The literature points out that the link between employee relation practices and organisational performance is like a 'black box', that is lack of clarity regarding 'what exactly leads to what' (Gerhart, 2005; Katou, 2008). Serious gaps also still remain with respect to the causal ordering of the variables involved in the employee relation–performance relationship (Purcell, Kinnie, Hutchinson, Rayton, & Swart, 2003; Wright, Gardner, Moyniham, & Allen, 2005; Katou, *et al.,* 2008).

Considering that previous researchers do not agree on the ER practices, policies, and systems employed, and accordingly the constructs developed scholars such as Boselie *et al*. 2005; Lepak, Liao, Chung and Harden, 2006; and Wright *et al.,* 2005 have argued that the results derived from these studies are not comparable. There is a great need for additional evidence to support the employee relation-performance relationship. Ngui, (2014) suggested similar studies to be done in other sectors of the economy such as the manufacturing sector, the transport sector and service sector among others in order to compare his findings with those from different sectors. Further research and data collection he said will help to develop the theory of performance linkage in contemporary organizations in the various sectors of the economy. Most of the research that had examined conflict resolution, employee empowerment, employee compensation and employee voice examined them broad them with reference to customer satisfaction, profitability, financial performance, and employee performance unlike the current study that will concentrate on quality of service, productivity and staff retention in Public Healthcare sector.

In the reviewed body of knowledge, conflict resolutions, employee empowerment, employee compensation and employee voice practices had not been analyzed with relation to public Healthcare sector. The related studies were carried out mainly in developed countries outside Africa. Public healthcare sector in provides 48% of healthcare services in the country that has a 80% population who are poor and are left to seek Healthcare services from the Public healthcare Sector. Therefore this study seeks to fill this gap.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology that was used in this study. The chapter highlights the research area, research design, target population, sampling techniques, data collection techniques and methods of data analysis as well as pilot testing. The statistical measurement model used in the analysis and the tests for hypotheses is also given.

3.2 Research Philosophy

Saunders, Lewis and Thornhill (2007) defines research philosophy as term relating to the development of knowledge and the nature of that knowledge. There are four pillars of research philosophy that is Positivism, Realism, Interpretivism, and Pragmatism (Saunder, Lewis, & Thornhill, 2009). This study adopted a positivism philosophy based upon values of reason, truth and validity and focuses purely on facts discovered through direct observation, experience or measured empirically using methods like surveys (Patton, 2002; Kothari, 2004). Predictions were based on previously observed and explained realities and their inter relationships.

3.3 Research design

Bryman and Bell (2007) defines research design as the structure that guides the execution of a research method, and the subsequent analysis of acquired data. It provides a framework for the generation of evidence that is suited both to a certain set of criteria and to the research design as an activity and time based plan which is based on research questions that guides the selection of source of information and specifies the relationship among study variables. It also outlines the procedure. For this study,

descriptive research design was used since it is a scientific method which involves observing and describing the behavior of a subject without influencing it in any way.

The subjects were observed in a completely natural and unchanged natural environment and often used as a pre-cursor to quantitative research designs, the general overview giving some valuable pointers as to what variables and hypotheses are worth testing quantitatively (Sekaran, 2006). Descriptive studies are done when researchers want to establish the relationship of events without interfering with the purpose of reporting facts as they are. This design was chosen and considered appropriate for this study since it was able to give room for exploratory and descriptive data. This form of data was important in understanding the influence of Employee relations practices on organisational performance in public healthcare sector in Kenya.

3.4 Target population

Population refers to an entire group of objects having common observable characteristics (Copper & Schinder, 2009). Population often tends to have a wide geographical spread and in most cases the researcher is not necessarily interested in the total or universal population (Kothari, 2008). The study was interested in the target population which comprises of all individuals, objects or things that can reasonably be generalized in research findings (Mugenda, 2008). In this research the target population was all 150 public healthcare hospitals in levels four and five hospitals in Kenya (Table 2.5). These are the referral Hospitals in Public healthcare sector in Kenya. According to the Healthcare facilities, there are 152 referral hospitals in Kenya; however, two of them are specialized facilities since they double as institutions of Higher learning hence categorized in level 6. (RoK, 2015).

3.5 Sampling Techniques

The study carried out a census on all the 150 Level four and five Public healthcare facilities in Kenya. There are nine (9) level five and one hundred forty one (141) level

four hospitals in Kenya. Level five hospitals employ 7,857 while level four employs 23,132 healthcare workers. These combined comprises 80% of all the HCWs in the Public Healthcare sector in Kenya. These are the County and District public hospitals that serve as regional centers of excellence in provision of referral services for all other lower level hospitals (MoH, 2015). The Unit of analysis of this research was the level 4 and 5 hospitals and unit of observation comprised of the Hospital Administrator, the Human Resource Manager and the Employee Representative or their substantive deputies. The selection of this category of employees was owed to their experience and the fact that they are responsible for the management of employee relations and organisational performance in their respective hospitals.

3.6 Data Collection Instruments

A standardized questionnaire, capturing the variables under study was prepared (Appendix 2). Kothari, 2004 defines a questionnaire as a set of questions printed or typed in a definite order or form of or set of forms. They are a list of research questions asked to respondents and they are designed to extract specific information. The questionnaires contained both closed and open ended questions. The closed questions were used to limit the respondents to the variables of the study while the open ended questions enabled respondents to freely give their opinions in a more pragmatic way (Kothari, 2008). Using a questionnaire, the researcher gathered significant amount of data at a very low cost (Cooper & Schindler, 2006). The research instrument was divided into seven parts. Part I covered general information, part II, III, IV, and V, covered questions related to employee relations practices and part VI focused on organisational performance in Public Healthcare sector in Kenya, Part VII gathered information on other factors influencing organisational performance in Public Healthcare sector in Kenya.

According to Nachmias & Nachmias (2008), questionnaires consist of a series of specific short questions which are usually asked either verbally or self-administered. The

questionnaires was administered personally by the researcher and the assistants to minimize variation in data collection procedure and ensure consistency (Mugenda, 2008; Kumar, 2005). Questionnaires were chosen since it is low cost, free from bias of the interviewer and respondents have adequate time to give well thought out answers (Cooper & Schinder, 2008).

Measurement of the variables was an integral part of research and an important aspect of research design (Sekaran, 2006). Abstract concepts were operationalized to render them measurable in a tangible way. This involved delineating the actual patterns of behavior that would be exhibited and made them quantitatively measurable. We measured the operationalized concept by using Scales (nominal, ordinal, interval, ratio). Nominal scale was used to obtain personal data, ordinal scale was used to rank the preferences and interval scale was used when responses to various items that measured a variable were tapped on a five-point scale which was thereafter summed across the items. Itemized rating scale was used because it provides the flexibility to use many points in the scale as considered necessary (4, 5, 7, 9 or whatever) and it also made it possible to use different anchors with a neutral point that provides a balanced scale. A 5-point scale was used in this study. Research indicates that a 5-point scale is just as good as any, and that an increase from 5 to 7 to 9 points on a rating does not improve the reliability of the ratings (Mugenda & Mugenda, 2008).

3.7 Pilot Testing

Pre-testing allowed for modifications of various questions in order to rephrase, clarify and clear up any shortcomings in the questionnaire. It also allowed discovering ways of increasing individual participation, increasing the likelihood that the participants remained engaged to the completion of the survey, discovering question content, wording, and sequencing problems, discovering target question groups where researcher training is needed and exploring ways to improve the overall quality of survey data (Cooper & Schindler, 2006).

To enhance reliability and validity, the questionnaire was pretested on six respondents who were selected using purposive sampling from two public hospitals. The hospitals were not part of the target population and this ensured that those who participate in the pilot study had no chance of appearing in the actual survey. This was done using the form of a third - split method where two respondents were hospital administrators, two human resource managers and two employee representatives. This made it possible to get a comparison of views from the three different categories of employees since owing to their experience both were considered to be knowledgeable in the research interest areas. Saunders, Lewis and Thornhill (2007) have explained that pilot-testing helps to refine the questionnaire so that respondents have no problem in answering the questions and there will be no problem in recording the data. Cronbach's alpha was used to assess internal consistency and reliability of the questionnaire based on the feedback of the pilot test. The subjects were encouraged to make comments and suggestions concerning instructions, clarity of questions and relevance. This revealed vague questions, deficiencies in the questionnaire and provide an opportunity to analyze the data to see if the methods of analysis are appropriate.

3.7.1 Reliability of the questionnaire

Data from the pilot study was tested using Cronbach alpha to determine internal consistency or average correlation of items in the survey instrument to gauge its reliability to assess and improve upon the reliability of variables derived from summated scales (Cronbach, 1951). Data reliability was measured using Cronbach's alpha coefficient with ranges between 0 and 1 (Sekaran, 2003). The Cronbach alpha values obtained for all the variables was higher than 0.7. The Cronbach's alpha statistic in this study for Conflict resolution was 0.845, Employee empowerment 0.92, Employee compensation 0.867, employee voice 0.932 and Organisational performance 0.813. Data reliability was measured using Cronbach alpha coefficient with ranges from 0 and 1 (Sekaran, 2003). If the Cronbach coefficient value realized is higher than 0.7, it will mean that the scales are reliable (Klein & Ford, 2003).

A commonly accepted rule of the thumb for describing internal consistency using Cronbach alpha is as shown in Table 3.2.

Table 3.1: Internal consistency- Cronbach's alpha

Cronbach's alpha	**Internal consistency**
$\alpha \geq 0.9$	Excellent(high stakes testing
$0.7 \leq \alpha < 0.9$	Good (low stake testing)
$0.6 \leq \alpha < 0.7$	Acceptable
$0.5 \leq \alpha < 0.6$	Poor
$\alpha < 0.5$	Unacceptable

3.7.2 Validity of the questionnaire

The validity of the questionnaire was determined using construct validity method. Using a panel of experts familiar with the construct is a way in which this type of validity can be assessed (Cooper & Schindler, 2006).The study used different groups of experts in the field of human resource management and issued them with the questionnaires. The experts were required to assess if the questionnaires could effectively be used in establishing influence of employee relations practices on organisational performance in Pubic Healthcare Sector in Kenya. This was in order to establish content and construct validity. The recommendations from the Human resource experts and the pilot study respondents were used to refine and improve the validity of the data collection instruments. Their suggestions helped in removing ambiguities, inadequate terms and this made it possible for the researcher to clarify questions and thereby improve the quality and increase the strength and validity of the research instrument. The coefficient of data gathered from the pilot study was computed with the assistance of Scientific Package of Social Studies (SPSS) version 23. A coefficient of above 0.7 obtained was an indication that the data collection instrument was valid (Klein & Ford, 2003).

3.8 Data Collection Procedure

The questionnaires were delivered to the sampled respondents by the researcher, follow ups were made through calls and visits and the questionnaires were collected upon completion. Permission was sought from the Hospital administrators before data collection. The researcher made use of four research assistants who underwent prior training on administering the questionnaire. The establishment of contact persons and follow up calls were strategies employed to enhance the response rate.

3.9 Data analysis

Before processing the responses, data preparation was done on the completed questionnaires by editing, coding and entering and cleaning the data. Data was accumulated data into manageable size, developing summaries, looking for patterns and applying statistical techniques such as bar charts, percentages, frequency tables, and pie charts (Cooper & Schindler, 2003). Data collected for this study was analyzed using descriptive statistics. Descriptive statistics was used to analyze quantitative data. Descriptive statistics provides for meaningful distribution of scores using statistical measures of central tendencies such as the mean and median, and measures of dispersion such as standard deviation will be used to describe the characteristics of the target population, (Kothari, 2008). Qualitative data was analyzed using content analysis method. This involved coding and classifying data in order to make sense out of what was said by the respondents.

SPSS was used to quantitatively analyze the data. Inferential data was analyzed using confirmatory factor analysis (CFA-AMOS), regression analysis and factor analysis to determine the strength and direction of the relationship between the independent and dependent variables. The analysis enabled prediction to be made as to how the variable deviates from the normal. Hierarchical models were fitted and hypothesis testing was carried out by use of confirmatory factor analysis. Qualitative data was analyzed

through content analysis which was deductive and numerically oriented. Content analysis is a systematic approach of getting the content of communication in the form of ideas and propositions through documents used in an organization. Usually, frequency of appearance of a particular idea is obtained as a measure of concern (Krishnaswamt, Sivakumar, & Mathirajan, 2006). The data was be presented in bar charts, pie charts and frequency distribution tables for ease of understanding.

3.9.1 Measurement of variables

This study measured of five (5) variables namely: conflict resolution, employee empowerment, employee compensation, employee voice and organisational performance. A five pointer likert scale (5-1) was used for each of the statements corresponding to the various parameters of the performance management initiatives. The independent variable for this study which is organisational performance was measured by objective measures of performance such as staff retention, productivity and quality of service.

3.9.2 Multiple Linear Regression Model

Organisational performance of Public Healthcare sector was regressed against four variables namely: Conflict resolution, employee empowerment, and employee compensation and employee voice. Multiple linear regression is a statistical tool used to derive the value of a criterion from several other independent or predictor variables. It is the simultaneous combination of multiple factors to assess how and what extent they affect a certain outcome. Using multiple regression, theories can be tested (or models) about precisely which set of variables is influencing our behavior; and in this case it is organisational performance. The study used level of significance of 0.05.

The following regression model was adopted.

$Y = B0 + B1X1 + B2X2 + B3X3 + B4X4 + e$

Where;

Y = Organisational Performance

X1= Conflict resolution

X2 = Employee Empowerment

X3 = Employee Compensation

X4 = Employee Voice

B0 = is a constant which is the value of dependent variable when all the independent variables are 0

Bi (where i =1, 2,3, 4) is the regression coefficients or change induced by conflict resolution, employee empowerment, employee compensation, and employee voice. It determined how much each independent variable (conflict resolution, employee empowerment, employee compensation, employee voice) separately contribute to organisational performance.

e is the error of prediction.

3.10 Ethical Aspects of Research

Due care was taken to avoid plagiarism, paraphrasing without referencing and quotations were included in the text after due deliberations. A conscious effort was made to keep the originality of the collected data and avoiding generalizations that would affect the results. According to McNamara (1994), ethical concerns in research

deal with voluntary participation, no harm to respondents, anonymity and confidentiality, identifying purpose and sponsor, and analysis and reporting.

To help eliminate or control any ethical concerns the researcher made sure that participation is completely voluntary. This could have led to low response rate which can in turn introduce response bias (McNamara, 1994).To encourage a high response rate, Kothari, (2004) suggests multiple contacts. For this study, up to three contacts were made per potential participant. To avoid possible harm such as embarrassment or feeling uncomfortable about questions to respondents, the study did not include sensitive questions that could cause embarrassment or uncomfortable feelings. Harm could also arise in data analysis or in the survey results.

CHAPTER FOUR

RESEARCH FINDINGS, ANALYSIS AND DISCUSSION

4.1 Introduction

This study sought to establish the effects of employee relations practices on organisational performance of Public Healthcare sector in Kenya. The study concentrated on the independent variables; Conflict resolution, Employee Empowerment, Employee Compensation and Employee Voice. The analysis was done using statistical package for social sciences (SPSS) version 23. The tabulation of the results was based on the data collected by use of the questionnaires and interviews.

4.2 Response Rate

The study involved 150 public hospitals across the country. 450 questionnaires were administered to Hospital Administrators, Human Resource Managers, and employee representatives. All questionnaires were correctly filled and returned forming a response rate of 100%. Mugenda and Mugenda (2008) states that a response rate of 50% is adequate, 60% and above good, and above 70% very good. Further, according to Kothari (2004), a response rate of 50% is considered average, 60-70% is considered adequate while anything above 70% is considered to be excellent. A study carried out by Hellen (2015) on the relationship between HRM practices and labour productivity in state corporations yielded a response rate of 83% which she considered excellent. Therefore, a response rate of 100%, cognizant of the sensitive nature of the study, was considered excellent. The high response rate was attributed to the techniques applied in administration of the questionnaire which ranged from the use of multiple contact persons, making follow up calls and visits and using research assistants who were trained prior to the exercise.

The respondents to the questionnaires were represented across the relevant departments as illustrated in table 4.1.

Table 4.1: Sampled Departments

Department	Frequency	Percent	Valid Percent	Cumulative Percent
Hospital Administrators	150	33	33	33
Human Resource Managers	150	33	33	67
Employee Representative	150	33	33	99
Total	450	100.0	100.0	

4.3 Reliability Analysis of the Pilot Study

The instrument's reliability was determined by Cronbach Alpha. According to Brown, (1996) a Cronbach alpha of at least 0.70 implies there is adequate internal consistency reliability of the test instrument. A Cronbach alpha test was conducted to check the validity of the responses from the pilot test. Cronbach's alpha reliability coefficient ranges between 0 and 1. However, there is actually no lower limit to the coefficient. The closer Cronbach's alpha coefficient is to 1.0 the greater the internal consistency of the items in the scale. George and Mallery (2003) provide the following rules of thumb: "_ >0.9 – Excellent, _ > 0.8 – Good, >0.7 – Acceptable, _ >0.6 – Questionable, _ >0.5 – Poor and _ <0.5 – Unacceptable". They further allude that while increasing the value of alpha is partially dependent upon the number of items in the scale, it should be noted that this has diminishing returns. They also note that an alpha of 0.8 is probably a reasonable measure.

4.3.1 Reliability Statistics

Cronbach's alpha was run for twenty seven Value items in each variable. From the results it was clear that overall alpha ranged from 0.932 to 0.813. Finchilescu (2002), however, indicated that reliability coefficients of .70 is adequate for research instruments. The overall alpha results were all above 0.7 which was an indication of strong internal consistency among the twenty seven (27) Task Value items in each independent variable and fifty four (54) in the dependent variable. Essentially, this means that respondents who tended to select high scores for one item also tended to select high scores for the others; similarly, respondents who selected low scores for one item tended to select low scores for the other Task Value items.

Table 4.2: Reliability Statistics

	Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
Conflict Resolution	.845	.843	27
Employee Empowerment	.920	.922	27
Employee Compensation	.867	.864	27
Employee Voice	.932	.928	27
Organisational Performance	.813	.799	54

4.3.2 Item Statistics

a) Item-Total Statistics for Conflict Resolution

Corrected Item-Total Correlation displays the correlation between a given Task Value item and the sum score of the other twenty six items. From the analysis it was clear that; Negotiation practices do not influence morbidity rates, Negotiation practices influence employee absenteeism, Mediation practices influence employee years of service,

Mediation practices influence employee absenteeism, Arbitration practices influence employee years of service, rate of staff leavers and influence employee absenteeism. All these items had a negative correlations with influence rate of staff leavers having a weak positive correlation. From the Cronbach's Alpha 'if Item Deleted column' however it can be noted that if the parameters are deleted, there would be no significant increase in the Cronbach's Alpha hence all items were retained for further analysis. (Appendix v)

b) Item-Total Statistics for Employee Empowerment

Corrected item-total correlation displays the correlation between a given task value item and the sum score of the other twenty six items. From the analysis it was evident that quality circles did not influence the cost of patient care, but had a positive influence on employee years of service. Resources and information sharing as empowerment practice did not influence cost of patient care hence both had a negative correlation. However, Resources had an influence on rate of staff leavers and a weak positive correlation on absenteeism. However from the Cronbach's alpha 'if item deleted column' however it was observed that if the parameters are deleted, there would be no significant increase in the Cronbach's alpha, thus all items were retained for further analysis. (Appendix vi)

c) Item-Total Statistics for Employee Compensation

Corrected item-total correlation displays the correlation between a given task value item under observation and the sum score of the other twenty six items. From the analysis it was clear that allowances influence average rate of stay of patients, allowances influence employee years of service, Fringe benefits do not influence morbidity rates, flexible work plans do not influence morbidity rates, flexible work plans influence average rate of stay of patients, flexible work plans influence employee years of service, flexible work plans influence rate of staff leavers and flexible work plans influence employee absenteeism had negative correlations. It was also evident that Fringe benefits influence the mortality rate, Fringe benefits influence hospital readmission rates, Fringe benefits

influence occupation rate of beds and flexible work plans influence the mortality rate however with a weak positive correlations. From the Cronbach's alpha "if item deleted column" however it can be noted that if the parameters are deleted, there would be no significant increase in the Cronbach's alpha hence all the items were retained for further analysis. (Appendix vii).

d) **Item-Total Statistics for Employee Voice**

Corrected item-total correlation displays the correlation between a given task value item and the sum score of the other twenty six items. From the analysis it was clear that works council do not influence the cost of patient care, works council influence employee years of service. Union as collective voice influence on employee absenteeism had negative correlation scores. Works council influence hospital readmission rates, works council influence rate of staff leavers, while suggestion schemes do not influence the cost of patient care. Union as collective voice does not influence morbidity rates but has influence on employee years of service. Union as collective voice influence rate of staff leavers. From the Cronbach's alpha if item deleted column however it can be noted that if the parameters are deleted, there would be no significant increase in the Cronbach's alpha. Thus they will all be retained (Appendix viii).

e) Item-Total Statistics for Organisational Performance

Corrected item-total correlation displays the correlation between a given task value item and the sum score of the other fifty four items. From the analysis it can be deduced that all the performance indicators had low Corrected Item-Total Correlation. It was however evident that if the parameters are deleted, there would be no significant increase in the Cronbach's alpha warranting the need for all parameter retention (Appendix ix).

4.3.3 Validity of the Research Instrument /Trialing the Interview Questions

Content validity refers to what the test actually measures and requires the use of recognized subject matter experts to evaluate whether test items assess defined content (Mugenda & Mugenda, 2003). Content validity was achieved by subjecting the data collection instruments to an evaluation by a group of six Employee Resource experts who provided their comments on the relevance of each item on the instruments. The experts were required to indicate whether the items were relevant or not. The results of their responses were analyzed to establish the percentage representation using the content validity index. The content Validity formula by Amin (2005) was used in line with other previous studies (Cull, Demirguc-Kunt, & Morduch, 2007; Lefort & Urzua, 2008). The formula is; *Content Validity Index = (No. of judges declaring item valid)/ (Total No. of items)*. Results from Table 4.2, shows that the test yielded an average validity index score of 92 %. This implied that the instrument was valid as emphasized by (Amin, 2005).

Table 4.3: Content Validity Index

EXPERT	TOTAL ITEMS	VALID ITEMS	FRACTION
1	27	24	0.8888889
2	27	26	0 .9629629
3	27	25	0.92592592
4	27	22	0.81418148
5	27	25	0.92592592
6	27	27	1.00000000
Average			**0.91964752**

4.4 Background Information

A profile of the respondents, which represents the demographic characteristics, is presented in figures 4.4.1 – 4.4.10. The demographic information captured in the study related to gender, age bracket, and position, level of the hospital, number of healthcare workers, human resource policy and the ranking in performance contracting. The sample varied adequately in terms of the most important background characteristics.

4.4.1 Gender of Respondents

The findings from the responses indicated that majority of the respondents were male (78%) while the minority were female (22%). Information from the gender distribution was to ascertain that there was a balance in distribution of views collected from both sides of gender. The findings indicated that while male respondents were more than female respondents, there was diversity in the respondents and hence the data collected was not expected to be distorted by factors relating to gender distribution. The data in the Gender distribution figure below shows that the number of females in leadership positions is still low as compared to their male counterpart's sentiments that are echoed not only in the in Public Healthcare Sector in Kenya but also in all employment industries (Hellen, 2015). This is also an indicator that Public Healthcare Sector is yet to comply with the gender equality rule in the Kenyan constitution, 2010 which states that none of the gender should be more than two thirds. The sector needs to embark on Gender Mainstreaming programs to ensure compliance. Gender distribution is presented in figure 4.1.

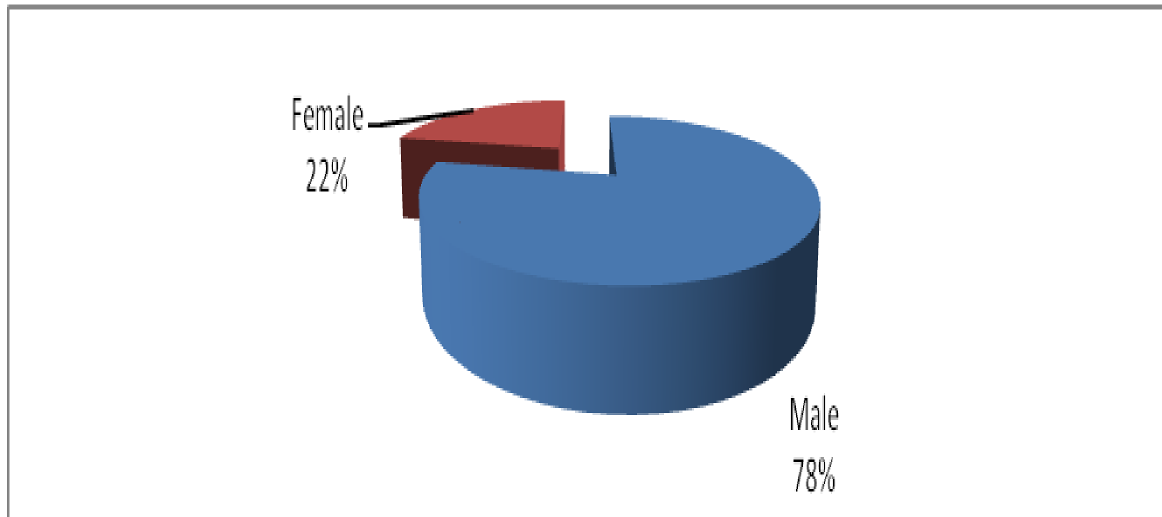

Figure 4.1: Gender Distribution

4.4.2 Age Bracket of respondents

When the respondents were asked to indicate their age bracket, 21% were between the ages 50-60 whereas 79% were between the ages of 40 and 50. This can be indicative of the experience one has due to the fact that majority of people between the ages of 40 and 50 are at their peak of their performance career and have at least more than 15 years of working experience post-graduation. This result can also be interpreted that majority of the employees in leadership positions were 40 years and above and capable of giving information that is useful to this study based on their extensive work experience. This is a similar finding by Chaundry *et.al,* (2011)

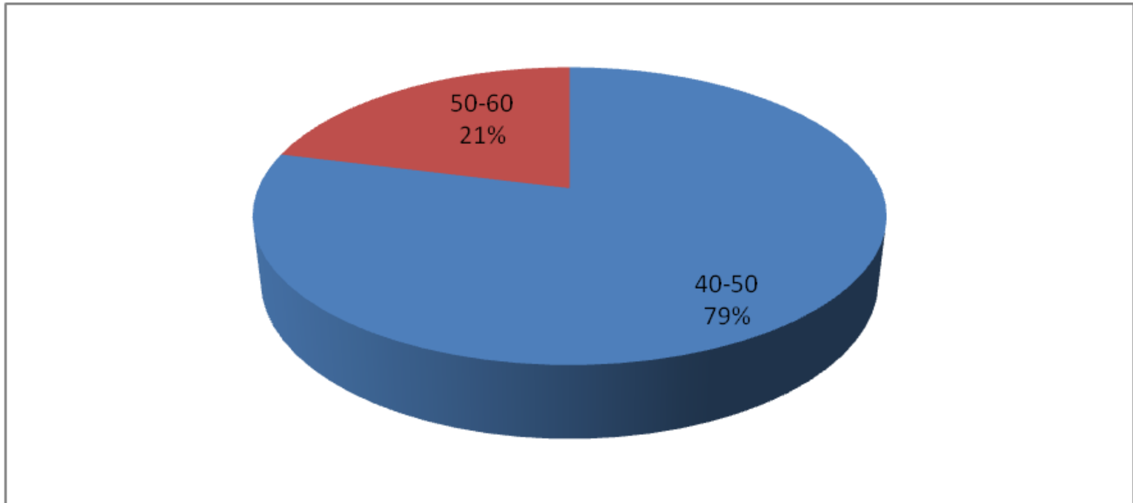

Figure 4.2: Respondents' Age Bracket

4.4.3 Respondents Description

The respondents to the research were equally represented at 33% in each case. These findings reveal that the sample size was well represented as per the research methodology and that the results arrived at was not biased to one department or category of the target population and therefore findings could be generalized to the entire population.

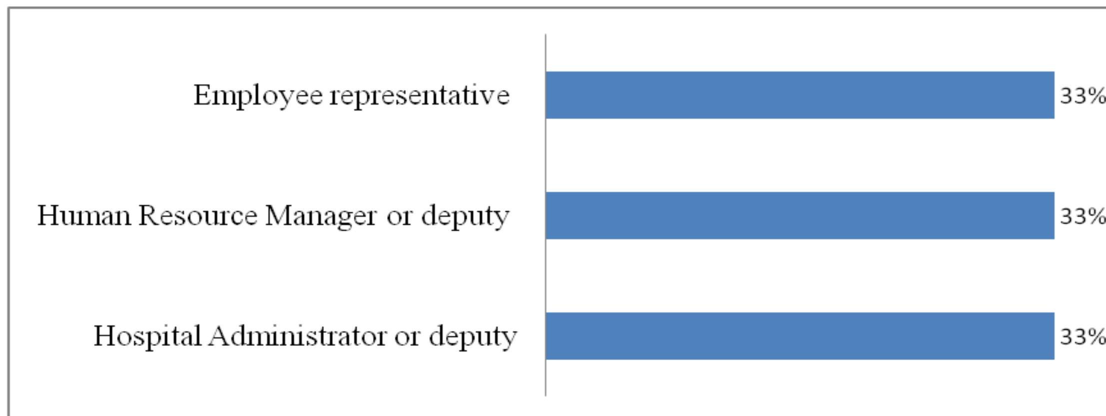

Figure 4.3: Respondents' position

4.4.4 Level of the Hospital

The study established that there are one hundred and forty one (141) hospitals in level four and nine (9) hospitals in level five. This is commensurate to the number of both level four and level five hospitals in the country hence representative of the same. This is the same number of hospitals presented in the Ministry of Health Facility list of 2015 (MoH, 2015).

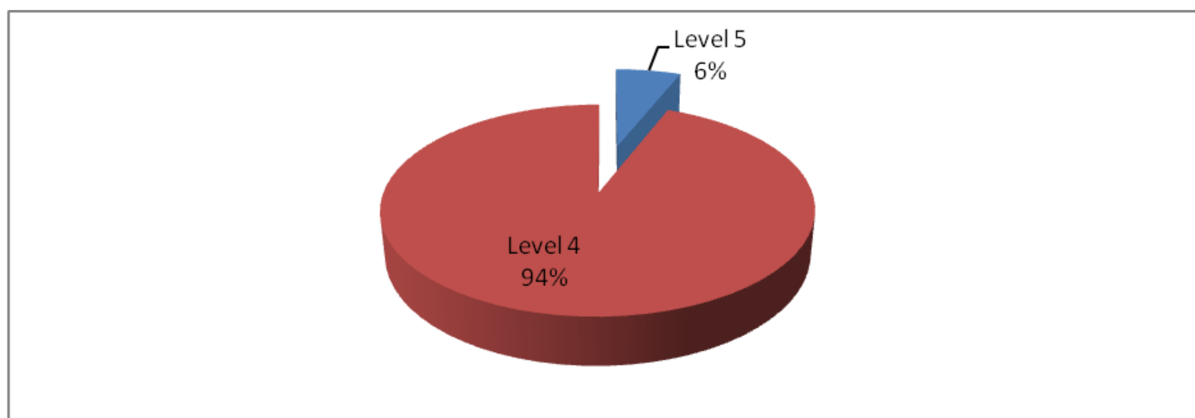

Figure 4.4: Level of the hospital

4.4.5 Number of year's hospital has been in the current level

The study sought to establish the number of years the hospital has been in the said level. 21 hospitals had been in the current level for between1-4 four years, 44 between 5-8 years, 50 between 9-12 years and 36 indicated above 12 years. This information was important as it was used to compute the relationship between the hospital level and performance. The study established that there was a mass upgrading of hospitals in the last eight years. From the Analysis, 43% of the Hospitals has been upgraded to a higer level in the facility category list. This confirms a study conducted by (Wamai, 2009) who indicates that some hospitals retained their level while others were upgraded under the country's new devolution strategy. The study further elaborates that provincial hospitals which had more than 12 years in their current level were responsible for delivering health services and implementing health programs hence considered to be the central element of the public health system in Kenya.

Table 4.3: Number of year's hospital has been in the current level

Years	N	Percentage
1-4	21	14
5-8	44	29
9-12	50	33
Above 12	36	24
Total	**150**	**100**

4.4.6 Number of health care workers in the Hospital

The number of HCW in each hospital was sought and majority of the respondents indicated thea 67% of the hospitals had above 300 employees, 28%, between 201 and 300 while 5% had between 100 to 200 employees. Most of the Hospitals that had over

300 employees were all in Nairobi and other major cities in the country. This confirms a finding by Waiganjo (2012) that 50% of the Healthcare Workers practice in Nairobi to serve an estimated population of 3 million representing 6.8% and leaving 93.2% of the entire population with inadequate HCWs. This confirms the global evidence which points out the direct correlation between the size and state of a country's healthcare workforce and its health outcomes (WHO, 2006). The study confirms that Kenya is one of the 57 countries in the world that face a severe HCW crisis and is number one amongst the 36 sub-Saharan Africa countries with highest brain drain (HRH, 2014).

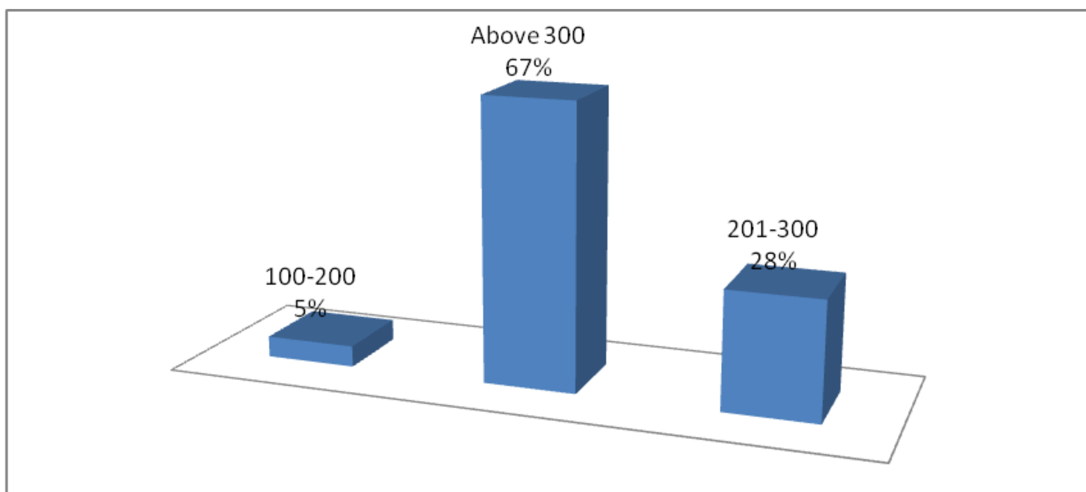

Figure 4.5: Number of health care workers in the Hospital

4.4.7 Percentage of Health care workers belonging to a Union

The question sought to investigate the level of unionization in Public Healthcare Sector. The study established that all hospitals under investigation had above 50% of HCWs belonging to a Trade union. This is an indication that Public Healthcare Sector is highly dominated by Union as a collective voice for employees. This explains why majority of the Strikes in Public Sector are in Public Healthcare sector (MOH, 2014). It is therefore important for the Public Healthcare Sector to establish a partnership kind of relationship with trade unions to avoid

staff unrest that sometimes take long to resolve conflicts and also to devise alternative dispute resolution methods to resolve employee-employer conflicts at the workplace.

The study also revealed that all the hospitals had a written human resource policy and procedure that was benchmarked on the government of Kenya Human Resource Policy for Health. The study established that the human resource policies in all the hospitals investigated had Conflict resolution practices, Employee empowerment practices, Employee compensation practices and Employee voice mechanisms. This finding was in support of findings by Wooden (2000) which established that effective Human resource Policies should be elaborate and include employee relations practices inorder to contribute to organization productivity.

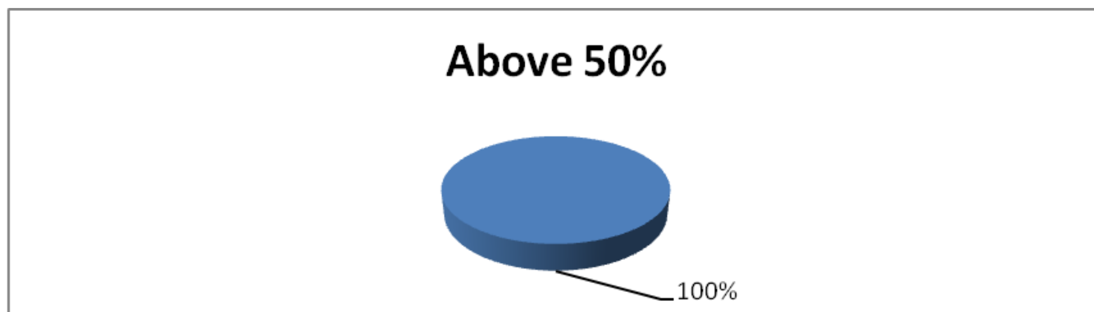

Figure 4.6: Union Representation and Human resource policy

4.4.8 Performance contracting level Ranking

The study wanted to establish the hospital's ranking at the Ministry of Devolution and Planning-Department of Performance Contracting. The data gathered revealed that 81%, 78%, 76% and 64% of the hospitals were ranked 'good' in 2011, 2012, 2013 and 2014 respectively. Improvement in the ranking was witnessed in the subsequent years as 19%, 21%, 24% and 36% were ranked 'very good' in 2011, 2012, 2013 and 2014 respectively. The findings were an impressive indication that organisational performance was improving with time and probably with the implementation of the human resource policy that included most of the employee relations elements under study.

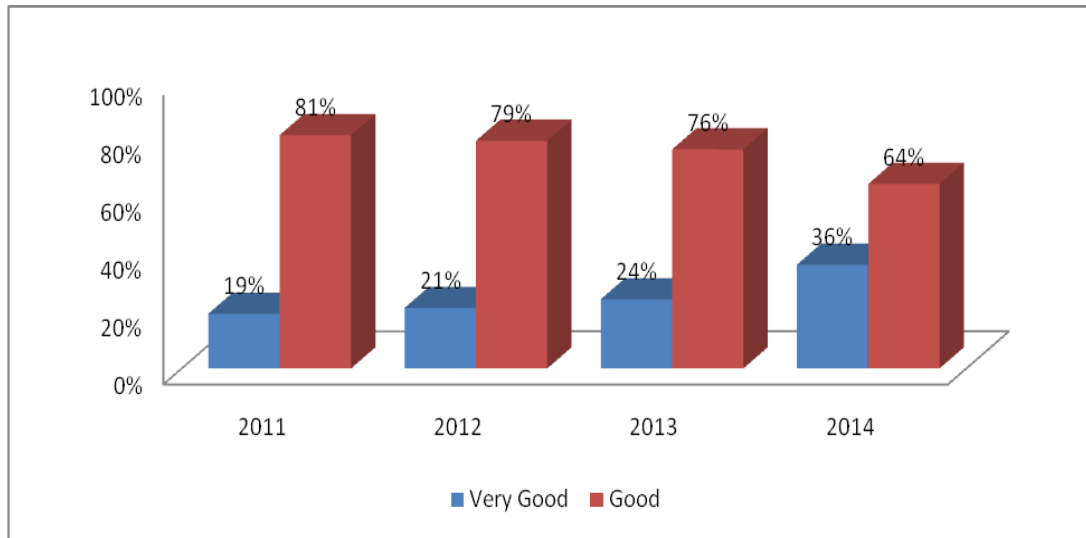

Figure 4.7: Performance contracting level Ranking

4.5 Influence of conflict resolution on organisational Performance

4.5.1 Used practice

The study sought to establish the pactices each institution used mostly to resolve conflicts at the workplace by ranking the practices under study. The most used practice was negotiation (mean= 3.54 and standard deviation of 1.30) followed by mediation (mean=3.44 with a standard deviation= 1.10) and finally arbitration (mean=3.00 with a standard deviation= 1.18). From the analysis it was clear that most hospitals preferred to negotiate. This is because of the high dominance of Trade Union in the Sector. Linking the findings of the study with the Thomas-Kilman conflict resolution model (1974), it is clear that the Public Health Sector prefer collaboration as a conflict resolution mechanism. This finding can be linked to Charles, et al (2013), that one can anticipate that in the near future there could be more wage negotiations and collective bargaining between doctors as employees and the employing healthcare organizations. The finding also means that negotiation as a conflict resolution option means being willing to believe that when two parties are at loggerheads, it is possible for both sides to come out with

what they want and develop conflict resolution skills based on mutual respect, willingness to listen to others, and creativity in finding solutions thereby improving organizational performance (Thomas & Kilmann, 1974).

Table 4.4: Conflict resolution used practice

	least Used	Averagely used	Used	Most Used	Mean	Sdv
Negotiation	146	86	45	176	3.54	1.30
Mediation	90	194	45	122	3.44	1.10
Arbitration	207	140	0	104	3.00	1.18

4.5.2 Year of commencement

The study established that 56% of the hospitals initiated negotiation as a conflict resolution mechanism in the year 2010 whereas 39% of the hospitals had started the same earlier than 2010. Only 6% of the hospitals most of them which had recently been upgraded to level five hospitals commenced Negotiation practice in the year 2013.39% of the hospitals initiated mediation in the year 2011 while 34% started in 2010 with the remaining 27% starting it in 2012. None of the hospitals under the study started mediation earlier than 2010 or later than 2012. The study revealed that the earliest hospital to initiate arbitration practice was in the year 2010 representing 21% of the population while only 1% started the same in the year 2011. 61% however started the same in the year 2012 with the remaining 16% starting in 2013. This is an indication that Negotiation as a conflict resolution practice is the oldest and most dominant practice adopted by public Healthcare sector to resolve workplace conflicts.

Table 4.5: Year of commencement

	2013	2012	2011	2010	Earlier	Mean	Sdv
Negotiation	26	0	0	246	172	5.60	1.31
Mediation	0	119	172	150	0	3.41	1.22
Arbitration	70	268	4	92	0	3.29	0.98

4.5.3 Negotiation

The study sought to find out influence of negotiation practices on organizational performance and found out that Negotiation as a Conflict Resolution Practice influenced occupation rate of beds of the hospital (mean=3.66) and employee years of service (Mean =3.5). The respondents were asked to indicate whether negotiation influence rate of staff leavers and the rate of mortality, 21% and 19% respectively strongly agreed while 24% and 26% strongly disagreed. This parameter had mean scores of 3.46 in each case. 17% of the respondents strongly agreed that negotiation practices do not influence the cost of patient care (mean=3.51) in a five point likert scale. The study established that Negotiation practices do not influence morbidity rates since 34% of the respondents disagreed with only 21% strongly agreeing. This parameter had a mean score of 3.4 alongside the sentiment that negotiation practices influence average rate of stay of patients at the hospital. 46% of the respondents strongly disagreed that negotiation practices influence employee absenteeism with 23% agreeing with the same this parameter had the lowest mean score of 3.14 alongside the parameter that sought to establish whether negotiations practices influence hospital readmission rates (mean=3.19).

These findings can be linked findings by (Olakunle, 2008) where he established that negotiation practices offers a private and voluntary option beyond the industrial courts where there is employment relationship one inevitably finds labour conflicts and the need to resolve them efficiently, effectively and equitably for the benefit of all the parties involved and the economy at large

Table 4.6: Negotiation as a conflict resolution practice

	Disagree	Uncertain	Agree	Strongly Agree	Mean	Sdv
Negotiation practices influence the mortality rate	26	21	34	19	3.46	1.07
Negotiation practices do not influence morbidity rates	34	13	31	21	3.40	1.17
Negotiations practices influence hospital readmission rates	37	19	33	11	3.19	1.07
Negotiation practices influence average rate of stay of patients at the hospital	31	16	34	19	3.40	1.12
Negotiation practices influence occupation rate of beds of the hospital	17	21	40	21	3.66	1.01
Negotiation practices do not influence the cost of patient care	23	20	40	17	3.51	1.03
Negotiation practices influence employee years of service	20	26	39	16	3.50	0.99
Negotiation influence rate of staff leavers	24	27	27	21	3.46	1.09
Negotiation practices influence employee absenteeism	46	17	14	23	3.14	1.23

4.5.4 Mediation

Analysis of the study parameters revealed that Mediation practices influence employee years of service (mean =3.66) as 27% agreed and 31% strongly agreed with the same; employee absenteeism (mean=3.63) and 30% strongly agreeing that mediation practices influence hospital readmission rates (3.40). 40% of the respondents strongly agreed that mediation practices do not influence the cost of patient care (Mean =3.4). The study sough to establish whether mediation practices influence morbidity rates. 29% of the respondents strongly agreed while 34% disagreed with the same (mean=3.39). 33% of

the respondents strongly agreed that mediation practices influence average rate of stay of patients at the hospital with 44% of the respondents disagreeing with the same. 4% of the respondents did not agree with the sentiments that mediation practices influences the rate of staff leavers 4% strongly agreeing with these sentiments with 33% disagreeing with the sentiments. The same applied to the parameters that sought to measure the influence of mediation practices on occupation rate of beds of the hospital and mortality rate as these parameters had the lowest mean scores of 3.16 and 3.00 respectively as 31% and 44% of the respondents disagreeing with these sentiments respectively. Robinson, et al, (1974) established that mediation as a conflict resolution practice is agreeing in part with the other person's view or demand in order to build the spirit of teamwork, motivation, productivity and cooperation among the employees of the organization.

Table 4.7: Mediation as a conflict resolution practice

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	Mean	Sdv
Mediation practices influence the mortality rate	0	49	20	14	17	3.00	1.15
Mediation practices do not influence morbidity rates	0	34	21	16	29	3.39	1.23
Mediation practices influence hospital readmission rates	0	37	16	17	30	3.40	1.27
Mediation practices influence average rate of stay of patients at the hospital	0	44	11	11	33	3.33	1.34
Mediation practices influence occupation rate of beds of the hospital	0	31	34	19	14	3.16	1.04
Mediation practices do not influence the cost of patient care	11	17	31	0	40	3.40	1.45
Mediation practices influence employee years of service	10	4	27	27	31	3.66	1.25
Mediation influence rate of staff leavers	0	33	20	43	4	3.19	0.95
Mediation practices influence employee absenteeism	0	31	13	17	39	3.63	1.29

4.5.5 Arbitration

The study sought to establish influence of arbitration practices on organizational performance and ascertained that arbitration practices influence hospital readmission rates (mean score of 3.7). Majority of the respondents (50%) agreed to this sentiments while 13% disagreed with the same. The study also established that arbitration practices influence occupation rate of beds of the hospital (Mean score 3.61). Another parameter

with an equally high mean score was the influence of arbitration practices on employee absenteeism (mean=3.59). 21% of the respondents strongly agreed with the parameter with only 17% disagreeing.

Twenty one percent (21%) of the respondents strongly agreed that arbitration practices do not influence the cost of patient care with 21% responding contrary to these sentiments. The parameters measuring the influence of arbitration practices on employee years of service and the rate of staff leavers had mean scores of 3.46 in each case. The parameter with the lowest mean score was the influence of arbitration practices on morbidity rates (mean = 3.04) as majority of the respondents (37%) disagreed with only 9% strongly agreeing with the same. Ongori, (2007) established that providing healthcare is very demanding and stressful work for HCWs who work long hours as many health care facilities operate 24-hours a day, seven days a week. He further clarifies that employment issues often arise when members of management are engaged in other duties or otherwise not present to receive complaints or monitor disputes and therefore an arbitrator is a key element of resolving conflicts in the workplace and avert employee relations tension thus curtailing employee relation issues festering and becoming major problems before they can be addressed.

Overall, it can be noted that negotiation is the most preferred conflict resolution practice in public healthcare sector in Kenya. This supports the Human relations theory which alleges that certain practices (negotiation) are always better than others (arbitration and mediation) and all organizations should adopt such practices on every occasion (Hsi-An, Yun-Hwa & Chu-Chun, 2006; Daud, 2006). The findings urge healthcare practitioners to create a high degree of internal consistency, or fit, among their ER practices. The findings are in line with a study conducted by Darling and Walker (2007) who indicate that negotiation mechanism is the most informal employee relations practice of conflict resolution where parties to the contract and their designated negotiators resolve the dispute on the best terms for the party they represents. They further emphasis that in a successful negotiation, the parties and their negotiators reach a resolution of the dispute

based on the parties' interests creating high level of motivation among the parties and impacting on productivity. The findings were similar to findings by Zhu et. al., (2013) who carried out a study in China and established that conflict resolution mechanisms have a relationship with organisational outcome.

Table 4.8: Arbitration a conflict resolution practice

	Disagree	Uncertain	Agree	Strongly Agree	Mean	Sdv
Arbitration practices influence the mortality rate	23	30	23	24	3.49	1.10
Arbitration practices do not influence morbidity rates	37	30	24	9	3.04	0.98
Arbitration practices influence hospital readmission rates	13	19	50	19	3.74	0.91
Arbitration practices influence average rate of stay of patients at the hospital	21	24	39	16	3.49	1.00
Arbitration practices influence occupation rate of beds of the hospital	17	29	30	24	3.61	1.04
Arbitration practices do not influence the cost of patient care	21	26	30	23	3.54	1.07
Arbitration practices influence employee years of service	23	29	29	20	3.46	1.06
Arbitration influence rate of staff leavers	23	26	34	17	3.46	1.03
Arbitration practices influence employee absenteeism	17	29	33	21	3.59	1.01

The study sought to find out whether other than Negotiation, Mediation and Arbitration practices, the Hospitals engaged in other conflict resolution practices. Analysis of the data collected from the 150 public healthcare facilities revealed that the Hospitals have elaborate disciplinary procedure and Code of Ethics which heps them resolve conflicts; hold informal discussions and departmental meetings, Employee counselling, group

retreats and parties, peace building abd Transfers and job rotation to different departments in the Hospital.

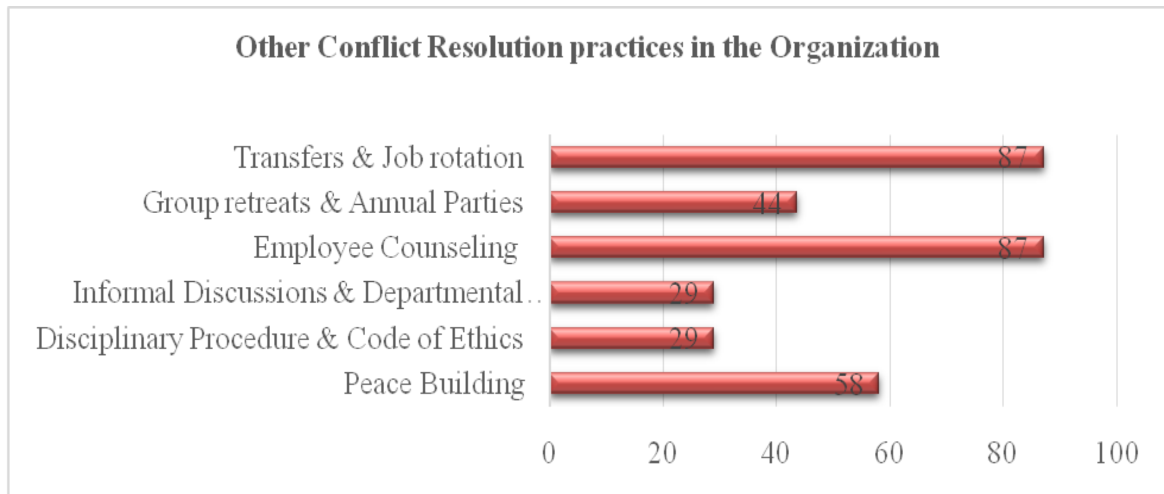

Figure 4.8: Other Conflict Resolution Practices in Public Healthcare

4.6 Influence of employee empowerment on organisational Performance

4.6.1 Employee empowerment practices used

When asked using a scale of 1 to 5 where 5 is highly used and 1 least used, to rank the practices their organization uses to empower employees, 26%, 34% and 37% of the respondents indicated that quality circles, information sharing and resources-equipment, drugs, Human resource was highly used as they ranked 5 where's 34%, 31% and 33% of the respondents indicated that quality circles, information sharing and resource-equipment, drugs was averagely used as they ranked them 3 with 19%, 21% and 11% of the respondents indicated that quality circles, information sharing and resources-equipment, drugs was least used as they ranked them 2.

The study established that employee empowerment practices have a positive effect on the performance of public healthcare sector. Similar findings were established by Samat, Ramayah and Saad (2006) who explored the relationship between employee

empowerment and quality of service as well as market orientation and concluded that employee empowerment had influence on both compared with other practices of total quality management (TQM). The sentiments were arrived at by Werbler and Harris (2009) who stated that best employee relations practices for improving organisational performance and having motivated employees include psychological and structural empowerment practices.

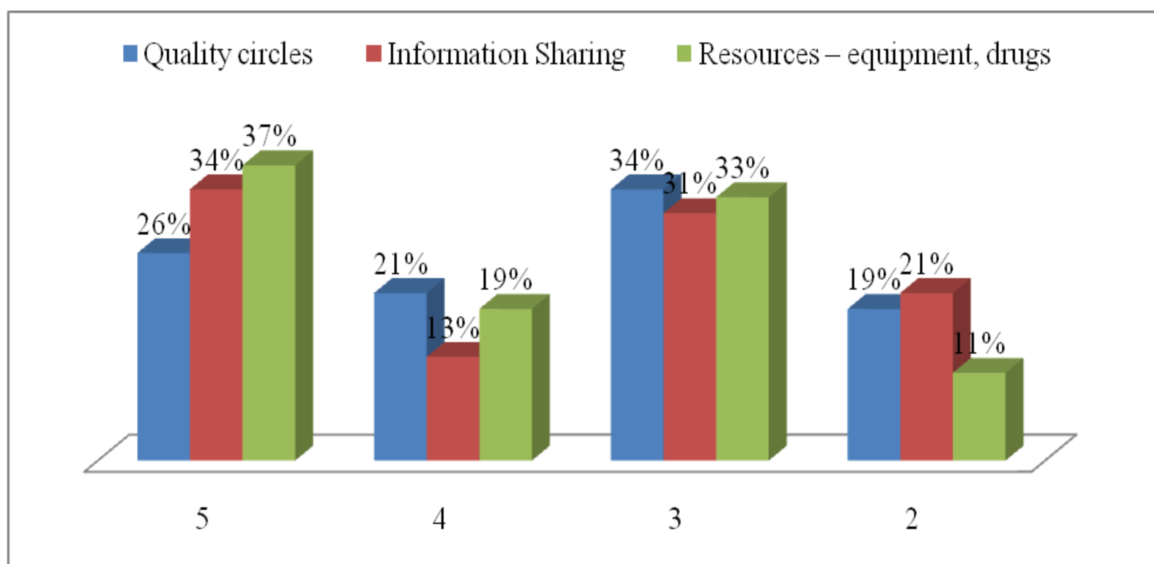

Figure 4.9: Employee empowerment practices used

4.6.2 Influence of Quality Circles on organisational Performance

The study sough to establish the relationship between quality circles and organizational performance and revealed that 71% of the interviewed respondents strongly agreed that quality circles influence the mortality rate, 12% disagreeing and 7% strongly disagreeing. This parameter had the highest mean score of 4.26 in a five point likert scale. As far as morbidity rate was concerned, 65% of the respondents indicated that quality circles did not have an influence on the rate, 14% disagreed and 6% strongly disagreeing. When the respondents were asked to indicate whether Quality circles influenced hospital readmission rates, 44% strongly agreed while 27% agreed. 19%

however disagreed whereas 9% strongly disagreed. On quality circles as a form of employee empowerment and influence on organizational performance, 56% strongly agreed that quality circles had an influence on patients stay at the hospital, 21% disagreed with 1% strongly disagreeing. 53% strongly agreed, 18% agreed, 18% while 3% strongly disagreed quality circles had influence on occupation rate of beds. The study established that 40% strongly agreed while 24% disagreed that quality circles had influence on cost of patient care in Public Healthcare in Kenya. These findings are a clear indication that Healthcare delivery occurs in a complex system of multidisciplinary professionals where care giving teams are expected to represent multiple disciplines on which patients depend on for healthcare service delivery and therefore important to have strong problem solving groups and team working spirit.

From the study it was evident that Quality circles influence employee years of service as 47% of the respondents strongly agreed with this sentiments whereas 22% disagreed, influence the rate of staff leavers, 31% of the respondents strongly agreed and 20% agreed whereas 22% disagreed with 17% strongly disagreeing. This parameter had the second lowest mean score of 3.54 since quality circles influence on employee absenteeism had the lowest mean score of 3.49 with only 25% of the respondents strongly agreeing with the sentiments as 24% disagreeing with the same. This is a clear indication that there is a strong relationship between quality circles and quality of service, productivity and staff retention.

Overall, quality circles had a mean score of 3.7 on a five point likert scale as indication that quality circle as a form of employee empowerment had influence on organizational performance of Public Healthcare sector in Kenya. These results are similar to previous study that indicate working in quality circles for these differing professional affect healthcare outcomes (Ramsay, 2001). Liu andFang (2006) revealed that power sharing significantly predicted team members' performance. The findings also agreed with the sentiments of Petter *et al*. (2002) who interviewed street level officials working in the welfare office to study dissimilar feature of employee empowerment, and reported that

quality circles was one of the important dimensions of empowerment These findings are a clear indication that Healthcare delivery occurs in a complex system of multidisciplinary professionals where care giving teams are expected to represent multiple disciplines on which patients depend on for healthcare service delivery and therefore important to have strong problem solving groups and team working spirit.

Table 4.9: Influence of quality circles on organisational Performance

Statements/Constructs	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	Mean	Std
Quality circles influence the mortality rate	7	12	1	10	71	4.26	1.33
Quality circles do not influence morbidity rates	6	14	1	14	65	4.17	1.33
Quality circles influence hospital readmission rates	9	19	1	27	44	3.80	1.40
Quality circles influence average rate of stay of patients at the hospital	1	21	2	20	56	4.09	1.23
Quality circles influence occupation rate of beds	3	18	9	18	53	4.01	1.26
Quality circles do not influence the cost of patient care	4	24	6	26	40	3.73	1.32
Quality circles influence employee years of service	1	22	8	22	47	3.92	1.23
Quality circles influence rate of staff leavers	17	22	11	20	31	3.54	1.38
Quality circles influence employee absenteeism	16	24	11	24	25	3.49	1.55

4.6.3 Influence of Information sharing on organisational Performance

The study revealed that sharing information influenced occupation rate of beds of the hospital to a great extent. This parameter had a score of 3.92 with 55% of the respondents agreed to the sentiments and only 12% disagreeing. As far as information sharing and mortality rate is concern, 43% of the respondents strongly agreed, 27% disagreeing and 12% strongly disagreeing. This parameter had a mean score of 3.87. The study established a strong relationship between information sharing and morbidity rate with a mean score of 3.57. 31% of the respondents strongly agreed to the sentiments and 34% agreed, however, 35% of the respondents disagreed and 2% strongly disagreed with the sentiments. The study also established influence of information sharing on had the average stay of patients in hospitals and occupation rate of beds with the parameters' recording mean scores of 3.92 and 3.95 respectively. However, the study revealed that information sharing did not influence average cost of patient as these parameter has 3.73 means score and was a negative question. The findings reveal that there is a strong relationship between information sharing and quality of service. The findings of the study are similar to those established by Liu and Fang, (2006) that power sharing significantly predicted team outcome. However, Potterfield, (1999) was not certain about when and where empowerment was influencing organizational outcomes.

The parameter that sought to measure the influence of information sharing on employee years of service revealed a mean score 3.66. 40% of the respondents strongly agreed and 30% agreed to the sentiments. The influence of information sharing on employee absenteeism was low as the parameter had a mean score of 3.55. 35% of the respondents strongly agreed, 26% agreeing, 18% disagreed and 10% strongly disagreeing with the sentiments. These findings on information sharing as a form of employee empowerment and the influence on organizational performance can be linded to similar being a form of structural empowerment can be linked to study by Laschinger, Almost, and Tuer-Hodes, (2003) who identified structural empowerment as important practice for retaining nurses and improving bed occupancy levels.

Table 4.10: Influence of Information sharing on organisational Performance

Statements/Constructs	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	Mean	Std
Sharing information influence the mortality rate	12	27	4	13	43	3.87	1.36
Sharing information do not influence morbidity rates	7	27	2	34	31	3.57	1.40
Sharing information influence hospital readmission rates	4	35	1	21	39	3.54	1.40
Sharing information influence average rate of stay of patients at the hospital	11	21	4	33	32	3.92	1.40
Sharing information influence occupation rate of beds of the hospital	9	12	12	12	55	3.95	1.22
Sharing information do not influence the cost of patient care	1	21	8	22	48	3.73	1.40
Sharing information influence employee years of service	10	18	3	30	40	3.66	1.25
Sharing information influence rate of staff leavers	4	26	2	39	30	3.59	1.38
Sharing information influence employee absenteeism	10	18	12	26	35	3.55	1.10

4.6.4 Influence of Resource on organisational Performance

When the respondents were asked to indicate whether the availability of resources such as drugs, equipment and human resources influence mortality rate, 41% strongly agreed 34% agreed, and 18% disagreed. The study sought to establish whether resources as a form of empowerment did not influence morbidity rates. This parameter had a mean score of 3.82 in a five point scale. 42% of the respondents strongly agreed, and 19% disagreed. As far as the influence of hospital resources on readmission rates was concerned, 35% of the respondents strongly agreed while 10% disagreed. The study established that influence of resources on the average rate of stay of patients at the hospital had the highest mean score (4.25). 51% of the respondents strongly agreed with the sentiments, 35% agreed while only 9% disagreed.

The study sought to establish whether resources influenced occupation rate of beds of the hospital. 34% of the respondents strongly agreed, 30% agreed and 22% disagreed with the sentiments. This parameter had a mean score of 3.5. The study also established that the patients were forced to dig from their pockets to cater for their bills in hospitals that had a problem with resources. The parameter that was used to measure the influence of resources on the cost of patient care had the highest mean score of 4.54.

Responses to establish influence of resources on employee years of service indicated that 2% strongly agreed; as 42% agreed whereas 21% disagreed with 4% strongly disagreeing. The study sought to establish the influence of resources on staff leavers' rate. 32% of the respondents strongly agreed, 21% disagreed. The study established that resources did not have influence on employee absenteeism as this parameter had the lowest mean score of 3.3 in a five point likert scale. This parameter had the 35% of the respondents strongly disagreeing.

These findings are in line with a survey conducted by WHO, (2013) which established that Kenya has weak public healthcare sector characterized by lack of funding, inadequate health infrastructure, human resources and other health care inputs exacerbating Health Care Workers (HCW) distribution inequalities, quality of service complains, low productivity and poor health services utilization.

Overall, empowerment practices were found to influence organizational performance. These findings were similar to earlier findings Boon, Arumugam, Safa, and Bakar (2007) who argue that employee empowerment is the most important employee relations practice that significantly affects the overall organization performance. The same sentiments were echoed by Jung and Hong (2008) who conducted a study to explore the link between organization performances and found that employee empowerment plays a significant role on organization performance. Similar study by Zhang *et al*. (2008) reported that employee empowerment plays a significant role in achieving and enhancing quality of service in organizations. A Study by Ongori, (2007) on employee empowerment and employee performance found out that a strong correlation exists between the two variables. The results of the findings are shown on table 4.11 below.

Table 4.11 Influence of Resource on organisational Performance

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	Mean	Std
Availability of resources influence the mortality rate	0	18	8	34	41	3.91	1.16
Resources not influence morbidity rates	1	19	11	28	42	3.82	1.10
Resources influence hospital readmission rates	3	10	26	27	35	3.90	1.23
Resources influence average rate of stay of patients at the hospital	4	9	1	35	51	4.25	1.03
Resources influence occupation rate of beds of the hospital	1	22	14	30	34	3.50	1.34
Resources do not influence the cost of patient care	6	9	1	25	58	4.54	1.40
Resources influence employee years of service	6	21	4	42	27	3.92	1.40
Resources influence rate of staff leavers	11	21	4	33	32	3.95	1.22
Resources influence employee absenteeism	9	32	12	12	35	3.33	1.32

The study sought to establish whether there were other empowerment practices in the public healthcare sector. 44.7% of the respondents implemented Continuous Medical Education as a means of empowering employees; 17.8% believed that trusting in employee capabilities and respecting boundaries, 7% implemented staff promotions, 7%

had shift-working and 5% had leadership support programs and 5% other forms of motivation of Human resources and 5 % had mentorship & coaching empowerment practices in the public healthcare as shown in figure 4.10 below.

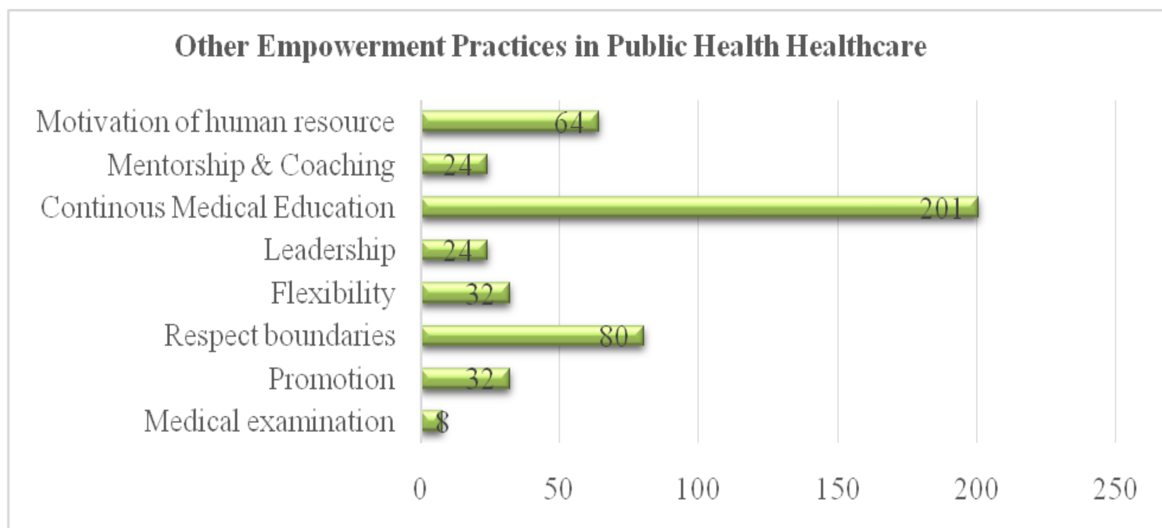

Figure 4.10: Other Empowerment Practices in Public Healthcare

4.7 Influence of Employee Compensation on Organisational Performance

When the respondents were asked using a Scale of 1 to 5 where 5 is the highly used and 1 least used, to rank the programs their organization used to compensate employees, 17%, 12% and 9% of the respondents indicated Fringe benefits, flexible work plans and allowance 5. 28%, 26% and 22% ranked flexible work plans, Fringe benefits and allowance 4. 27%, 24% and 23% of the respondents ranked allowance, flexible work plans and Fringe benefits 3 while 31%, 27% and 25% ranked allowance, Fringe benefits and flexible work plans 2. 7% of the respondent's ranked Fringe benefits 1 while 10% ranked allowance and flexible work plans 1 in each case. The findings can be linked to staff retention in Public Healthcare sector in Kenya and the findings by WB (2013) that Kenya has one of the highest net emigration rates of HCWs in the world, with 51% leaving the country to work elsewhere seeking better working conditions, better remuneration packages and fringe benefits. The contemporary trend in the global public healthcare sector shows

that there are widespread cases of HCW strikes, poor quality healthcare services, and high employees' turnover (WB, 2013). The findings are similar to findings by Njau, (2012) who in his report he indicated that most of the strikes and high staff turnover in the healthcare sector was caused by poor implementation of collective bargaining agreements, lack of facilities in the healthcare Centers, delayed payment of salaries in some counties especially following the devolution of public healthcare or inadequate funding by the government.

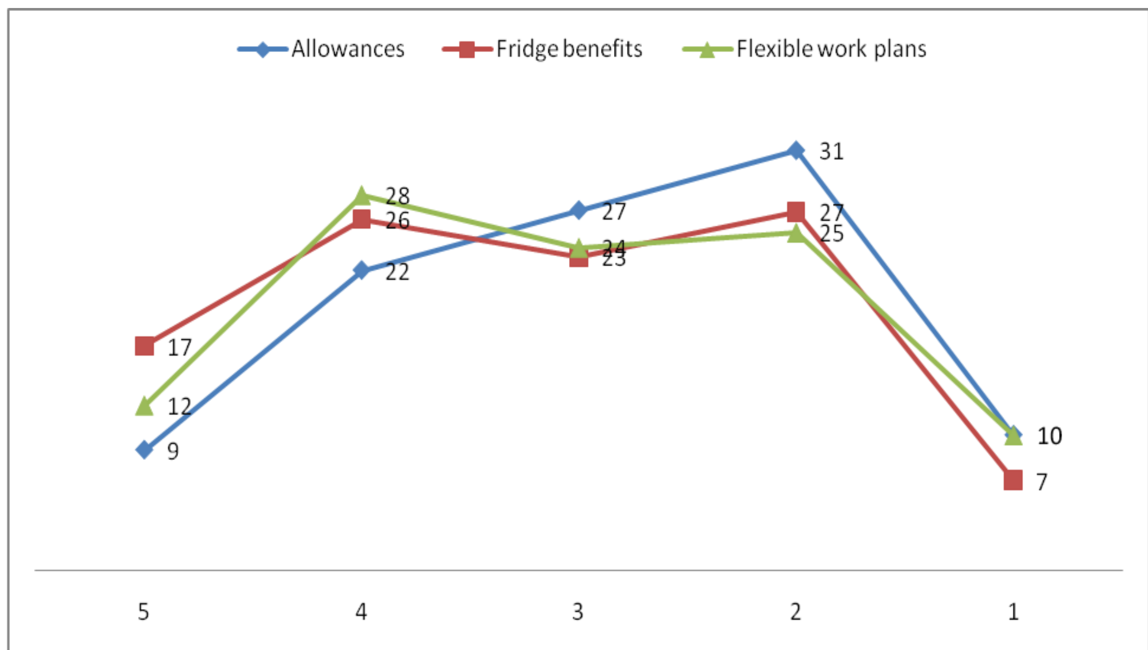

Figure 4.11: Influence of Employee Compensation on Organisational Performance

4.7.1 Influence of Allowance on Organisational Performance

The study revealed that allowances had a great influence on the overall performance of the organization as the parameter scored high mean scores of 4.408 in a five point likert scale. The study revealed that allowance have a strong influence on the rate of mortality as 29% of the respondents strongly agreed, 53% agreed, 4% disagreed and only 1% strongly disagreed. As far as morbidity is concern, the study established that allowances

had substantial influence with a high mean score of 4.34 in a five point likert scale. 7% of the respondents strongly agreed, 55% agreed, while 10% of the respondents disagreed with the sentiments. The study sought to establish if allowances influenced hospital readmission rates. 12% of the respondents strongly agreed, 57% agreed, 6% disagreed while 1% strongly disagreed. These findings agreed with similar findings established Kalumba and K'Obonyo (2012) in a study on employee compensation practices and organisational financial performance in the banking Sector in Kenya.

When respondents were asked to indicate whether allowances influenced average rate of stay of patients, 13% strongly agreed, 44% agreed, 21% disagreed while 4% strongly disagreed The parameter had a mean score of 3.9 on a five-point likert scale. These findings echoed the findings of a study conducted by Frye (2004) who examined the relationship between equity based compensation and firm performance and found positive relationship between the two. However, the study found out that allowances do not influence the cost of patient care with 13% strongly agreeing and 31% agreeing while 8% strongly disagreeing and 24% disagreeing.

When the respondents were asked to indicate whether Allowances influence employee years of service, 12% strongly agreed 25% agreed, 12% disagreed and 28% strongly disagreed. Influence of allowances on Staff leavers rate had the same mean score of 3.4. When the respondents were asked to indicate whether allowances influence staff leavers rate, 8% strongly agreed, 29% agreed, 24% disagreed while 9% strongly disagreed. These findings can be linked to Adam (1965) equity theory. The theory presupposes that a person identifies the amount of input gained from a relationship compared to the output, as well as how much effort another person's puts forth. Further suggest that if an employee thinks there is inequity the employee is likely to be distressed or dissatisfied hence quit. In most case, employees compare themselves with the other health workers in the private sector who earn more, have more benefits and have flexible working conditions justifying the findings that allowances influence the mortality rate with a high mean score of 4.408 in a five point likert scale. Findings of these study have a close association with expectancy theory. The nature of work in health industry

requires high skill levels and thus compensation and allowances are dimmed to be commensurate of the output given but this is not the case (Wright & Niishi, (2007).

Table 4.12: Influence of Allowance on Organisational Performance

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	STD
Allowances influence the mortality rate	29	53	12	4	1	4.408	0.769
Allowances do not influence morbidity rates	7	55	28	10		4.348	1.654
Allowances influence hospital readmission rates	12	57	25	6	1	3.978	1.146
Allowances influence average rate of stay of patients	13	44	20	20	4	3.960	1.110
Allowances influence occupation rate of beds	8	29	30	24	9	3.756	1.175
Allowances do not influence the cost of patient care	8	24	24	31	13	3.639	1.242
Allowances influence employee years of service	12	25	22	28	13	3.528	1.083
Allowances influence rate of staff leavers	7	28	28	28	8	3.434	1.136
Allowances influence employee absenteeism	8	27	28	26	11	3.412	1.139

4.7.2 Influence of fringe benefits on Organisational Performance

The study established that influence of fringe benefits on the mortality rate was low as the parameter scored a mean of 2.927 as 31% of the respondents disagreed, and 27% of the respondents were uncertain of influence of fridge benefit of organizational performance. This was a clear indication that the benefits were not popular in the sector and if provided, they were either outdated or irrelevant to the HCWs. The study sough to establish whether fringe benefits influenced morbidity rates. 17% disagreed, and only

7% strongly agreed to the statement. It is clear that the employees in the health sector are not keen with fringe benefits and hence contradicting the findings of a study conducted by Guest (2004) who developed a theoretical framework to show how employee benefits as a vital practice linking it to organisational outcomes. He concluded that compensation policy that included fringe benefits well outlined played an importance role in employee relationships and contribute to improved strategic integration, employee commitment, low staff turnover, and reduced absence.

The other parameters the study sough to establish were influence of fringe benefits was on hospital readmission rates, average rate of stay of patient, occupation rate of beds and the cost of patient care. 14% of the respondents strongly agreed, 16% agreed, 22% disagreed while 27% strongly disagreed that fridge benefits had influence on readmission rates. The study established that on readmission rate, the mean score was 2.8.2, average stay had the least score of 2.02, occupation rate of beds had a mean score of 2.9 while cost of patient care had the highest mean score of 3.1 in the entire sub-variable. To ascertain influence of fringe benefits on employee years of service, rate of staff leavers and employee absenteeism, the study established mean scores of 2.74 years of service, 2.8 for staff leavers' rate, 2.9 for employee absenteeism. These findings contradicts with findings of a study conducted by Horton (2007) who noted that an organization with effective fringe benefits reward systems like transactional and relational rewards improves the level of employee motivation and this supports realization of increased organization performance. Overall, the study established that fringe benefits had low influence on organizational performance a clear indication that the penetration of the fringe benefits was low in Kenyan Public Healthcare sector and those that existed were either outdated or ineffective.

Table 4.13: Influence of fringe benefits on Organisational Performance

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	STD
Fringe benefits influence the mortality rate	9	22	27	31	10	2.927	1.198
Fringe benefits do not influence morbidity rates	17	26	23	27	7	3.106	1.322
Fringe benefits influence hospital readmission rates	12	28	24	25	10	2.821	1.259
Fringe benefits influence average rate of stay of patients	16	19	17	33	15	2.202	0.935
Fringe benefits influence occupation rate of beds	19	25	20	29	8	2.950	1.246
Fringe benefits do not influence the cost of patient care	20	54	15	9	2	3.006	1.181
Fringe benefits influence employee years of service	14	25	26	22	13	2.855	1.167
Fringe benefits influence rate of staff leavers	12	22	32	22	12	2.949	1.080
Fringe benefits influence employee absenteeism	16	21	30	27	6	2.743	1.312

4.4.3 Influence of flexible work plans on Organisational Performance

The study set out to establish the effects of flexible work plans on the performance of public healthcare sector in Kenya. As far as mortality is concern, the study found out that it had an influence which was somewhat indirect. (27%) of the respondents disagreed with the sentiments that flexible-work plans influence mortality rates, (27%)

of the respondents agreed that flexible work plans influence morbidity rate while 22% disagreed with the sentiments.

When the respondents were asked whether flexible work plans had effect on average rate of readmission, 22% strongly agreed, 26% agreed, 24% disagreed while 10% strongly disagreed. The study also tried to find out the effect of flexible work plans on average rate of stay of patient; occupation rate of beds and the cost of patient care. It was clear that patients had to stay a little bit more in hospitals where flexible work plans existed. 15% of the respondents agreed, and 20% strongly agreed with the sentiments. Responses of influence of flexible work plans on employee years of service indicated that 25% strongly agreed, 28% agreed, 20% disagreed while 10% strongly disagreed. The influence of flexible work plans on employee years of service has a mean score of 3.8 with (38%) of the respondents agreed to the sentiments, 23% strongly agreed while 7% disagreed. The parameter that had the greatest mean score on flexible work plans was its influence on employee absenteeism as the parameter had a mean score of 3.866. 28% of the respondents strongly agreed, 35% agreed while 10% disagreed that flexible work plans influence organisational performance. These findings are similar to findings by Ihniowski *et al.,* (1997) who established that allowances positively and substantially affect performance of workers and effectively that of the organization if combined with innovative work practices like, flexible work plans, employee participation in problem-solving teams, training, extensive screening and employment security.

Table 4.14: Influence of flexible work plans on Organisational Performance

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	STD
Flexible work plans influence the mortality rate	16	21	30	27	6	3.135	1.359
Flexible work plans do not influence morbidity rates	8	27	34	22	8	3.123	1.202
Flexible work plans influence readmission rates	22	26	18	24	10	3.106	1.104
Flexible work plans influence average rate of stay of patients	15	20	21	24	20	3.118	1.299
Flexible work plans influence occupation rate of beds	12	16	35	22	15	2.362	1.095
Flexible work plans do not influence the cost of patient care	8	21	35	25	11	2.715	1.138
Flexible work plans influence employee years of service	25	28	16	28	16	3.793	1.120
Flexible work plans influence rate of staff leavers	23	38	23	11	5	3.827	1.176
Flexible work plans influence employee absenteeism	28	34	16	15	8	3.866	1.083

Other compensations practices in Public healthcare sector include Performance reward such as incentive pay, awards and letters of recognition, medical cover for the family, study leave, annual leave and rest day. Most of the respondents indicated that most HCW do not take their rest day or annual leave despite being provided due to inadequate staffing levels and this led to fatigue. Medical cover for the family and Staff promotion were other forms of compensation practice reported by 24% and 6% of the respondents respectively.

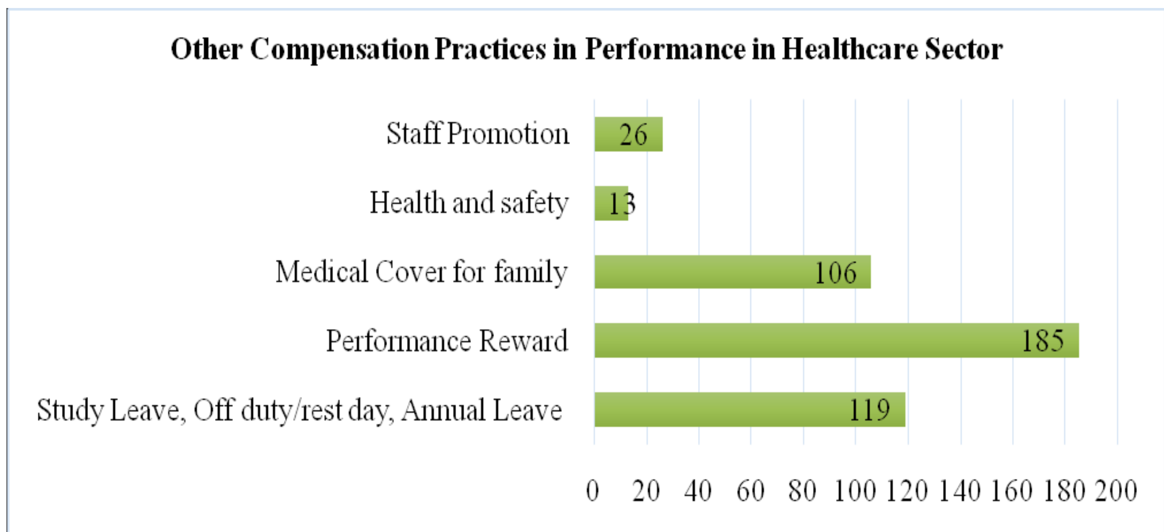

Figure 4.12: Other Compensation practices in Public Healthcare Sector

4.8 Influence of employee voice on organisational performance

The respondents were asked using a scale of 1 to 5 where 5 was highly used and 1 least used to rank the practices their organization uses to provide employees with a voice. The study revealed that 12% rated works council 5, 57% ranked it 4, 25% rated 3, 6% percentage of the respondents rated it 2 and only 1% rated it 1. As far as suggestion schemes were concerned, 13%, 24%,20% , 40%, and 4% of the respondents rated it 2 while 15% rated it 5. Union as a collective voice was rated by 7%, 28%, 28%, 28% and 7% as 5, 4,3, 2 and 1 respectively. The respondents rated work councils as a form of employee voice at 4 on a 5-point likert scale an indication that this form of voice play a critical role in ensuring employees views are

represented and heard. The above findings are similar to sentiments recorded by (Boxall & Purcell, 2003) in their study that linked employee turnover rate to the opportunities they have to voice their issues. According to Boxall & Purcell, (2003), the main focus for representation of employee voice was on the union collective bargaining and joint consultative committees. Findings by Freeman and Medoff (1984) argued that union played a vital role in minimizing turnover rate as they provided employees with the voice mechanisms through which they can rectify the work related problems and can negotiate higher compensation packages.

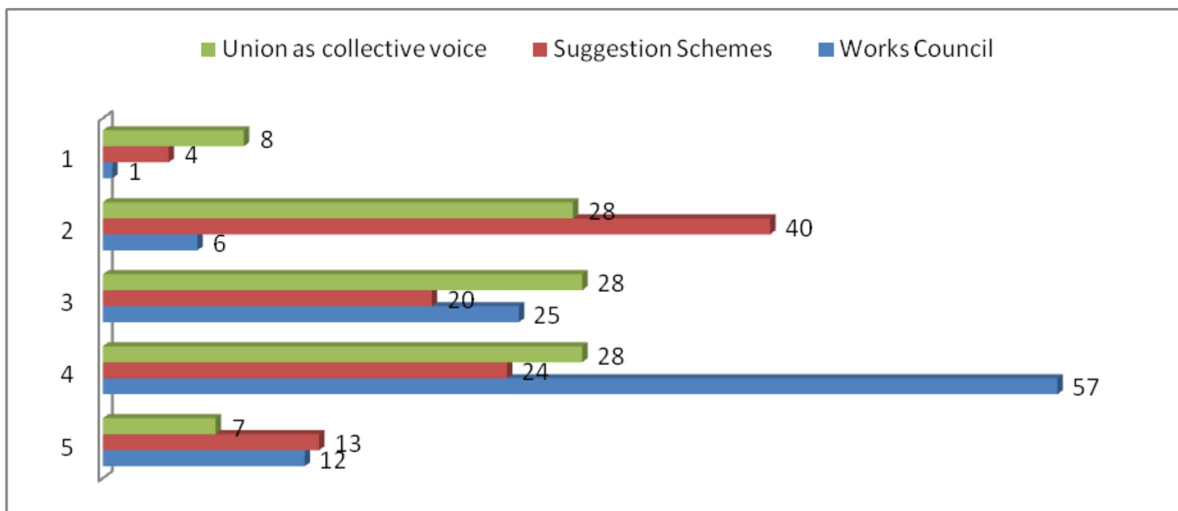

Figure: 4.13: Influence of employee voice on organisational performance

4.8.1 Influence of Works council on organisational performance

When the respondents were asked to indicate the influence of work council on mortality rate, 16% strongly agreed, 21% agreed while 27% of the respondents disagreed. The study also sought to establish whether works council do not influence morbidity rates. 8% of the respondents disagreed 27% agreed whereas 22% disagreed making the parameter score a mean score of 2.888 in a five point Likert scale. The study sought to

establish whether Works council influence hospital readmission rates. 22% strongly agreed 35% neither agreed nor disagreed while 10% disagreed resulting to a mean of 2.961. The level of uncertainty experienced in this variable did influence the overall outcome and contradicts the findings of the study conducted by Dundon *et al*. (2004) who established that employee voice recognition positively affects quality of service and productivity. Influence of works council on the average rate of stay of patients at the hospital had a mean score of 2.5 which is the median in a five point scale. The study however established that works council had influence on occupation rate of beds of the hospital as this parameter had a mean score of 3.145.

The study also established that 16% of the respondents strongly agreed that work council influence employee years of service while 16% of the respondents disagreed and 10% strongly disagreed resulting to a mean of 2.7. As far as the influence of the works council on the rate of staff leavers was concerned, 5% of the respondents strongly agreed 28% agreed, 10% strongly disagreed and 10 % disagreed with the sentiments. The study also endeavored to establish whether works council had influence on employee absenteeism. 16% of the respondents strongly agreed, 28% agreed, 30% were uncertain whereas 15% disagreed. These findings of influence of work councils on employee turnover contradicts the study conducted by Boxall and Purcell, (2003) who indicated that employee turnover rate is believed to be positively related to the opportunities they have to voice their issues; the more opportunities employees have to voice their dissatisfaction and changing the disgruntling work situations, the more they will be interested in staying with the organization.

Table 4.15: Influence of Works council on organisational performance

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	SDV
Works council influence the mortality rate	16	21	30	27	6	2.810	1.193
Works council do not influence morbidity rates	8	27	34	22	8	2.888	1.226
Works council influence hospital readmission rates	22	26	18	24	10	2.916	1.288
Works council influence average rate of Hospital stay of patients	15	20	21	24	20	2.402	1.094
Works council influence occupation rate of beds of the hospital	12	16	35	22	15	3.145	3.255
Works council do not influence the cost of patient care	8	21	35	25	11	2.849	1.068
Works council influence employee years of service	16	16	25	28	16	2.736	1.027
Works council influence rate of staff leavers	23	38	23	11	5	2.698	0.999
Works council influence employee absenteeism	16	28	34	15	8	2.816	1.025

4.8.2 Influence of Suggestion Schemes on organisational performance

When the respondents were asked to indicate the influence of suggestion schemes on the mortality rate, 15% strongly agreed, 23% agreed while 21% disagreed. 16% of the respondents agreed that suggestion Schemes do not influence morbidity rates while 15% agreed and 25% disagreed. 13% percent of the respondents agreed that suggestion schemes influence hospital readmission rates, 10% disagreed and 37% were uncertain. The study also established that suggestion schemes have low influence on the average rate of stay of patients at the hospital as this parameter scored a mean score of 2.62 with 17% of the respondents strongly agreed while 16% disagreed with majority being uncertain on the influence of suggestion boxes on organisational performance. From the study it is clear that suggestion schemes do not have an effect on performance notwithstanding the fact brought forth by Dundon *et al.* (2004) who suggest that employee voice recognition through suggestion schemes could positively affect their quality of service and productivity, and on the other hand it could help to deflect the problems, which otherwise might explode.

The influence of suggestion schemes on occupation rate of beds of the hospital was also sought. The study established that 18% of the respondents strongly agreed on the same sentiments, 25% disagreed while 9% strongly disagreed with the statement. As far as the suggestion schemes on the cost of patient care was concern, 14% of the respondents strongly agreed, 20% agreed, 24% disagreed while 16% strongly disagreed that suggestion schemes influence cost of patient care. When the respondents were asked to indicate the influence of Suggestion Schemes on employee years of service, 21% strongly agreed, 40% agreed, 12% disagreed while 5% strongly disagreed with the sentiments. The study also sought to establish the influence of suggestion schemes influence on rate of staff leavers. 7% of the respondents strongly agreed, 35% agreed, 26% of the respondents disagreed while 7% strongly disagreed. As far as employee

absenteeism was concern, the study sought to establish whether Suggestion Schemes influence employee absenteeism and found out that 8% of the respondents strongly agreed, 36% agreed, 28% of the respondents disagreed with the sentiment. These findings are consistent with sentiments echoed by Freeman and Medoff (1984) who argued that suggestion schemes play a vital role in minimizing turnover rate as they provide employees with the voice mechanisms through which they can rectify the work related problems and can negotiate higher compensation packages. This also concurs with a study conducted by Martin (2008) who indicated that management encouraged employees to participate in organization processes and changes through the use of suggestion schemes in order to increase employee productivity and organisational performance.

Table 4.16: Influence of Suggestion Schemes on organisational performance

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	SDV
Suggestion Schemes influence the mortality rate	15	23	35	21	6	2.665	1.051
Suggestion Schemes do not influence morbidity rates	16	15	37	22	9	2.511	1.043
Suggestion Schemes influence hospital readmission rates	13	22	35	25	5	2.575	1.085
Suggestion Schemes information influence average rate of stay of patients at the hospital	17	20	37	16	10	2.626	1.027
Suggestion Schemes influence occupation rate of beds of the hospital	18	18	30	25	9	2.635	1.061
Suggestion Schemes do not influence the cost of patient care	16	24	25	20	14	2.458	1.056
Suggestion Schemes influence employee years of service	21	40	22	12	5	2.388	0.890
Suggestion Schemes influence rate of staff leavers	7	35	25	26	7	2.891	0.996
Suggestion Schemes influence employee absenteeism	8	36	23	28	4	2.719	1.120

4.8.3 Influence of Union as collective voice on organisational performance

The study sought to establish whether union as collective voice influenced mortality rate. 15% of the respondents strongly agreed, 23% agreed, while 6% disagreed with sentiments. The respondent were asked to rate whether union as a collective voice had influence on morbidity rates. The study established that union as collective voice influenced morbidity rates. 36% of the respondents strongly agreed, while 15%

disagreed. When the respondents were asked to indicate whether the union as collective voice influenced hospital readmission rates, 11% strongly agreed, 34% agreed, 17% disagreed while 4% strongly disagreed. The study also sought to establish whether the union as collective voice influenced average rate of stay of patients at the hospital. 9% strongly agreed, 32% agreed, 22% disagreed and 5% strongly disagreed. As for the question on whether union as collective voice influenced occupation rate of beds of the hospital, 11% of the respondent strongly agreed, 41% agreed 21% disagreed and 4% strongly disagreed. The researcher sought to establish whether union as a collective voice did not influence the cost of patient care. This parameter had a mean score of 2.56 this is slightly above 2.5 which is considered the median this question however was negatively framed hence the influence was still moderate. 13% of the respondents strongly agreed, 41% agreed, 12% of the respondents however disagreed with this sentiments.

The findings of this study furnish support for the Competing aspect of the Thomas-Kilmann model that elaborates that the approach of 'win-lose' is appropriate for emergencies when time is of the essence, or when one needs quick, decisive action, and people are aware of and support the approach (Kilmann, 1974). From the findings of this study it is clear that declining union membership has renewed interest in the fundamental importance of voice while also prompting inquiries into what forms of voice employees want (Budd, 2004) and what public policy reforms are necessary to support broad forms of voice at the workplace and especially in the public healthcare sector in Kenya. It is clear that the influence of unions had a great influence on average stay of patients since the sector is highly unionized and engage on lengthy negotiations practices that result into mass action hence forcing the patients to stay longer in hospitals.

Table 4.17: Influence of Union as collective voice on organisational performance

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	SDV
Union as collective voice influence the mortality rate	15	23	35	21	6	2.665	1.051
Union as collective voice does not influence morbidity rates	9	36	34	15	6	2.721	1.13
Union as collective voice influence hospital readmission rates	11	34	35	17	4	3.654	1.148
Union as collective voice influence average rate of stay of patients at the hospital	9	32	32	22	5	3.646	1.200
Union as collective voice influence occupation rate of beds of the hospital	11	41	23	21	4	3.218	0.920
Union as collective voice does not influence the cost of patient care	13	46	24	12	6	3.564	1.022
Union as collective voice influence employee years of service	13	43	22	16	6	3.436	0.954
Union as collective voice influence rate of staff leavers	13	39	23	25	1	3.349	3.286
Union as collective voice influence employee absenteeism	14	38	24	23	3	3.268	1.047

The study sought to establish if there were other voice practices in public health sector and found out that some hospitals use informal discussions (29%), staff meetings (23%), open door policy (24%), heads of departments (12%) and staff welfare activities (6%).

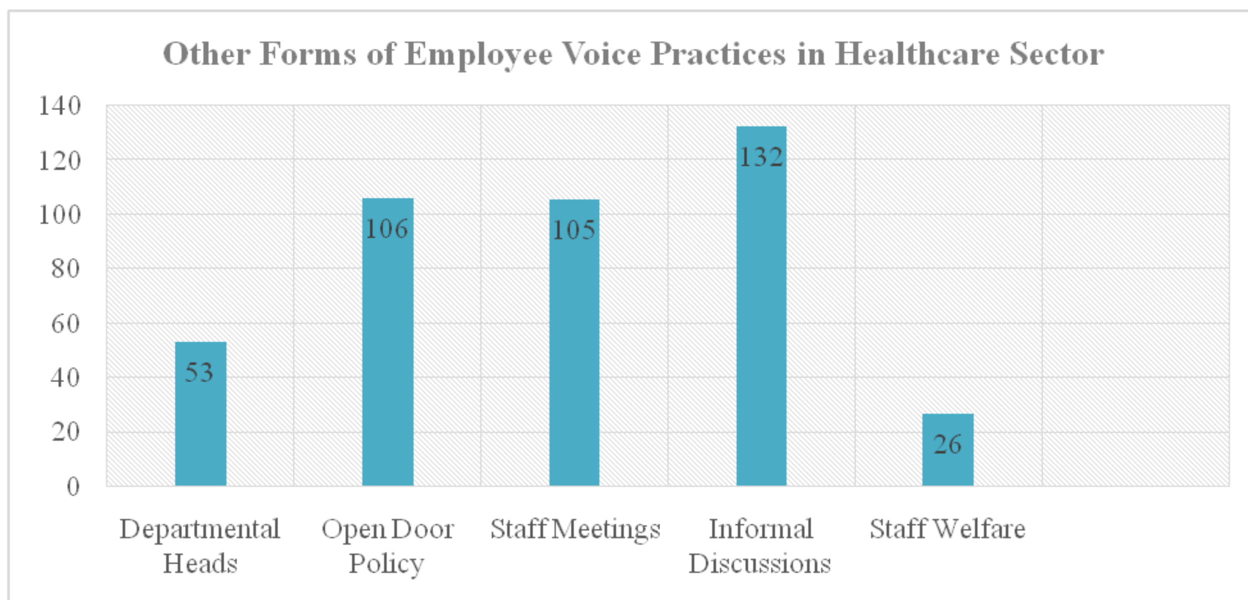

Figure 4.14: Other Employee Voice Practices in Public Healthcare sector

4.9 Organisational Performance

4.9.1 Mortality Rate

As a measure of performance, mortality rate was measured by the number of deaths per 1000 reported cases in the hospitals. The study revealed that the mortality rate experienced a downward trend with 61 deaths per 1000 reported in 2009 and 49 casses in 2014. Differences were found across facilities located in urban and rural areas. Rural level four and five hospitals generally lagged behind their urban counterparts as they recorded higher mortality rates. Another trend on the referrals was also witnessed as there was a proportionate increase in the cases of outwards referrals as compared to inwards referrals with most of the cases being referred to level 6 hospitals.

According to the WHO (2015), the mortality rate in Kenya stood at an average of 67 deaths per 1000 life cases. This shows a higher mortality rate considering the trend the study has established. However a further analysis on the same revealed that the report took into consideration all the hospitals including the level six hence justifying the disparities. This is contrary to the Kenyan national bureau of statistics 2014 which put the Life expectancy of the population as at 2013 was about 46 years and 51 years for men and women respectively compared to global average of 68 years (KNBS, 2014) and the mortality rate was147 per 1,000 life which is double the global average

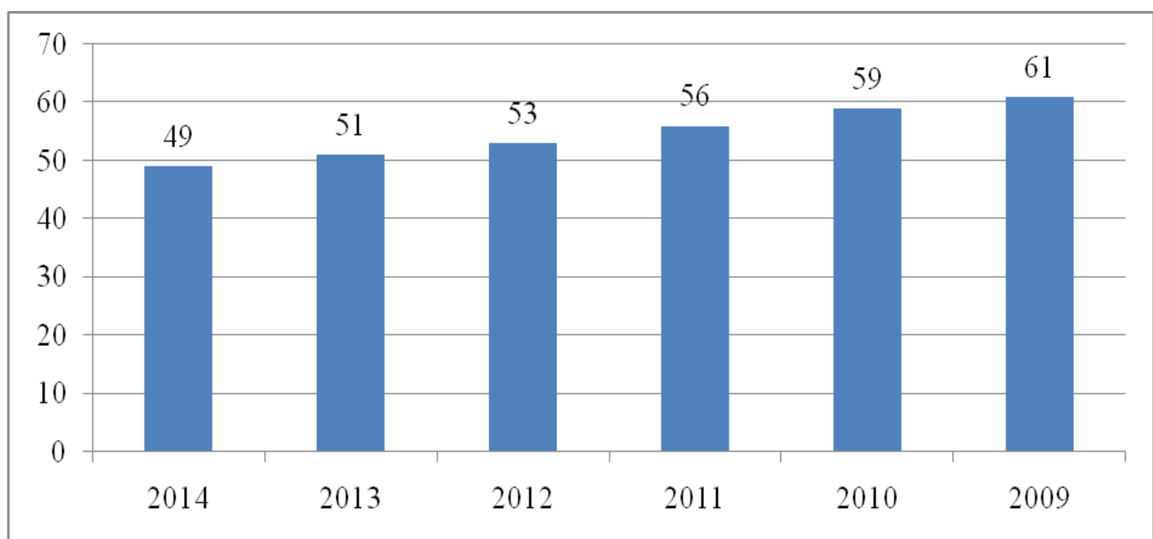

Figure 4.15: Mortality Rate

4.9.2 Morbidity Rate

Morbidity rate was measured through incidence proportion also known as cumulative incidence. According to WHO (2014), incident proportion is the number of new cases within a specified time period divided by the size of the population initially at risk. This study used the most prevalent diseases recorded in Kenya such as Malaria, Tuberculosis and HIV/AIDS to come up with the morbidity rate. The study established that morbidity rate was high in 2009 and experienced a downward trend until 2013 with a low of 2.6%

in all the 47 counties in Kenya. The trend however changed in 2014 to 2.7%, trend that could be associated with several outbreaks recorded in the country. This study is in line with the WHO (2015) report indicated that across platforms, facilities in Kenya are generally more prepared to diagnose and treat infectious diseases than a subset of non-communicable diseases (NCDs) and injuries. The study also established that facilities showed the high capacity for managing lower respiratory infections (LRIs), HIV/AIDS, and malaria; whereas by contrast, primary care facilities carried less than half of the recommended medical equipment and medications to properly administer care for ischemic heart disease. A similar survey was conducted by WHO (2012) which established that level five hospitals stocked an average of 92% of necessary supplies for infectious diseases and 87% for NCDs, whereas level four hospitals stocked an average of 54% of infectious disease medical supplies and 27% for NCDs. This can justify the fluctuations in the morbidity rate as from 2009 to 2014.

The study concurs with a study conducted by Mohajah, (2014) who concluded that Morbidity and Mortality rates remain high with Kenya being rated 13th high TB burden country in the world. The study further elaborates that globally, the trends in healthcare performance are different, average life expectancy for the Organization for Economic Cooperation & Development (OECD) countries is 80 years, and mortality rate is 7.16 per 1,000 populations. Sub-Saharan Africa healthcare is ranked among the lower fifty percent (50%) performing healthcare sectors in the World (TI, 2011; WB, 2013).

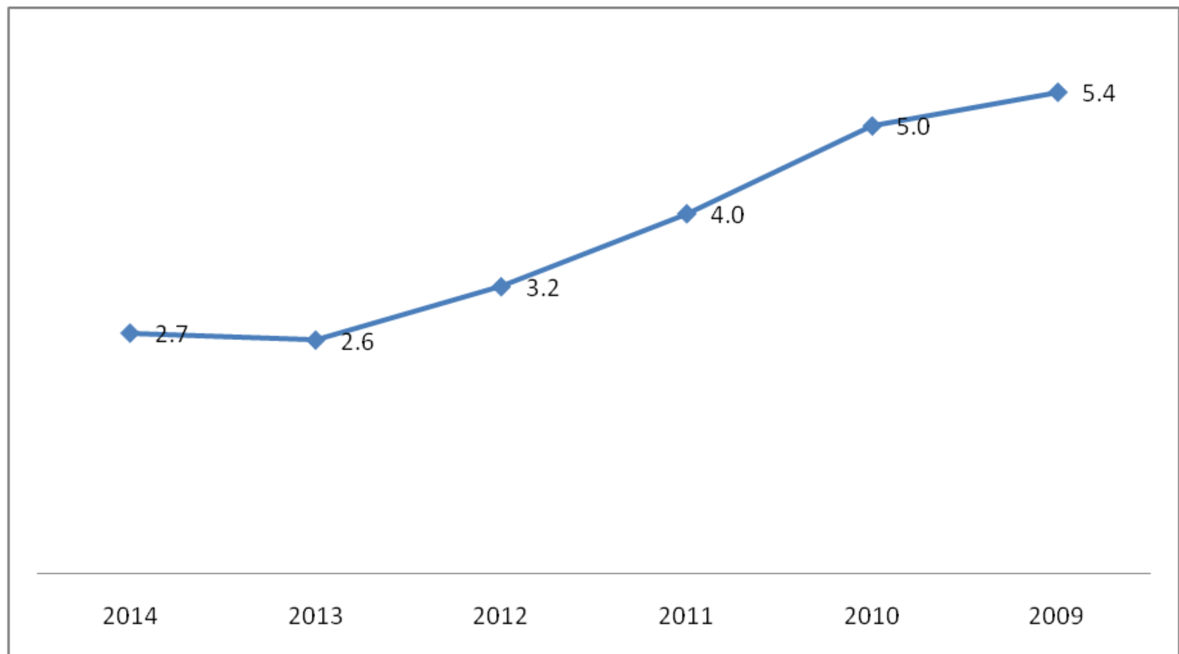

Figure 4.16: Morbidity Rate

4.9.3 Average Stay of Patient

The study established that the average stay of patients differed across the years targeted with the year 2013 recording the highest average time of stay in hospital of 12.8 days. The year that recorded the lowest average stay in hospitals was 2010 with an average of 11.7 days. From these findings, we observed that patients are discharged after full recovery as opposed to being they have to be discharged in order to give way for other patients. However, the latter was observed in most level five hospitals as the beds were full all the time. According to the WHO (2014) report, level four and Level five hospitals provide a wide range of services, including surgical services, internal medicine, and specialty services such as emergency obstetric care (EmOC) and anesthesiology. Hence the reason as to why the beds are ever full warranting early discharge of patients to give way to referrals from other lower level hospitals

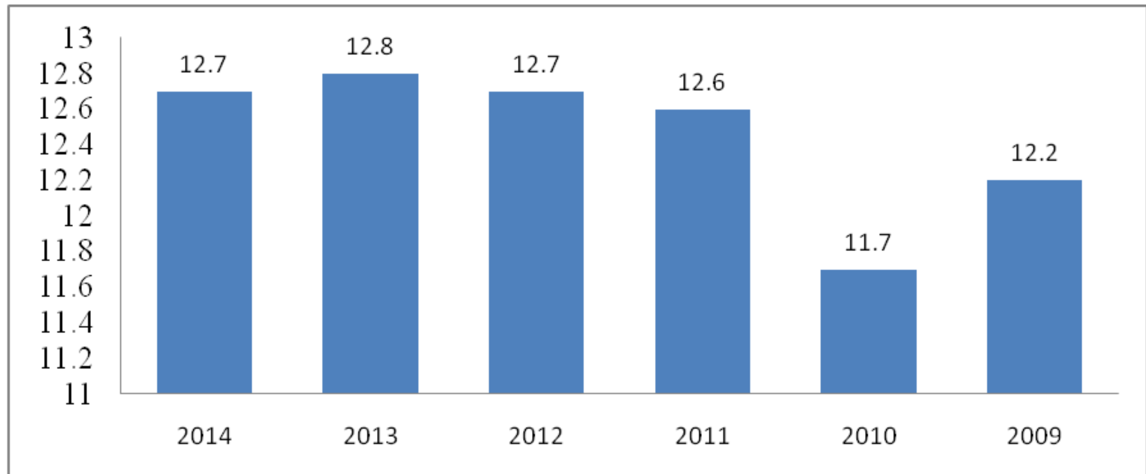

Figure 4.17: Average stay of Patient

4.9.4 Readmission rates

The study sought to establish the readmission rates of patients after being treated in an effort to ascertain the performance of the hospitals. The year 2013 had the highest rate of readmission rates of 51 patients per every 1000 cases reported. This year 2013, the Public Healthcare sector witnessed rampant industrial unrest. It was observed that the effects of these strikes contributed to higher readmission rates which were as a result of premature discharge to pave way for the striking HCWs. After the issues were resolved, the situation returned to normalcy in 2014 and 32 patients out of 1000 were readmitted in the same hospitals.

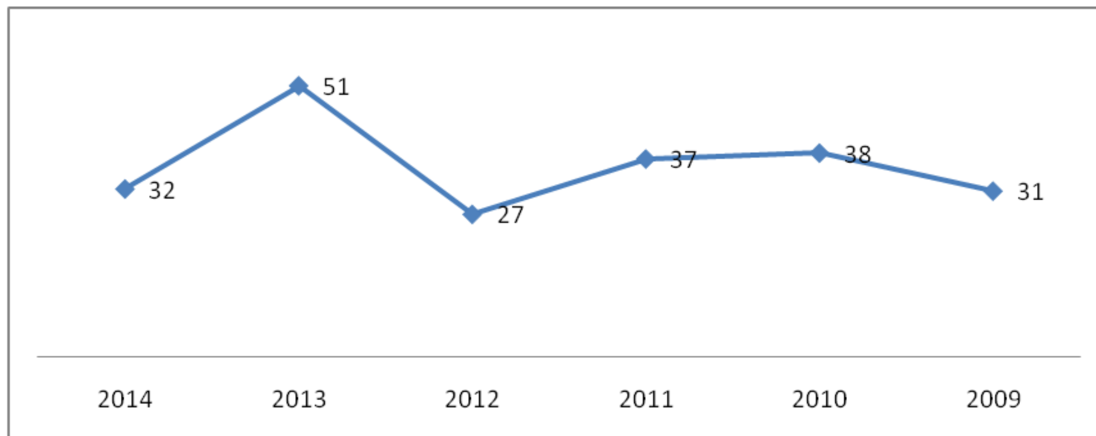

Figure 4.18: Readmission rates

4.9.5 Bed Occupancy rate

The study revealed that there was increase in bed occupancy in the periods under study, with the year 2009 recording 86.7%, 2010 recording 88.3%, 2011 recording 91.4%, 2012 recording 93.8%, 2013 recording 93.6% and 2014 recording 95.4% bed occupancy rates. The study established that in all the level five hospitals visited, the beds were full with some patients being forced to share a bed with others. The level four hospital mostly in the rural areas had low bed occupancy rates, an observation that warranted the percentage drop in the occupancy level. In counties such as Tana River, Turkana, Kilifi, Isiolo and Wajir, the bed occupancy was less than 50% as the facilities lacked crucial supplies to sustain patients. Most of these hospitals however recorded more adult's patients than the young people. According to the WB report (2014) adults and the elderly require a spectrum of health services, as they can often experience both acute conditions (accidents, pneumonia) and more chronic diseases (Diabetes, cancer).

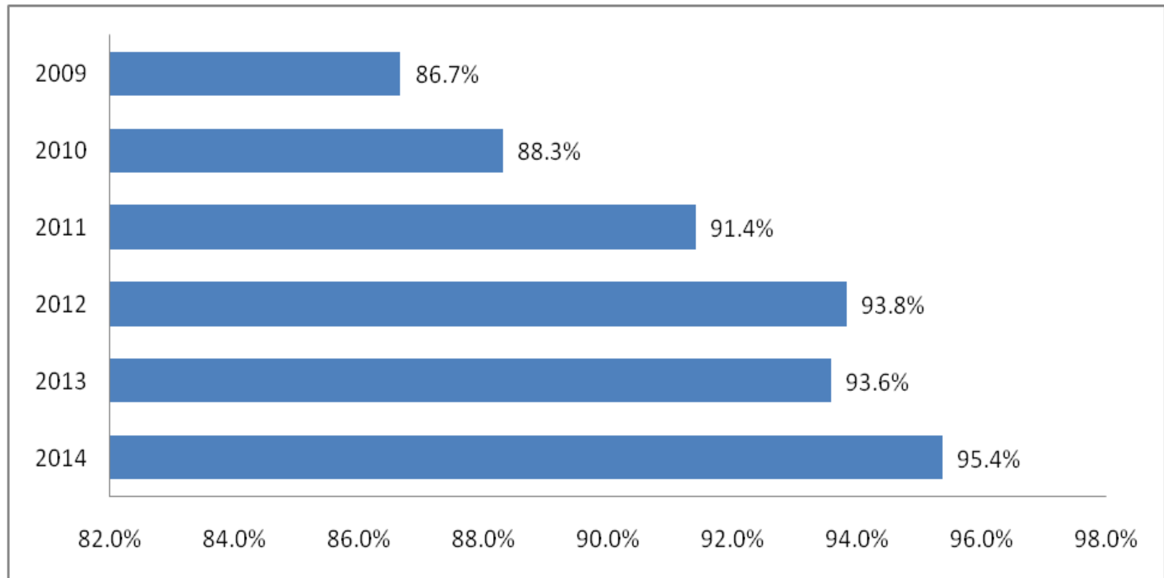

Figure 4.19: Bed Occupancy rate

4.9.6 Average cost per patient

The average cost per patient experienced a downward trend from 2009 with a high of Kenya Shillings 730 per patient to an average of Kenya Shillings 170 most of which was subsidized amounts from the government. This could be attributed to improved efficiency in service delivery or lack of drugs and other disposable medical services which patients purchase from outside the Public institution hence not captured under the cost of patient. It further elaborates that while most encounters with the Kenyan healthcare system result in some type of medical expense, the country has made policy decisions to decrease or eliminate registration and user fees at a subset of facilities and for certain types of patients. This however has not been reflective on the patients as they still have to part with some money at the hospitals. The findings of this study showed that Over 63% of patients receiving services at Level five and four hospitals incurred both medical and transportation expenses which was not factored in the cost of patient at the Public Healthcare facility records.

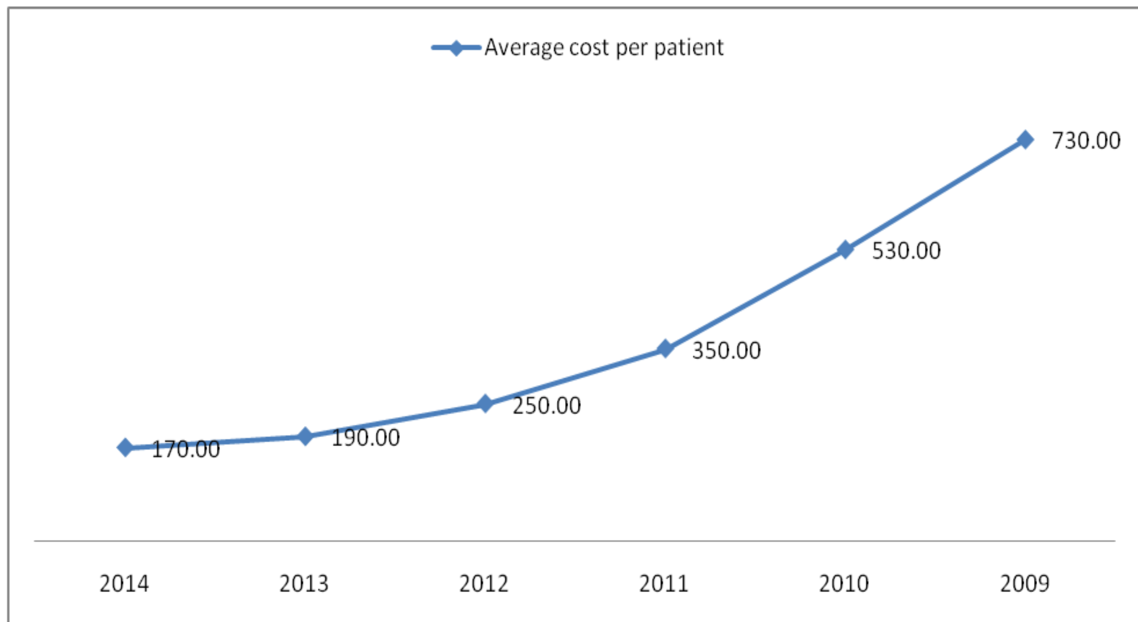

Figure 4.20: Average cost per patient

4.9.7 Average employee years of service

Kenyan public health sector is experiencing a lot of job shifting either to the private sector or to private venture. The study established that the year 2010 experienced the highest rate of years of service as employees recorded the highest stay of 17.9 years with a slight dip in (2011) recording the lowest stay of 15.7 years. The trend has however experienced an upward trend with 2014 recording a high of 16.9 years. This is in line with a study conducted by WHO (2014) which indicates that the public sector has become the single largest employer of HCWs in the country in the past three years (2009- 2012) because of expanding and opening new facilities and upgrading existing ones from level three to four. The survey further elaborates that the number of HCWs in the public sector was 31, 060 in 2013. Njau (2012) in his study established that high staff turnover in the healthcare sector is caused by poor implementation of collective bargaining agreements, lack of facilities in the healthcare Centers, delayed payment of salaries in some counties especially following the devolution of public healthcare or inadequate funding by the government.

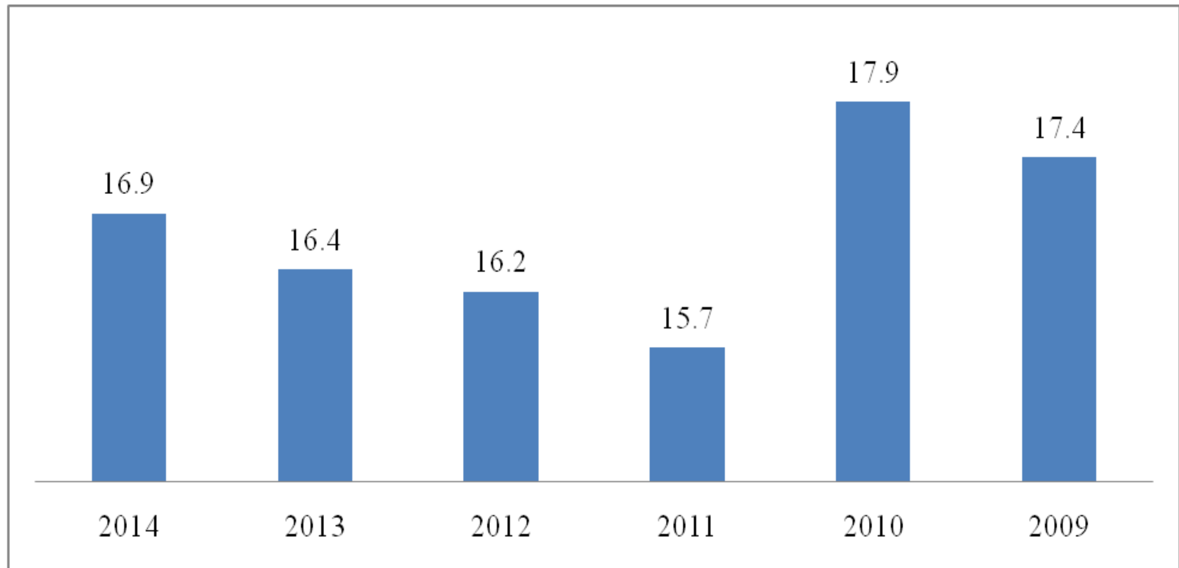

Figure 4.21: Average employee years of service

4.9.8 Employee Leavers Rate

Staff leavers' rate included normal attrition, resignation and internal and external migration. In this study, the rate of turnover per 1000 employees in the year 2009 was 9.6, 51.4 in 2010, 57.8 in 2011, 18.4 in 2012, 57.9 in 2013 and 42.1 in 2014. There was an average attrition rate of Healthcare Workers of 5.1% in the period under study. This confirms findings by Muchiri, Chankova, and Kombe, (2009) who established that Kenya is currently experiencing an attrition rate of healthcare workers of 5% per annum. This findings also concur with findings that Kenya has the highest net immigration rates of HCWs in sub-Saharan Africa (WB, 2013).

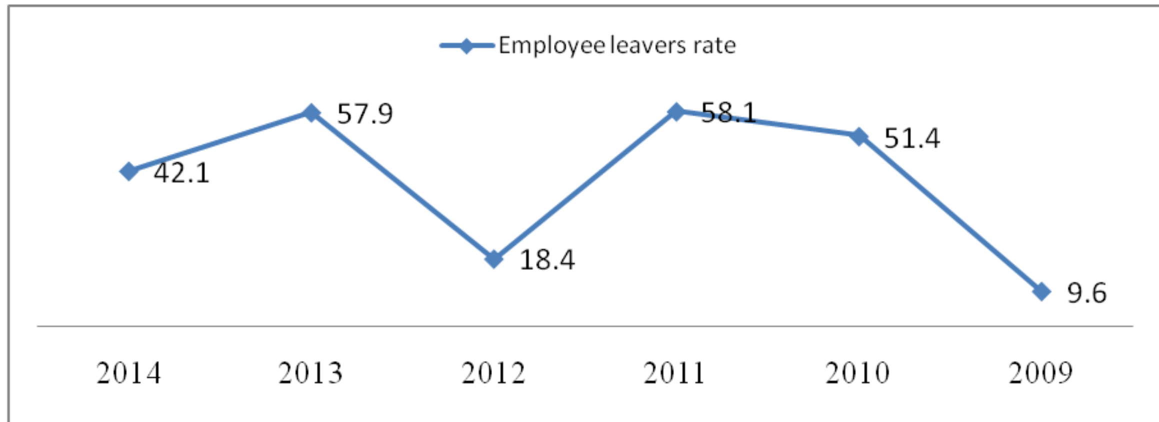

Figure 4.22: Employee Leavers Rate

4.9.9 Rates of Absenteeism

Another measure of performance was to ascertain the rate of absenteeism. This was established by; the annual/ vacation, study, maternity, off-duty leave, training, workshops, conferences. Sickness absence to attend to personal matters as they arise but reported as minor illness, often short-term self-certified, failing to report to work and not giving a valid and acceptable reason for one's absence (moonlighting or locuming), transport problem, taking care of a sick child/relative, personal injury and sickness that is medically certified. The highest computed rate was an average of 52 lost days in the year 2009. The trend however decreased as years moved to 24 days in 2012 and 22 days in 2014. In 2013 however the rates went up a factor that can be attributed to the numerous strikes and mass actions that were witnessed in the industry.

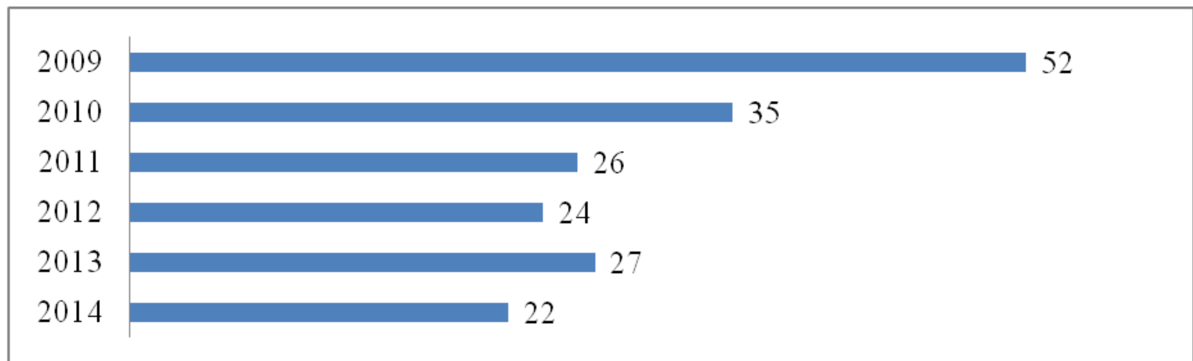

Figure 4.23: Rates of Absenteeism

4.11 Other Factors Influencing Organisational Performance

The study sought to establish whether there were other factors influencing organisational performance in Public Healthcare sector in Kenya other than those covered. It was established that 38% of the respondents think that prompt salary payment would influence performance, 16% organisational culture, 13% Training & Development, 11% Leadership and Administration commitments; 9% Information Technology, 9% Working Environment and 4% Staff Promotion, Transfers and Job rotation. The study did not seek clarification as these were not among the variables under study and respondents were only asked to list.

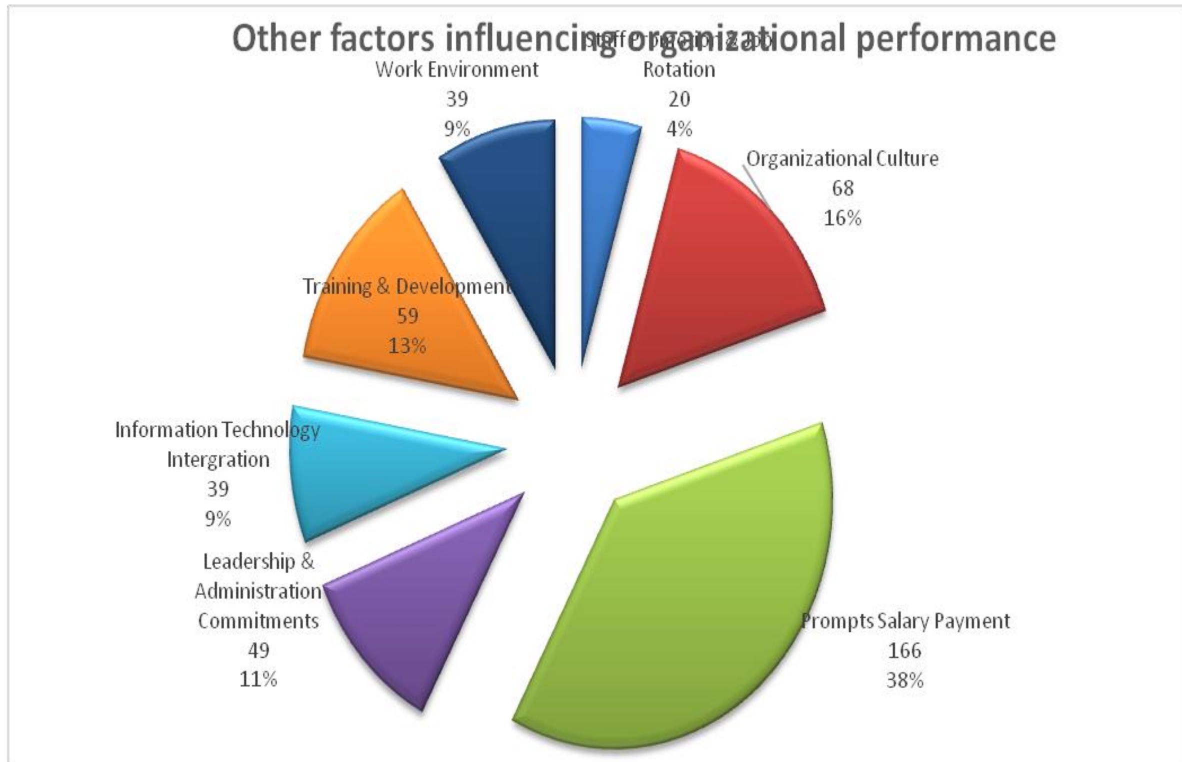

Figure 4.24: Other Factors influencing organisational Performance

4.10 Tests for the Model Assumptions

To achieve the study objectives, the study highly relied on Kolmogorov-Smirnov tests, Confirmatory Factor Analysis and multiple regression analysis. For ordinary least of squares and in order to provide unbiased estimates of the study parameters, various assumptions which mainly relate to normality and multicollinearity had to be in place (Creswell, 2008).

4.10.1 Multi-collinearity

According to DeFusco (2007), multicollinearity arises when two or more independent variables are highly correlated with each other. Multicollinearity test was done so as establish if the independent variables (conflict resolution, Employee Empowerment, Employee Compensation and Employee Voice)are inter-related with one another others

or not. For this study, the collinearity tests were conducted using correlation analysis, tolerance and variance inflation factor (VIF) analysis. Table 4.17 shows the correlation matrix for the four variables.

It is important to note that there is no consensus in extant literature on the acceptable correlation value/level between two variables, but Cooper and Schindler (2008) recommend a correlation value of 0.8 or greater to denote multicollinearity between two IVs (The IV - constant value is ignored, since collinearity among the predictors is what is under investigation). As is evident in the correlation matrix (Table 4.17), the correlation values for the tested variables are; 0.519, 0.562, 0.663 and 0.624 which is lower than the recommended hence all the Independent variables were retained for further analysis.

As a confirmation of the above finding, tolerance and variance inflation factor (VIF) analysis was used to determine the multicollinearity. Results of the study reveal no multicollinearity problem for the tested IVs. This is due to the fact that the tolerance values for the variable were greater than 0.1, while the VIF values are all less than 10, it shows that there was no collinearity (Field, 2005). Consequently, the variables were retained in current research model and used for further analysis.

Table 4.18: Collinearity Statistics

Variable	**Tolerance**	VIF
Conflict resolution	0.591	3.826
Employee Empowerment	0.562	4.625
Employee Compensation	0.663	2.362
Employee Voice	0.624	2.135

4.10.2 Confirmatory Factor Analysis

The study applied confirmatory factor analysis (CFA) in an attempt to explain the pattern within a set of observed variables. This tool helps in the identification of variables that would best explain the variance observed in each variable (Cooper et al, 2008). The CFA loading factor applied was 0.800 as recommended by Zikmund (2008) for a study of this nature. It was evident that all the tested variables accounted for a considerable large variance that is more than 80% of the variance. These observations, however, changed after extraction as all the variables accounted for a high percentage of the variance as shown in the table below.

Table 4.19: Confirmatory Factor Analysis

Study Variable	Initial	Extracted
Conflict Resolution	1.000	.973
Employee Empowerment	1.000	.962
Employee Compensation	1.000	.915
Employee Voice	1.000	.922

4.10.3 Kolmogorov-Smirnov

This study used the formal normality test, specifically the 1-sample Kolmogorov-Smirnov (KS), to test for evidence of the normality of the independent variables distribution, in line with Razali and Wa (2011). The outcome of the test as is shown in Table 4.5. According to the KS test, if the significant value is less than 0.05, there is a significant difference between the population and sample, implying that the data is not normally distributed.

The study results in Table 4.19 show that the overall KS test p-value ranged from (.200 to 0.332) for the composite, the distribution were greater than the significant level (p =

0.05), thus implying that all the variables tested were normally distributed. This means that the variables satisfy the assumptions of equal variance and normality. Since the assumptions of the three confirmatory tests were satisfied, the study proceeded to perform further analysis, both descriptive and inferential statistics.

Table 4.20: Kolmogorov-Smirnov Normality Test

Predictor Variable	Significant Value
Conflict resolution	0.200
Employee Empowerment	0.335
Employee Compensation	0.245
Employee Voice	0.458

4.11 Summary of Hypotheses Test Results

The results of the regression analysis indicate that all the five hypotheses were not confirmed. As the study endeavored to establish the influence of employee relations practices on organisational performance in Public Healthcare sector in Kenya, the study concentrated on the independent variables; Conflict resolution, Employee Empowerment, Employee Compensation and Employee Voice.

The table 4.21: Tests for Hypothesis

Objectives	Hypothesis	Type of Tests	Test Results & Interpretation
To examine the influence of conflict resolution practices on organisational performance of Public Healthcare Sector in Kenya	**Ho_1:** Conflict resolution Practices have no significant influence on organizational performance of Public Healthcare Sector in Kenya.	Pearson correlation Linear regression analysis	If p value < 0.05 reject null hypothesis if p value is > 0.05 fail to reject the null hypothesis.
To examine the influence of employee empowerment practices on organisational performance in public healthcare sector in Kenya	**Ho_2:** Employee empowerment practices have no significant influence on organizational performance of Public Healthcare Sector in Kenya.	Pearson correlation Linear regression analysis	If p value < 0.05 reject null hypothesis if p value is > 0.05 fail to reject the null hypothesis.
To examine the influence of employee compensation practices on organisational performance in public healthcare sector in Kenya	**Ho_3:** Employee empowerment practices have no significant influence on organizational performance of Public Healthcare Sector in Kenya.	Pearson correlation Linear regression analysis	If p value < 0.05 reject null hypothesis if p value is > 0.05 fail to reject the null hypothesis.
To examine the influence of employee compensation practices on organisational performance in public healthcare sector in Kenya	**Ho_4:** Employee empowerment practices have no significant influence on organizational performance of Public Healthcare Sector in Kenya.	Pearson correlation Linear regression analysis	If p value < 0.05 reject null hypothesis if p value is > 0.05 fail to reject the null hypothesis.

4.11.1 Tests for hypothesis 1

H_{01}: Conflict resolution has no significant influence on organisational Performance of public healthcare sector in Kenya.

a) Conflict resolution and organisational performance Model Summary

The coefficient of determination between conflict resolution and organisational performance was 0.589 indicating a positive effect of conflict resolution and organisational performance. The coefficient of determination (R squared) of 0.347 indicated that 34.7% of variation in organisational performance could be explained by conflict resolution. The adjusted R-square of 34.6% indicated that conflict resolution in exclusion of the constant variable explained the change in organisational performance by 34.6%, the remaining percentage could be explained by other factors excluded from the model. This implies that there exists a positive significant relationship conflict resolution practices and organizational performance.

Table 4.22: Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.589[a]	.347	.346	.56233
a. Predictors: (Constant), Conflict Resolution				

b. Conflict resolution and organisational performance ANOVA

The result of Analysis of Variance (ANOVA) for regression coefficient revealed (F=238.378, p value = 0.000a). The results indicated that the significance of the P value is 0.00 which is less than 0.05, this, therefore, implies that the regression model

statistically and significantly predicts the outcome variable and is, therefore, a good fit for the data. This is an indication that there exists a significant relationship between conflict resolution and organisational performance in public healthcare sector in Kenya.

Table 4.23: ANOVA

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	75.378	1	75.378	238.378	.000[b]
	Residual	141.663	448	.316		
	Total	217.041	449			

a. Dependent Variable: Organisational Performance

b. Predictors: (Constant), Conflict Resolution

c. Conflict resolution and organisational performance Regression Weights

The study hypothesized that Conflict resolution has no significant influence on organisational performance in public healthcare sector in Kenya. The study findings therefore indicated that there was a positive significant relationship between Conflict resolution practices and organisational performance of Public Healthcare Sector in Kenya (β=.450, t= 15.440and p value 0.000). This, therefore, means that an increase in Conflict resolution will increase organisational performance significantly. Since the t was 15.440 which is greater than zero, the null hypothesis H_{01}: 'Conflict resolution practices has no significant influence on organisational performance of public healthcare sector in Kenya' was rejected and the alternative hypothesis accepted. It was therefore concluded that conflict resolution practices had significant influence on organisational performance of Public Healthcare Sector in Kenya.

Table 4.24: Coefficients

Coefficients						
Model		**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
		B	Std. Error	Beta		
1	(Constant)	2.294	.117		19.592	.000
	Conflict Resolution	.450	.029	.589	15.440	.000

a. Dependent Variable: Organisational Performance

4.11.2 Tests for hypothesis 2

H_{02}: Employee empowerment has no significant influence on organisational performance in public healthcare sector in Kenya.

a) Employee empowerment and organisational performance Model Summary

The coefficient of determination between Employee empowerment and organisational performance was 0.534 indicating a positive and significant influence of Employee empowerment on organisational performance. The coefficient of determination (R squared) of 0.285 indicated that 28.5% of variation of organisational performance could be explained by Employee empowerment practices. The adjusted R-square of 28.3% indicated that Employee empowerment in exclusion of the constant variable explained the change in organisational performance by 28.3%, the remaining percentage could be explained by other factors excluded from the model.

Table 4.25: Model Summary

Model Summary				
Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.534[a]	.285	.283	.58862

a. Predictors: (Constant), Employee empowerment

b. Employee Empowerment and organisational performance ANOVA

The result of Analysis of Variance (ANOVA) for regression coefficient revealed (F=178.438, p value = 0.000a). The results indicate that the significance of the P value of 0.00 which is less than 0.05, this, therefore, implies that the regression model statistically and significantly predicts the outcome variable and is, therefore, a good fit model for the data analysis. This is an indication that there exists a significant positive relationship between employee empowerment and organisational performance in public healthcare sector in Kenya.

Table 4.26: ANOVA

ANOVA[a]						
Model		**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**
1	Regression	61.823	1	61.823	178.438	.000[b]
	Residual	155.218	448	.346		
	Total	217.041	449			

a. Dependent Variable: Organisational Performance

b. Predictors: (Constant), Employee empowerment

c. **Employee empowerment and organisational performance Regression Weights**

The study hypothesized that employee empowerment has no significant influence on organisational performance in public healthcare sector in Kenya. The study findings indicated that there was a positive significant relationship between employee empowerment and organisational performance in public healthcare sector in Kenya. (β=.431, t=13.358 and p value 0.000). Since the t was 13.358 which is greater than zero, the null hypothesis H_{02}: 'Employee empowerment practices has no significant influence on organisational performance of public healthcare sector in Kenya' was rejected and the alternative hypothesis accepted.

Table 4.27: Coefficients

Coefficients						
Model		**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
		B	Std. Error	Beta		
1	(Constant)	2.344	.131		17.886	.000
	Employee empowerment	.431	.032	.534	13.358	.000
a. Dependent Variable: Organisational Performance						

4.11.3 Tests for hypothesis 3

H_{03}: Employee compensation has no significant influence on organizational performance in public healthcare sector in Kenya.

a) Employee compensation and organisational performance Model Summary

The coefficient of determination between Employee compensation and organisational performance was 0.359 indicating a positive effect of Employee compensation and organisational performance. The coefficient of determination (R squared) of 0.129indicated that 12.9% of variation in organisational performance could be explained by Employee compensation. The adjusted R-square of 12.7% indicated that Employee compensation in exclusion of the constant variable explained the change in organisational performance by 12.7%, the remaining percentage could be explained by other factors excluded from the model.

Table 4.28: Model Summary

Model Summary				
Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.359[a]	.129	.127	.64965

a. Predictors: (Constant), Employee compensation

b. Employee compensation and organisational performance ANOVA

The result of Analysis of Variance (ANOVA) for regression coefficient revealed (F=66.268, p value = 0.000a). The results indicate that the p value is 0.00 which is less than 0.05, this, therefore, implies that the regression model statistically and significantly predicts the outcome variable and is, therefore, a good fit for the data. This is an

indication that there exists a significant positive relationship between Employee compensation and organisational performance in public healthcare sector in Kenya.

Table 4.29: ANOVA

ANOVA[a]						
Model		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
1	Regression	27.968	1	27.968	66.268	.000[b]
	Residual	189.073	448	.422		
	Total	217.041	449			

a. Dependent Variable: Organisational Performance

b. Predictors: (Constant), Employee compensation

d. Employee compensation and organisational performance Regression Weights

The study hypothesized that Employee compensation has no significant influence on organisational performance in public healthcare sector in Kenya. The study findings indicated that there was a positive significant relationship Employee compensation and organisational performance in public healthcare sector in Kenya. (β=.345, t= 15.863, p value 0.000). Since the t was 8.141 which is greater than zero, the null hypothesis, H_{04}: 'Employee compensation has no significant influence on organisational performance of public healthcare sector in Kenya' was rejected and the alternative hypothesis accepted.

Table 4.30: Coefficients

Coefficients[a]						
Model		**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
		B	Std. Error	Beta		
1	(Constant)	2.694	.170		15.863	.000
	Employee compensation	.345	.042	.359	8.141	.000
a. Dependent Variable: Organisational Performance						

4.11.4 Tests for hypothesis 4

H_{01}: Employee voice has no significant influence on organisational performance in public healthcare sector in Kenya.

a) Employee voice and organisational performance Model Summary

The coefficient of determination between Employee voice and organisational performance was 0.312 indicating a positive effect of Employee voice and organisational performance. The coefficient of determination (R squared) of 0.097 indicated that 9.7% of variation of organisational performance could be explained by employee voice. The adjusted R-square of 9.5% indicated that Employee voice in exclusion of the constant variable explained the change in organisational performance by 34.6%, the remaining percentage could be explained by other factors excluded from the model.

Table 4.31: Model Summary

Model Summary				
Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.312[a]	.097	.095	.66140
a. Predictors: (Constant), Employee voice				

b. Employee voice and organisational performance ANOVA

The result of Analysis of Variance (ANOVA) for regression coefficient revealed (F=48.145, p value = 0.000a). The results indicate that the significance of the P value was 0.00 which is less than 0.05, this, therefore, implies that the regression model statistically and significantly predicts the outcome variable and is, therefore, a good fit for the data. This is an indication that there exists a significant relationship between employee voice and organisational performance in public healthcare sector in Kenya.

Table 4.32: ANOVA

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	21.061	1	21.061	48.145	.000[b]
	Residual	195.980	448	.437		
	Total	217.041	449			
a. Dependent Variable: Organisational Performance						
b. Predictors: (Constant), Employee voice						

c. Employee voice and organisational performance Regression Weights

The study hypothesized that Employee voice has no significant influence on organisational performance in public healthcare sector in Kenya. The test statistics finding findings indicated that there (β=.251, t= 6.939 and p value 0.000). Since the t was 6.939 which is greater than zero, the null hypothesis H_{04}: "Employee voice has no significant influence on organisational performance of public healthcare sector in Kenya' was rejected and the alternative hypothesis accepted.

Table 4.33: Coefficients

Coefficients[a]						
Model		**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
		B	Std. Error	Beta		
1	(Constant)	3.063	.146		20.956	.000
	Employee voice	.251	.036	.312	6.939	.000

a. Dependent Variable: Organisational Performance

4.11.5 Model summary of employee relations practices on organisational performance of public healthcare sector in Kenya

The general objective of the study was to determine the influence of employee relations practices on organizational performance, multiple linear regression analyses techniques was used to enable us to assess the ability of an independent variable(s) to predict the dependent variable(s).

R is the multiple correlation coefficients between all the predictors and Organisational Performance. Since its value ranges between 0 and 1, an R of .693 showed that the

predictors in the model were highly correlated to the dependent variable. R squared measures how much variability in the dependent variable the predictors account for. The R2 in this model was found to be 0.680, which means that the four predictors could explain about 68% of the variation in performance of public hospitals.

Adjusted R square provides information on how well a model can be used to generalize findings of a study in the population. The model accounted for approximately 67.4% of the variance in the dependent variable, which is just about 0.6% less than what the model explains. The standard error of the estimate, also known as the standard deviation of Y about the regression line, was 0.00089. Since its *e* value was small, it means that the observed Y-values in this study did not differ greatly from the values on the regression line.

Table 4.34: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.693(a)	.680	.674	.0089097

a) Predictors: (Constant), Conflict resolution, Employee Empowerment, Employee Compensation, Employee Voice

The ANOVA table also called the overall regression F test is used to test several equivalent null hypotheses: that there is no linear relationship in the population between the dependent variables, that all of the population partial regression coefficients are 0, and that the population value for multiple R2 is 0. This study found a significant regression equation, ($F_{4,\ 444}$=102.354, p<0.05) which are similar values to the change statistics presented in Table 4.35 below.

Table 4.35: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	324.595	4	81.149	102.354	.000(a)
	Residual	325.015	444	.793		
	Total	676.610	448			

a) Predictors: (Constant), Predictors: (Constant), Conflict resolution, Employee Empowerment, Employee Compensation, and Employee Voice

b) Dependent Variable: Organisational Performance

Optimal Regression Coefficients

The partial regression coefficient (B coefficient) indicates the individual contribution of a predictor to a model. The partial coefficient for a variable shows how much the value of the dependent variable changes when the value of that independent variable increases by one, when other independent variables are held constant. A positive coefficient means that the predicted value of the dependent variable increases when the value of the independent variable increases. Since the partial regression coefficients for all the four predictors in the model are positive, this indicated that employee relations practices had a positive influence on organisational performance whenever there is an increase in any independent variable.

It was be observed that every time Employee Compensation is increased by 1 unit, Organisational Performance is increased by 0.408 when all other variables are held constant. When Employee Empowerment is increased by 1 unit, Organisational Performance is increased by 0.400 when all other variables are held constant and when Conflict resolution is increased by 1 unit Organisational Performance is increased by 0.173 when all other variables are held constant. When Employee Voice is increased by

1 unit Organisational Performance is increased by 0.311 when all other variables are held constant.

The optimal regression equation is thus:

$$Y = 0.27+0.408X1+ 0.400X2+ 0.311X3 +0.173X4+ e$$

Where Xi is Compensation practices, Employee Empowerment, Employee Voice and Conflict Resolution and respectively

Y is Organisational Performance

E = error term

The study also applied tolerance test; tolerance is the proportion of variability of that variable that is not explained by its linear relationships with the other independent variables in the model. Tolerance ranges from 0 to 1. When tolerance is 0 there is high multi-colinearity of that variable with other independents and the beta coefficients become unstable. In this model, tolerance values for all the independents are between .0.386 to 0.711, suggesting that multi-colinearity was not a problem.

Table 4.36: Coefficients

Model		**Unstandardized Coefficients**		**Standardized Coefficients**			
					B	**Sig**	**Tolerance**
1	(Constant)	.270	.149		1.816	.070	
	Employee Compensation	.408	.049	.340	8.255	.000	.434
	Employee Empowerment	.400	.048	.036	8.290	.008	.711
	Conflict resolution	.173	.045	.174	3.819	.000	.653
	Employee Voice	.311	.046	.326	6.754	.000	.386

a) Dependent Variable: Organisational Performance

4.12 Confirmatory Factor Analysis by AMOS

Factor analysis is a statistical method used to find a small set of unobserved variables (also called latent variables, or factors) which can account for the covariance among a larger set of observed variables (also called manifest variables). Confirmatory factor analysis (CFA), on the other hand, is theory- or hypothesis driven. With CFA it is possible to place substantively meaningful constraints on the factor model. They further indicate that the researchers can specify the number of factors or set the effect of one latent variable on observed variables to particular values (these are the parameters in each variable) (Kothari, 2003).

The path diagram displays the standardized regression weights (factor loadings) for the common factor and each of the indicators. The squared multiple correlation coefficients (R^2), describing the amount of variance the common factor accounts for in the observed variables, are also displayed. Additionally, a $\chi 2$(chi-square) statistic was listed in the column between the tools and the path diagram. This study employed CFA to test the effects of each variable's parameters and optimize the effects of the parameters on the variable in order to recommend the best framework to measure performance. From the Analysis, it was clear that the tested parameters had high loadings with the highest being 0.96 and the lowest being 0.76. The analysis also confirmed large standardized Residual Covariance's for all the variables.

It was evident that the four items related to performance load on the common factor while the standardized regression weights were near zero. The Employee Compensation and Employee empowerment variables appear to be the best indicators of Performance of Public Hospitals in Kenya. Their standardized regression weights are, respectively, .408 and .400. Additionally Employee voice explains about 0.31 of the variance in performance. Conflict resolution is the poorest among the employee relations indicators of performance under study with an R^2 of .173 and a standardized regression weight of .86. Meanwhile the four employee relationship values do not appear to have a

relationship with the hypothesized performance. The null hypothesis therefore is easily rejected.

4.12.1 Regression weights

The χ2statistic for model fit is still significant, meaning that the null hypothesis of a good fit to the data was rejected. Under the Regression Weights heading the unstandardized loadings appear along with standard errors (S.E), a critical ratio (C.R), and p-values (P). All of the unconstrained estimates are significant.

Table 4.37: CFA Regression weights

	Estimate	S.E	C.R	P
Conflict resolution←------- Performance	1.000	.426	2.978	***
Employee empowerment←- Performance	1.268	.074	15.619	***
Employee compensation←-- Performance	1.148	.062	16.204	***
Employee voice←----------- Performance	1.289	.085	3.518	***

***** = 0**

4.12.2 Standardized regression weights

Standardized Regression Weights can be interpreted as the correlation between the observed variable and the corresponding common factor. For this two-factor model the regression weights are all significant. In addition, the R^2corresponding to the four variables indicate that the respective factor explains a respectable portion of the variance (between 59.2% and 79.2%).

Table 4.38: Standardized regression weights

	Estimate
Conflict resolution←-------Performance	.592
Employee empowerment←-Performance	.706
Employee compensation←--Performance	.632
Employee voice←-----------Performance	.792

4.14 The Optimal Model

Based on the outcomes of the requisite and inferential analysis, the following figure is the optimal model for the study. All the variables were found to be valid; none of them was rendered redundant. There was no need for revision of the model since the hypotheses tested established that all the variables were relevant. The optimal model is represented in figure 4.26 below.

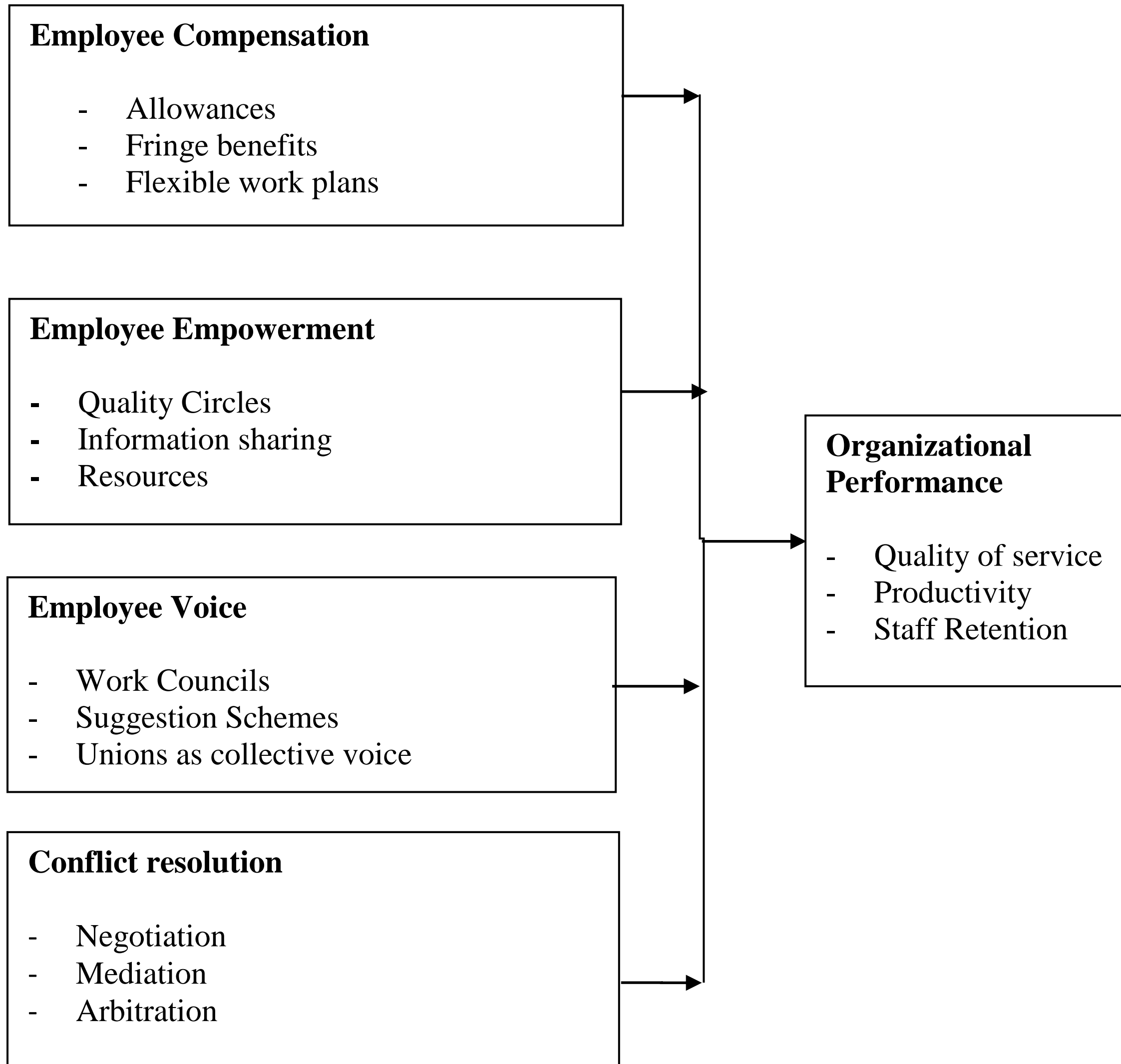

Figure 4.25: Conceptual relationships of variables

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, the conclusion drawn and the recommendations for policy and future research. The overall objective of this study was to examine the influence of employee relation practices on organisational performance of public healthcare sector in Kenya. Specifically, the study sought to examine the influence of conflict resolution practices on organisational performance in public healthcare sector in Kenya, determine influence of employee empowerment in public healthcare sector in Kenya, Establish influence of compensation practices in public healthcare sector in Kenya, and examine the influence of employee voice on organisational performance in public healthcare sector in Kenya.

5.2 Summary of Major findings

5.2.1 Conflict resolution

The study found out that conflict resolution practices affect the organisational performance in public healthcare sector in Kenya. The study established that majority of the hospitals initiated negotiation as a conflict resolution mechanism in the year 2010 with a minority initiating the same when they were upgraded to level four and five hospitals. The same trend was witnessed as far as mediation is concern as majority of the hospitals initiated it earlier than 2010 with some commencing the same in the year 2012. The trends were however different with arbitration as a conflict resolution practice as none of the hospitals initiated it earlier than the year 2010.

The study established that negotiation practices influence occupation rate of beds of hospital as this parameter had the highest mean score. The study also established that negotiation practices influence average rate of stay of patients at the hospital as there was still hope that a conflict will be resolved since there is a neutral third party involved in the conflict. It was however evident that negotiation practices did not influence employee absenteeism. It was evident that mediation practices influence employee years of service and the rate of absenteeism as it is obvious that if a mediator is one sided, employees tend to be absent as they are demotivated. The study found out that arbitration practices influence hospital readmission rates. Overall, the findings from the study revealed that conflict resolution practices influence organizational performance of public hospitals.

The regression analysis results revealed that conflict resolution has a weak but positive influence on organisational performance of Public Healthcare Sector in Kenya.

5.2.2 Employee Empowerment

The study established that resources inform of medical equipment and information sharing as employee empowerment factors influence mortality rate, morbidity rate, hospital rate of stay and readmission rates. This was ascertained by the high number of respondents who ranked these two parameters five. The study further established that quality circles influence the mortality rate in public healthcare hospitals. The same trend was witnessed with the question that endeavored to establish whether quality circles do not influence morbidity rates. The study further established that sharing information influence occupation rate of beds of the hospitals and the average rate of stay of patients at the hospital. Contrary to the norm, the study established that sharing information influence hospital readmission rates. From the study, it was evident that resources both equipment, drugs and human resources have influence on performance of public healthcare sector. This parameter had the highest mean score which established that resources influence the average rate of stay of patients and in hospitals where facilities

were strained, patients had either to stay long awaiting availability of facilities or be readmitted again due to pre-mature discharge from the hospitals to pave way for other critically ill patients.

Regression analysis showed that Employee empowerment has positive and moderate influence on organisational performance of Public Healthcare Sector.

5.3.3 Employee Compensation

The study established that allowances as an employee compensation package was the least used form of compensation in Public healthcare sector. Findings from the field established that the respondents mostly from the hard ship areas such as the north eastern, some parts of the coastal region and some parts of north western area indicated that allowances such as hardship and risk allowances influence their productivity as healthcare workers and organisational performance directly.

Findings from the study revealed that allowances influence the mortality rate and morbidity rates in pubic healthcare sector. However, the study established that allowances do not influence employee absenteeism and most of the staff would be absent from duty because of their engagements in personal practice and others due to burnout.

The study found out that even though fringe benefits in form of meals, housing and transport was commonly used as employee compensation practice in the Public Healthcare Sector, it did not have influence on the organisational performance. Influence of fringe benefits on the average rate of stay of patients and morbidity rate in all public hospitals was not found.

The study also established that flexible work plans had influence on employee years of service, staff leavers' rate and employee absenteeism. Overall, the study established that Employee Compensation practices had a strong and positive influence on organizational performance. This was the highest level of influence on organizational performance compare to other variables under study.

5.3.4 Employee Voice

The study established that work council as an employee voice sub variable was the highly used practice compared to union as a collective voice and suggestion schemes. This was due to the fact most of the staff working in Healthcare sector belong to either union or management and work councils accommodate both categories of staff. The effectiveness of the union as an employee voice was found to be less influential to organisational performance. Compared to suggestion schemes and work councils, the staff union was poorly rated bearing in mind that third of the respondents were union representatives. This is an indication that the staff is seriously in need of a voice mechanism and union voice is not the option. The management need to rethink the voice mechanisms suitable for the Public Health care sector if organisational performance is to improve.

The study established that work councils have influence on the performance of hospitals as they influence occupation rate of beds of the hospital and average rate of stay of patients at the hospital. Suggestion schemes was found to influence rate of staff leavers while union as collective voice was found to influence hospital readmission rates and average rate of stay of patients at the hospital. This meant that when the union called on strike, most of the patients would be discharged and readmitted later on when the strike is called off. Overall, the study revealed that employee voice had a weak but positive influence on organizational performance in public healthcare sector in Kenya.

5.3 Conclusion

Based on the findings, it can be concluded that employee relations practices influence organizational performance of public healthcare sector in Kenya. This confirms the findings by Rees and Johari (2010) who established a linkage between performance and human resource practices; Njau, (2012) whose linked dispute management, information sharing and financial resource allocation to quality of healthcare outcomes. The government should also ensure all facilities upgraded in the past are well funded to ensure high quality service delivery and availability of services at all levels. Further it can be concluded that employee relations policies must incorporate compensation practices, empowerment practices, employee voice mechanisms and conflict resolutions practices for overall improved organisation performance. The findings of this research support the findings of previous researchers that the government and hospital administrators should develop policies that are fit to their situation and environment with elaborate employee relations practices addressed in the policies (Mary, 2007).

Despite that the sector is highly unionized, it was concluded that Union as a collective voice did not significantly influence organisational performance and that quality circles and suggestion schemes can be a good source of idea channel and part of staff retention strategy. Sound Employee Relation practices must be supported at all levels since positive outcome on organisational performance is dependent on these practices.

The study conclude that other factors not under study such as technology, organisational culture, training & development, work environment and leadership commitment may influence organizational performance and hence area for further study. Due to the disparities experience with the rate of mortality between the national and the study, the study can conclude that hospitals in levels 1, 2, 3 and 6 hospitals not under study could account for the deficit experienced

The study concludes that the influence of employee relation practices on organisational

performance in public healthcare sector was strong and positive. This is in support of a similar finding by (Kalumba & K'Obonyo, 2012).

5.4 General Recommendations

5.4.1 Conflict resolution

The study also recommends to the administrators in public healthcare sector to embrace sound employee relations practices such as alternative conflict resolution practices in order to improve organisational performance. The Public Healthcare sector therefore need to design conflict resolution mechanisms that emphasis willingness to listen to one another and creativity to resolve conflicts within the shortest time possible to avoid lengthy protracted court battels that adversely affect organisational performance. The Conflict resolutions practices developed and adopted by the healthcare sector must be appropriate to situation and institutions. It's also recommended that Public Healthcare sector should develop high degree of internal consistency and fit among it conflict resolution practices.

The study also recommends that mediation should only come in place when negotiation as a conflict resolution process has failed to materialize and the use of arbitration as the last resort to resolve conflicts since it may trigger more tension if not properly handled.

The study also recommends that the Ministry of Health should come up with an elaborate plan to equip all hospitals elevated to levels 4 and 5 as these acts as centers of excellence in Medicare in the counties. The hospitals should be fitted with necessary equipment, drugs, supplies and adequate staffing levels for them to be able to offer referral services to the population of Kenya.

5.4.2 Employee Empowerment

It's also recommended that the hospital management should come up with innovating practices to reinforce HCW's sense of power and assists in developing employees' self-efficacy and confidence. This is crucial for the decision making that will facilitating delivery of healthcare service as well as staff retention. Employee empowerment programs must be fully supported by both top and middle level management. Therefore the hospitals management must focus on removing barriers that keep employees from exercising their talents fully and this can only be achieved by embracing empowerment programs which will give employees autonomy in their work.

In order to avert employee leavers rate, the study recommends that the employees should be involved more in decision making concerning setting goals, objectives and performance targets and decisions on rewarding for performance improvement, innovation and creativity for the department to enable them feel as partners in decision making process of the organization. In an effort to improve employee loyalty and subsequent performance, the study recommends that the public hospitals should introduce flexible working plans. Employees should be allowed to work a specific number of hours in a week regardless of the pattern as long as they accomplish the targeted hours allocated within the week. This will reduce the rate of absenteeism, staff leavers and improve the years of service an employee dedicates to the employer.

The study recommends that the level 4 & 5 hospitals should be properly supported with resources to ensure service delivery. These resources include human resources, drugs and equipment.

5.4.3 Employee Compensation

The study recommends use of allowances especially in hardship areas as a form of compensation to attract HCWs, reduce absenteeism and enhance organisational performance.

The study recommends to the Hospital Administrators to rethink fridge benefits currently enjoyed by the HCWs as they do not influence organisational performance significantly. The benefits could either be outdated or not comparable to other sectors hence the study makes recommendation for benchmarking with similar comparator sectors.

5.4.4 Employee Voice

In order for union voice to remain relevant and contribute to organisational performance as well as promote her strategic position, the study recommends a strategic overhaul of the adversarial approach used by the Unions in representing their members and adopt a more friendly partnership relationship that fosters trust and congruency of goals. The study recommends use of work councils as opposed to union voice in order to enhance organisational performance.

The study finally recommends for enhanced use of employee relations practices since they will lead to improved organisational performance in Public healthcare. This is because organizational performance remains paramount to private entities and more importantly public funded organizations. The institutions need to continuously monitor the environment and determine the appropriate practices that need be adopted to improve quality of service, productivity and staff retention.

5.5 Recommendation for Policy

The study found that compensation and empowerment practices significantly influence organisational performance in Public Healthcare Sector in Kenya. Therefore, Public healthcare Sector should come up with policy guidelines that will lead to design compensations practices that can cultivate commitment and motivation among employees in all levels and thus the practices need to be timely, market driven, appropriate and effective. With improvement in compensation and empowerment practices, organisational performance in Public Healthcare sector will significantly improve.

The study recommends to the Human resource practitioners in public healthcare sector should develop and implement appropriate policies and procedures that are unique to their situations and institutions. These will improve HCW commitment towards work, and improve on quality of service delivered and choice to stay employed by the public healthcare sector.

Generally, employee relation practices were found to have positive and significant influence on organisational performance. The study recommends that the government issue policy guidelines employee relations practices applicable to the sector. Further, the Ministry of health should formulate a harmonized and detailed employee relations practices policy manual should to ensure that no one public hospital is left out in providing quality services to the public. Public Hospitals further need to continuously monitor the environment and determine the additional practices that need be adopted to improve customer service.

The study also recommends to the government of Kenya through the Ministry of Health both at the national Level and county level to dedicate a big portion of their budget to Public Healthcare and use it for the purpose intended to ensure that all hospitals are well equipped and sufficiently staffed. This is because to any government, performing

healthcare sector to the public is their main objective and economies are grown by human capital.

The Public Healthcare Sector in Kenya needs to carry out a comprehensive Compensation Survey to enable understanding of which practices would be more appropriate in their situations and develop appropriate compensation policies. The Public healthcare sector should ensure that compensation is paid on time if they are committed to improving organisational performance. This study therefore recommends to the management to ensure consistencies and uniformity in compensation practices.

5.6 Areas for Further Research

This study examined employee relations practices and their influence on organisational performance in Public healthcare sector in Kenya. The study concentrated on describing the practices and how those practices influence organisational performance. The study did not examine the differences in employee relations among the hospitals and established whether differences in organisational performance among hospitals was attributed to the employee relations practices. A further study is, therefore, recommended to determine whether employee relations practices adopted in different hospitals in different counties could explain the differences in performance among various public healthcare facilities.

The current study looked at employee relations practices and their influence on organisational performance. The study concentrated on four variables: compensation, conflict resolution, employee empowerment and employee voice. From the findings, respondents felt that other factors such as Technology, training and development, staff promotions, work environment, prompt salary payment and leadership commitment have could have some influence in organisational performance. Further study is, therefore, recommended to establish whether these factors actually influence organisational performance in public healthcare sector. Due to the emergence of technology in the

Medical sphere, a study should be done to establish the applicability of Rodgers diffusion and innovation theory on the adoption healthcare technology in Kenya.

This study used data collected related to organizational performance in public Healthcare from the organisational perspective. Organisational performance data collected from patients' point of view could give different results. A similar study is therefore recommended but incorporating patients views.

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APPENDICES

Appendix I: Letter of introduction

School of Human Resource Development
Nairobi CBD campus
JKUAT
P.O. Box 49663, 00100
Nairobi

RE: LETTER OF INTRODUCTION

I am a postgraduate student undertaking PhD degree in Human Resource Management, in EPD department, SHRD, Jomo Kenyatta University of Agriculture and Technology.

I am conducting a study on the topic: **Influence of Employee Relations Practices on Organisational Performance in Public Healthcare Sector in Kenya**.

The information gathered will be useful to various stakeholders in the healthcare sector in the country. All information provided will be treated with the highest confidentiality and will be used for academic purposes only.

Thanking you in advance for your time and cooperation.

……………………….. …………………………….

Magdalene Muthoka Dr. Kabare Karanja

PhD Student **University Supervisor**

…………………………… ……………………………

Dr. Ngugi Karanja **Prof. Romanus Odhiambo**

University Supervisor **University Supervisor**

Appendix II: Data collection questionnaire

This research seeks to study employee relations practices on organisational performance in Public Healthcare sector in Kenya. To achieve this objective, relevant questions have been provided to gather data for analysis. Kindly spare some time to provide the requested information as accurately as possible. Please note that information given will be used for academic purposes only and will be treated with strict confidence.

Code No…………………………………..

Date…………………………..

PART I: BACKGROUND INFORMATION

1. Gender :

Male [ ] Female [ ]

2. What is your age bracket?

20-30 [ ] 30-40 [ ] 40-50 [ ] 50-60 [ ] Above 60 [ ]

3. Kindly tick the term that describes your position in the hospital

i. Hospital Administrator or deputy [ ]
ii. Human Resource Manager or deputy [ ]
iii. Employee representative [ ]

4. What is the Name of the Hospital? …………………………….

County………………

5. What level is the Hospital?

i. Level 4 [ ]
ii. Level 5 [ ]

6. How many years has your hospital been in this level?

i. 1-4 [ ]
ii. 5-8 [ ]
iii. 9-12 [ ]
iv. Above 12 [ ]

7. How many healthcare workers does your hospital employ?

i. 1-100 [ ]
ii. 101-200 [ ]
iii. 201-300 [ ]
iv. Above 300 [ ]

8. What percentage of the above Healthcare Workers belong to a union?

i. None [ ]
ii. 1-25% [ ]
iii. 26-50% [ ]
iv. Above 50% [ ]

9. Does your hospital have written Human Resource Policies and procedures?

i. Yes [ ]
ii. No [ ]

If yes, what does the policy document contain with regard to employee relations practices?

i. Conflict resolution practices [ ]
ii. Employee empowerment practices [ ]
iii. Employee compensation practices [ ]
iv. Employee voice mechanisms [ ]

10. Please specify other areas captured in the Human Resource policy document not captured in 7 above.

i. ……………………………………………………………………………………………
ii. ……………………………………………………………………………………………….
iii. ……………………………………………………………………………………………….

11. What was your Ranking at the Performance Contracting level in the Ministry of Devolution, and Planning, department of Performance Contracting?.

i. 2014………………………………………….
ii. 2013………………………………………….
iii. 2012………………………………………….
iv. 2011………………………………………….

PART II: INFLUENCE OF CONFLICT RESOLUTION ORGANISATIONAL PERFORMANCE

12. List the types of conflicts that exist in your organization?

i. ………………………………………………………………………………………………
ii. ………………………………………………………………………………………………
iii. ………………………………………………………………………………………………

13. Using a scale of 1 to 5 where 5 is highly used and 1 least used, rank the practices your organization use to resolve the above conflicts?

Conflict resolution practice	**5**	**4**	**3**	**2**	**1**
Negotiation					
Mediation					
Arbitration					

14. Other than the three above please specify any other conflict resolution practices used in your organization.

i. …………………………………………………………………………………………………..
ii. …………………………………………………………………………………………………...

15. To what extend do you agree with the following statements concerning conflict resolution at the workplace? Please tick as appropriate

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Negotiation practices influence the mortality rate					
Negotiation practices do not influence morbidity rates					
Negotiations practices influence hospital readmission rates					
Negotiation practices influence average rate of stay of patients at the hospital					
Negotiation practices influence occupation rate of beds of the hospital					
Negotiation practices do not influence the cost of patient care					
Negotiation practices influence employee years of service					
Negotiation influence rate of staff leavers					
Negotiation practices influence employee absenteeism					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Mediation practices influence the mortality rate					
Mediation practices do not influence morbidity rates					
Mediation practices influence hospital readmission rates					
Mediation practices influence average rate of stay of patients at the hospital					
Mediation practices influence occupation rate of beds of the hospital					
Mediation practices do not influence the cost of patient care					
Mediation practices influence employee years of service					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Mediation influence rate of staff leavers					
Mediation practices influence employee absenteeism					
Arbitration practices influence the mortality rate					
Arbitration practices do not influence morbidity rates					
Arbitration practices influence hospital readmission rates					
Arbitration practices influence average rate of stay of patients at the hospital					
Arbitration practices influence occupation rate of beds of the hospital					
Arbitration practices do not influence the cost of patient care					
Arbitration practices influence employee years of service					
Arbitration influence rate of staff leavers					
Arbitration practices influence employee absenteeism					

16. What are the other conflicts resolution practices in healthcare sector that influence organisational performance?

i. ………………………………………………………………………………………… ………

ii. ………………………………………………………………………………………… ………

iii. ………………………………………………………………………………………… ………

iv. ………………………………………………………………………………………… ………

PART III: INFLUENCE OF EMPLOYEE EMPOWERMENT ON ORGANIATIONAL

PERFORMANCE

17. Using a scale of 1 to 5 where 5 is highly used and 1 least used, rank the practices your organization uses to empower employees.

Employee empowerment practices	**5**	**4**	**3**	**2**	**1**
Quality circles					
Information Sharing					
Resources – equipment, drugs					

18. Other than the three above, what are the other practices your organization used to empower employees?

i. …………………………………………………………………………………………
ii. …………………………………………………………………………………………
iii. ………………………………………………………….………………………...
iv. …………………………………………………………………………………………

19. To what extend do you agree with the following statements concerning employee empowerment at the workplace? Please tick as appropriate.

Statements/Constructs	**Strongly Agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
Quality circles influence the mortality rate					
Quality circles do not influence morbidity rates					
Quality circles influence hospital readmission rates					
Quality circles influence average rate of stay of patients at the hospital					
Quality circles influence occupation rate of beds					
Quality circles do not influence the cost of patient care					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Quality circles influence employee years of service					
Quality circles influence rate of staff leavers					
Quality circles influence employee absenteeism					
Sharing information influence the mortality rate					
Sharing information do not influence morbidity rates					
Sharing information influence hospital readmission rates					
Sharing information influence average rate of stay of patients at the hospital					
Sharing information influence occupation rate of beds of the hospital					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Sharing information do not influence the cost of patient care					
Sharing information influence employee years of service					
Sharing information influence rate of staff leavers					
Sharing information influence employee absenteeism					
Availability of resources influence the mortality rate					
Resources not influence morbidity rates					
Resources influence hospital readmission rates					
Resources influence average rate of stay of patients at the hospital					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Resources influence occupation rate of beds of the hospital					
Resources do not influence the cost of patient care					
Resources influence employee years of service					
Resources influence rate of staff leavers					
Resources influence employee absenteeism					

20. What are there other forms of empowerment practices in the healthcare sector that influence organisational performance?

i. …………………………………………………………………………………………
…….

ii. …………………………………………………………………………………………
…….

PART IV: INFLUENCE OF EMPLOYE COMPENSATION ON ORGANISATIONAL PERFORMANCE

21. Using a Scale of 1 to 5 where 5 is the highly used and 1 least used, please rank the programs your organization uses to compensate employees?

Employee Compensation practices	5	4	3	2	1
Allowances					
Fridge benefits					
Flexible work plans					

22. Other than the three above, what are the other compensation practices in your organization?

i. …………………………………………………………………………………………………..

ii. ..………………………………………………………………………………………………..

23. To what extend do you agree with the following statements concerning employee compensation at the workplace? Please tick as appropriate

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Allowances influence the mortality rate					
Allowances do not influence morbidity rates					

Allowances influence hospital readmission rates					
Allowances influence average rate of stay of patients					
Allowances influence occupation rate of beds					
Allowances do not influence the cost of patient care					
Allowances influence employee years of service					
Allowances influence rate of staff leavers					
Statements/Constructs	**Strongly Agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
Allowances influence employee absenteeism					
Fridge benefits influence the mortality rate					
Fridge benefits do not influence morbidity rates					
Fridge benefits influence hospital readmission rates					
Fridge benefits influence average rate of stay of patients					
Fridge benefits influence occupation rate of beds					

Fridge benefits do not influence the cost of patient care					
Fridge benefits influence employee years of service					
Fridge benefits influence rate of staff leavers					
Fridge benefits influence employee absenteeism					
Flexible work plans influence the mortality rate					
Flexible work plans do not influence morbidity rates					
Flexible work plans influence readmission rate					
Flexible work plans influence average rate of stay of patients					
Flexible work plans influence occupation rate of beds					
Flexible work plans do not influence the cost of patient care					
Flexible work plans influence employee years of service					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Flexible work plans influence rate of staff leavers					
Flexible work plans influence employee absenteeism					

24. What are the other employee compensation practices in healthcare sector that influence organisational performance?

i. ………………………………………………………………………………………………

ii. ……………………………………………………………………………………….....

iii. ……………………………………………………………………………………………….

PART V: INFLUENCE OF EMPLOYEE VOICE ON ORGANISATIONAL PERFORMANCE

25. Using a scale of 1 to 5 where 5 is highly used and 1 least used, rank the practices your organization use to provide employees with a voice.

Conflict resolution practice	**5**	**4**	**3**	**2**	**1**
Works Council					
Suggestion Schemes					
Union as collective voice					

26. What are the other forms of employee voice in your organization? Please specify

i. ……………………………………………………………………………………………………..

ii. ……………………………………………………………………………………………………….

iii. ..…………………………………………………………………………..………………………...

iv. ……………………………………………………………………………………………………….

27. To what extend do you agree with the following statements concerning employee voice at the workplace? Please tick as appropriate

Statements/Constructs	**Strongly Agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
Works council influence the mortality rate					
Works council do not influence morbidity rate					
Works council influence hospital readmission rates					
Works council influence average rate of stay of patients at the hospital					
Works council influence occupation rate of beds of the hospital					
Works council do not influence the cost of patient care					
Works council influence employee years of service					
Works council influence rate of staff leavers					
Works council influence employee absenteeism					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Suggestion Schemes influence the mortality rate					
Suggestion Schemes do not influence morbidity rates					
Suggestion Schemes influence hospital readmission rates					
Suggestion Schemes information influence average rate of stay of patients at the hospital					
Suggestion Schemes influence occupation rate of beds of the hospital					
Suggestion Schemes do not influence the cost of patient care					
Suggestion Schemes influence employee years of service					
Suggestion Schemes influence rate of staff leavers					

Statements/Constructs	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Suggestion Schemes influence employee absenteeism					
Union as collective voice influence the mortality rate					
Union as collective voice does not influence morbidity rates					
Union as collective voice influence hospital readmission rates					
Union as collective voice influence average rate of stay of patients at the hospital					
Union as collective voice influence occupation rate of beds of the hospital					
Union as collective voice does not influence the cost of patient care					
Union as collective voice influence employee years of service					
Union as collective voice influence rate of staff leavers					
Union as collective voice influence employee absenteeism					

28. What are the other forms of employee voice in healthcare sector that influence organisational performance?

i. ………………………………………………………………………………………
………..

ii. ………………………………………………………………………………………
………..

iii. ………………………………………………………………………………………
………..

iv. ………………………………………………………………………………………
………..

PART VI: PERFORMANCE OF HEALTHCARE ORGANIZATIONS

Please indicate the performance outcome of your organization during the last five years from 2009 to 2014.

Performance Indicator	2014	2013	2012	2011	2010	2009
Mortality rate						
Morbidity rate						
Average stay of patient						
Readmission rates						
Bed occupancy rates						
Average cost per patient						
Average employee years of service						
Employee leavers rate						
Rates of absenteeism						

PART VII: OTHER FACTORS INFLUENCING ORGANISATIONAL PERFORMANCE

What are the other factors that influence organisational performance? Please Specify

i. ..………………………………………………………………………………………
……
ii. …………………..……………………………………….……………………………
………
iii. ………………………...…………………………………………………………
………
iv. ………………………………………………………………………………………
……….

Appendix III: Table 3.1: Level 4 & 5 Public healthcare facilities in Kenya

County	Number of Level 5 Hospitals	Number of Level 4 Hospitals	Total	County	Number of Level 5 Hospitals	Number of Level 4 Hospitals	Tot al
Baringo	0	4	4	Marsabit	0	2	2
Bomet	0	1	1	Meru	0	5	5
Bungoma	0	6	6	Migori	0	4	4
Busia	0	5	5	Mombasa	1	2	3
Elgeyo Marakwe t	0	2	2	Murang'a	0	2	2
Embu	1	2	3	Nairobi	0	3	3
Garissa	1	3	4	Nakuru	1	3	4
Homa Bay	0	5	5	Nandi	0	2	2
Isiolo	0	2	2	Narok	0	3	3
Kajiado	0	2	2	Nyamira	0	3	3
Kakameg a	1	4	5	Nyandaru a	0	1	1
Kericho	0	4	4	Nyeri	1	3	4
Kiambu	1	3	4	Samburu	0	1	1
Kilifi	0	3	3	Siaya	0	2	2
Kirinyaga	0	1	1	Taita Taveta	0	3	3
Kisii	1	7	8	Tana River	0	2	2
Kisumu	1	3	4	Tharaka Nithi	0	3	3
Kitui	0	3	3	Trans Nzoia	0	3	3
Kwale	0	3	3	Turkana	0	3	3
Laikipia	0	3	3	Uasin Gishu	0	2	2
Lamu	0	1	1	Vihiga	0	1	1
Machako s	1	5	6	Wajir	0	4	4
Makueni	0	4	4	West Pokot	0	2	2
Mandera	0	5	5	**Total**	**9**	**141**	**150**

Appendix IV: Item-Total Statisticsfor Conflict Resolution

	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Negotiation practices influence the mortality rate	.751	.827
Negotiation practices do not influence morbidity rates	-.529	.868
Negotiations practices influence hospital readmission rates	.951	.815
Negotiation practices influence average rate of stay of patients at the hospital	.998	.823
Negotiation practices influence occupation rate of beds of the hospital	.830	.834
Negotiation practices do not influence the cost of patient care	.509	.835
Negotiation practices influence employee years of service	.706	.835
Negotiation influence rate of staff leavers	.014	.848
Negotiation practices influence employee absenteeism	-.532	.864
Mediation practices influence the mortality rate	.998	.823
Mediation practices do not influence morbidity rates	.830	.834
Mediation practices influence hospital readmission rates	.978	.814
Mediation practices influence average rate of stay of patients at the hospital	.951	.815
Mediation practices influence occupation rate of beds of the hospital	.978	.814
Mediation practices do not influence the	.038	.863

cost of patient care		
Mediation practices influence employee years of service	-.706	.861
Mediation influence rate of staff leavers	.014	.848
Mediation practices influence employee absenteeism	-.042	.849
Arbitration practices influence the mortality rate	.951	.815
Arbitration practices do not influence morbidity rates	.978	.814
Arbitration practices influence hospital readmission rates	.830	.834
Arbitration practices influence average rate of stay of patients at the hospital	.998	.823
Arbitration practices influence occupation rate of beds of the hospital	.830	.834
Arbitration practices do not influence the cost of patient care	.800	.820
Arbitration practices influence employee years of service	-.846	.876
Arbitration influence rate of staff leavers	-.664	.880
Arbitration practices influence employee absenteeism	-.752	.862

Appendix V: Item-Total Statistics for Employee Empowerment

	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Quality circles influence the mortality rate	.826	.914
Quality circles do not influence morbidity rates	.476	.918
Quality circles influence hospital readmission rates	.000	.923
Quality circles influence average rate of stay of patients at the hospital	.826	.914
Quality circles influence occupation rate of beds	.774	.913
Quality circles do not influence the cost of patient care	-.044	.924
Quality circles influence employee years of service	-.218	.924
Quality circles influence employee absenteeism	.565	.919
Sharing information influence the mortality rate	.547	.917
Sharing information do not influence morbidity rates	.851	.912
Sharing information influence hospital readmission rates	.821	.912
Sharing information influence average rate of stay of patients at the hospital	.930	.909
Sharing information influence occupation rate of beds of the hospital	.989	.907
Sharing information do not influence the cost of patient care	.063	.929
Sharing information influence employee years of service	.821	.912
Sharing information influence rate of staff leavers	.782	.914
Sharing information influence employee absenteeism	.851	.912
Availability of resources influence the mortality rate	.821	.912
Resources not influence morbidity rates	.142	.922
Resources influence hospital readmission rate	.782	.914
Resources influence average rate of stay of patients at the hospital	.930	.909
Resources influence occupation rate of beds of the hospital	.774	.913
Resources do not influence the cost of patient care	-.186	.936
Resources influence employee years of service	.792	.917
Resources influence rate of staff leavers	.162	.921
Resources influence employee absenteeism	.197	.923

Appendix VI: Item-Total Statistics for Employee Compensation

	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Allowances influence the mortality rate	.650	.857
Allowances do not influence morbidity rates	.950	.850
Allowances influence hospital readmission rates	.650	.857
Allowances influence average rate of stay of patients	-.123	.872
Allowances influence occupation rate of beds	.950	.850
Allowances do not influence the cost of patient care	.650	.857
Allowances influence employee years of service	-.202	.876
Allowances influence rate of staff leavers	.950	.850
Allowances influence employee absenteeism	.735	.851
Fridge benefits influence the mortality rate	.273	.866
Fridge benefits do not influence morbidity rates	-.164	.872
Fridge benefits influence hospital readmission rates	.000	.869
Fridge benefits influence average rate of stay of patients	.423	.865
Fridge benefits influence occupation rate of beds	.392	.864
Fridge benefits do not influence the cost of patient care	.596	.857
Fridge benefits influence employee years of service	.564	.858
Fridge benefits influence rate of staff leavers	.853	.845

	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Fridge benefits influence employee absenteeism	.877	.843
Flexible work plans influence the mortality rate	.342	.870
Flexible work plans do not influence morbidity rates	-.087	.873
Flexible work plans influence readmission rates	.670	.861
Flexible work plans influence average rate of stay of patients	-.202	.876
Flexible work plans influence occupation rate of beds	.746	.852
Flexible work plans do not influence the cost of patient care	.748	.851
Flexible work plans influence employee years of service	-.990	.884
Flexible work plans influence rate of staff leavers	-.480	.876
Flexible work plans influence employee absenteeism	-.708	.878

Appendix VII: Item-Total Statistics for Employee Voice

	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Works council influence the mortality rate	.803	.928
Works council do not influence morbidity rates	.453	.931
Works council influence hospital readmission rates	.020	.935
Works council influence average rate of stay of patients at the hospital	.803	.928
Works council influence occupation rate of beds of the hospital	.777	.926
Works council do not influence the cost of patient care	-.092	.937
Works council influence employee years of service	-.235	.936
Works council influence rate of staff leavers	.000	.934
Works council influence employee absenteeism	.571	.931
Suggestion Schemes influence the mortality rate	.554	.930
Suggestion Schemes do not influence morbidity rates	.878	.926
Suggestion Schemes influence hospital readmission rates	.845	.925
Suggestion Schemes information influence average rate of stay of patients at the hospital	.934	.923
Suggestion Schemes influence occupation rate of beds of the hospital	.994	.922
Suggestion Schemes do not influence the cost of patient care	.017	.941
Suggestion Schemes influence employee years of service	.845	.925
Suggestion Schemes influence rate of staff leavers	.812	.927

Suggestion Schemes influence employee absenteeism	.878	.926
Union as collective voice influence the mortality rate	.845	.925
Union as collective voice does not influence morbidity rates	.135	.934
Union as collective voice influence hospital readmission rates	.812	.927
Union as collective voice influence average rate of stay of patients at the hospital	.934	.923
Union as collective voice influence occupation rate of beds of the hospital	.777	.926
Union as collective voice does not influence the cost of patient care	.857	.927
Union as collective voice influence employee years of service	.387	.933
Union as collective voice influence rate of staff leavers	.000	936
Union as collective voice influence employee absenteeism	-.050	.936

Appendix VIII: Item-Total Statistics for Organisational Performance

Performance Indicator	2014		2013		2012		2011		2010		2009	
	CITC	CAID	CITC	CAID	CITC	CAID	CITC	CAID	CITC	CAID	CITC	CAID
Mortality rate	.313	.821	.418	.818	.489	.817	.361	.820	.306	.822	.091	.826
Morbidity rate	.249	.823	.376	.820	.529	.817	.428	.818	.174	.824	.080	.827
Average stay of patient	.249	.823	.313	.822	.437	.818	.308	.822	.212	.824	.236	.823
Readmission rates	.255	.823	.341	.821	.453	.818	.097	.826	.206	.824	.110	.826
Bed occupancy rates	.353	.821	.493	.817	.370	.820	.308	.822	.090	.826	.056	.827
Average cost per patient	.344	.821	.514	.817	.454	.818	.082	.826	.062	.826	-.080	.855
Average employee years of service	.374	.820	.430	.819	.419	.819	.222	.823	.110	.826	.082	.826
Employee leavers rate	.308	.821	.476	.817	.367	.820	.119	.825	.074	.827	.000	.827
Rates of absenteeism	.308	.821	.448	.818	.395	.819	.195	.824	.290	.822	.091	.826

(Key: CITC- Corrected Item- Total Correlation, CAID – Cronbach's Alpha if item deleted)