CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

This chapter provides a theoretical framework of the concepts relating to Human Resource Development and patient care quality used in the present study.

2.1 Human Resource Development (HRD)

Malcom Knowles and Leonard Nadler were the two major contributors during 60’s and 70’s in the field of HRD (Nadler, 1979). The concepts, contents and structure of HRD is the culmination of the gradual importance given by different organisations to human resources from time to time in response to the changing socio-economic and political environment. There are numerous definitions of HRD and each of these definitions focuses on different aspects. The definition of HRD has widened in scope with the passage of time. Nadler and Gerbie (1970) stated that HRD comprises of a series of organised activities, conducted within a specified period of time and designed to produce behavioural change. HRD is a systematic expansion of peoples’ work-related abilities focused on attainment of both organisational and personal goals (Jones, 1982).

In the words of Rao (1985), HRD is a process by which the employees of an organisation are helped in a continuous and planned way to (i) acquire or sharpen capabilities required to perform various functions associated with their present or expected future roles; (ii) develop their dormant capabilities as individual and discover and exploit their own inner potential for their own and/or organisational development purposes; (iii) develop an organisational culture in which superior-subordinate relationship, team work and collaboration among sub-units are strong and contribute to the professional well being, motivation and pride of employees.

Nadler (1989) has revised his earlier definition of HRD as an organised learning experience provided by employees within a specified period of time to bring about the possibility of performance improvement and/or personal growth. While the focus of his earlier definition was on learning and behavioural change, the later focused on performance improvement.
Human Resource Development is a process for developing and unleashing human expertise through organisation development and personal training and development for the purpose of improving performance (Hammer, Tateda and Swanson, 2002). Lynham and Cuningham (2004) defines human development as a process or processes of organised capability and competency based learning experiences undertaken by employees within a specified period of time to bring about individual and organisational performance improvement, and to enhance national economic, cultural and social growth.

Though the primary focus of HRD has been employee learning and development, the recent definitions are much broader and have even included national development under its purview.

2.1.1 Origin of HRD

The history of Human Resource Development was as old as that of human beings. Training in its most simple form was found among our most primitive ancestors in the form of training to make tools out of wood, stone etc. This type of training was however limited to their family or tribe. Over time, people tried to acquire skills by consciously imitating those who have mastered a skill. But still there was no formal system of education. The Greece education system was the one which is most consistent with the present day notion of liberal education (Moore, 1936). This was followed by the middle ages which were characterised by the influence of Christianity. Under the dominance of Christianity, the education of that era received a completely new character with a focus on academic, artistic, technical and spiritual education. This period was also marked by the development of ‘guilds’ which were association of craftsmen with common interest. This was followed by the protestant reformation, the rebellion Christianity movement which was further followed by renaissance period which witnessed the origin of various concepts like secular education for boys and girls, sensory learning etc. The next was the colonial period of America during which apprenticeship received more focus. After this was the industrial era which replaced apprenticeship with the establishment of institutions for imparting work related training. With the outbreak of world wars I and II, training assumed greater significance and paved way for the development of a new concept, ‘Training within Industry’, which was an initiative aimed at imparting work related training to employees. This has set the stage for the modern form of training and development of people.
2.1.2 Sub systems of HRD

The Human Resource Development is a system by itself. Its prime objective is to have an organisation which takes care of recruitment, staffing, training and development of the employees in accordance with the set objectives of the organisations.

Various HRD thinkers and professionals have designed the system of the HRD in different ways. Rao (1991) opines that the HRD sub-systems should comprise: (i) the performance appraisal, (ii) potential appraisal, (iii) career planning, (iv) training, (v) feedback and performance coaching, (vi) organisation development, (vii) rewards, (viii) employee welfare, (ix) quality of work life and human resource information system. Pareek and Rao (1981) makes a reference of (i) performance appraisal, (ii) feedback, (iii) counseling, (iv) potential appraisal, (v) career advancement, (vi) career planning and (vii) training under the HRD system.

Varadhan (1984) traces the HRD mechanism into (i) performance appraisal, (ii) role analysis, (iii) organisation development and (iv) quality circles. Lallen Prashad (1981) listed out (i) manpower planning, (ii) injection of new blood, (iii) promotion scheme, (iv) job rotation, (v) job enrichment and (vi) job redesign. Singh (1987) observes that the HRD mechanism includes (i) induction, (ii) performance appraisal, (iii) motivation and (iv) training and development.

The important variables relating to HRD to be used in this study are drawn from existing literature (Rao, 1991; Pareek and Rao, 1981; Varadhan, 1984).

**TABLE 2.1**

**Major set of variables relating to HRD**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Variable Set</th>
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<tr>
<td>2.</td>
<td>Induction and Training</td>
<td>7.</td>
<td>Rewards and Recognition</td>
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<tr>
<td>3.</td>
<td>Performance Appraisal and Management</td>
<td>8.</td>
<td>Teamwork</td>
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<tr>
<td>5.</td>
<td>Career Guidance and Mentoring</td>
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</table>
2.1.2.1 Human resource planning and management

For any organisation to be successful it should possess the right number and kind of human resources at any given point of time. It is possible to ensure the availability of right kind of people in right quantum only by having an effective manpower planning and management system. Human resource planning is defined as analysing organisation’s human resource needs under changing conditions and developing the activities necessary to satisfy these needs. Vetter (1967) defined human resource planning as the process by which management determines how the organisation should move from its current manpower position to its desired position. Through planning, management strives to have the right number and the right kinds of people, at the right places, at the right time, doing things which result in both the organisation and the individual receiving maximum long-run benefits. The findings of a study by Nzuve and Mwarey (2013) underline the fact that proper manpower planning system is very essential for the effective functioning of a hospital. Hence the present study tries to examine the effectiveness of manpower planning and management system at government hospitals in Kerala.

2.1.2.2 Induction and training

Employees will be able to perform their work smoothly only if they are properly familiarised with the organisation which is possible through proper induction procedure. Induction is the process of familiarising a new recruit with an organisation and setting him/her into the job. Induction or orientation is the process of receiving and welcoming employees when they first join a company and giving them the basic information they need to settle down quickly and happily and start working (Armstrong, 2003). Most labor turnover usually occurs during the initial days and by planning an effective induction program, an organisation will be able to develop confidence among new entrants. Avillion (2006) clearly states that health care employees need to get oriented towards hospital routines, policies, procedures, equipments etc. so as to perform their duties well. With the advancement in technology, the skill level of employees may become outdated which may make the employees obsolete. In order to avoid this, it is very much essential to update the skill of employees through proper training programs. So, the effectiveness of an organisation, to a great extent, depends on the effectiveness of induction and training programs. Government hospitals are no exception from this. Hence, the present study
examines the effectiveness of induction and training process at government hospitals in Kerala.

### 2.1.2.3 Performance appraisal and management

The performance of any organisation is more or less dependent on the performance of its employees. So it is very important to sustain the optimum performance of employees. Each of the employees may be performing at their own level of expertise. As such it is important to periodically appraise and manage the performance of employees in order to identify the shortfalls in their performance so that appropriate training can be provided to them in order to overcome the shortfalls. Briscoe and Claus (2008) defines performance appraisal as a “process through which organisations set work goals, determine performance standards, assign and evaluate work, provide performance feedback, determine training and development needs and distribute rewards”. Boxall et al. (2007) considers performance management as a continuous process while performance appraisal as an event at discrete time intervals. West and his colleagues (2002) found considerable evidence that the extensiveness and sophistication of appraisal are linked to changes in individual performance, with appraisal systems, team work and the sophistication of training having the strongest relationship with lower patient mortality. The researchers also found that hospitals with the greatest clinician participation in management scored about 50 percent higher on important drivers of performance than those will low levels of clinical leadership (Castro et al., 2008). Hence, the present study evaluates the effectiveness of performance appraisal and management system at government hospitals.

### 2.1.2.4 Job analysis and management

An organisation is a group of people working towards the achievement of a common goal. In any organisation, on the one hand, there will be many people with varied skill sets, and on the other hand there may be multiple tasks to be performed at any point of time. So the organisation has to match the skill set of the employees with the tasks to be performed. This can be done through job analysis. Sackett et al. (2003) describes job analysis as a wide variety of systematic procedures for examining, documenting and drawing inferences about work related activities, worker attributes and work context. An employee will be able to perform at his/her best if he/she is assigned a task at which he/she is skilled. As such, effective job analysis and management is a pre-requisite for any organisation. In the guidelines on task analysis prepared for the WHO, De La Sante (1999) clearly emphasises
the role of proper job analysis and management in ensuring effective job performance by health workforce. Hence, the present study examines the effectiveness of job analysis and management system at government hospitals in Kerala.

2.1.2.5 Career guidance and mentoring

Every individual joins an organisation with the belief that it will help him/her to meet his/her career aspirations. Employees naturally have a desire to move up in their career ladder. They will be willing to remain in an organisation only if they are sure that they will have good career growth within it. So in order to retain employees with them, every organisation will have to provide a clear career path to them right at the time of their joining the organisation. Also, they should be vested with greater authority and responsibility at an appropriate time based on their performance. This is to be done through proper career guidance and mentoring system. According to the Organisation for Economic Co-operation and Development, Paris, (OECD, 2004), career guidance refers to services and activities intended to assist individuals, of any age and at any point throughout their lives, to make educational, training and occupational choices and to manage their careers. Such services may be found in schools, universities and colleges, training institutions, public employment services and at the workplaces. The activities may take place on an individual or group basis, and may be face-to-face or at a distance (including help lines and web-based services). They include career information provision (in print, ICT-based and other forms), assessment and self-assessment tools, counseling interviews, career education programmes (to help individuals develop their self awareness, opportunity awareness, and career management skills), taster programmes (to sample options before choosing them), work search programmes, and transition services. In addition to this, organisations need to provide guidance to employees regarding the additional skills and capabilities to be acquired by them in order to take up higher responsibilities through effective mentoring. Buddeberg-Fischer et al. (2006) opine that mentoring programs contribute effectively towards the professional and personal development of health care professionals. Hence, the present study tries to examine the effectiveness of career guidance and mentoring system at government hospitals in Kerala.
2.1.2.6 Communication

An organisation is defined as a group of people working together for achieving a common purpose. As such, there should be a common understanding about the organisational goals and purposes. This shared understanding can be achieved only through proper communication between the staff members. Similarly, as there will be many people in an organisation who divide work amongst them, proper co-ordination among them is very essential. This can be achieved only through effective communication. Communication, which is etymologically related to both communion and community, comes from the Latin word *communicare*, which means to make common (Weekley, 2012) or to share. DeVito (1986) expanded on this, writing that communication is the process or act of transmitting a message from a sender to a receiver, through a channel and with the interference of noise. As health care is a group process, effective communication is even more important in case of hospitals. Guastello et al. (2008) opines that communicating effectively with patients and families is a cornerstone of providing quality health care. The manner in which a health care provider communicates information to a patient can be equally important as the information being conveyed. Hence, the present study examines the effectiveness of communication system at government hospitals in Kerala.

2.1.2.7 Compensation and reward management

Compensation refers to all forms of financial returns and tangible services and benefits employees receive as part of employment relationship (Mickovich and Newman, 1999). Every individual works for some kind of reward or compensation, be it monetary or non-monetary. So it is need less to state that every employee needs to be rewarded for their performance. But the kind of reward expected varies from person to person. For e.g. some employees may be interested in monetary compensation while others may be interested in non-monetary compensation. However, in order to motivate an employee, an organisation has to provide them the rewards that they expect. As such, an effective compensation strategy is very essential for an organisation to devise a proper compensation package that suits the requirements of it employees. The case of government hospital staff is not different from this. Hence, this study tries to examine the effectiveness of compensation management system at government hospitals in Kerala.
2.1.2.8 Teamwork

An organisation is a group of people working together towards a common goal. So the meaning of the term organisation itself underlines the importance of teamwork. Teamwork is defined by Scarnati (2001) as a cooperative process that allows ordinary people to achieve extraordinary results. For any organisation to be successful there should be joint effort on part of all the employees. Salas et al. (2007) defines teamwork as the dynamic, simultaneous and recursive enactment of process mechanisms which inhibit or contribute to team performance and performance outcomes. All staff members should have a sense of unity and oneness in order to facilitate the smooth accomplishment of organisational objective. Therefore, teamwork is an inevitable requirement for the success of any organisation. Health care is one such industry where teamwork assumes utmost importance. Improved teamwork and collaborative care have shown improved performance in many aspects of the healthcare system, including primary healthcare and public health care systems (Clements et al., 2007). As such, the present study examines the effectiveness of teamwork at government hospitals.

2.1.2.9 Overall work environment

Work environment comprises of all the conditions in which an employee has to perform the tasks and duties belonging to his/her function (Gielen et al., 1996). Work environment is a broad concept covering numerous aspects like physical facilities, job analysis, role clarity, performance feedback, goal setting, etc. Work environment highly influences employee productivity irrespective of the nature and characteristics of the industry. While positive work environment will improve productivity, a negative feeling in the minds of employees regarding the environmental factors may have serious consequences including the employees moving out of the organisation. So an organisation should make all possible efforts to provide a positive work environment to its employees so that they contribute to the organisational goals in the best possible way. Hospitals are no exception from this. Hence, this study tries to analyse the perception of doctors regarding the work environment at government hospitals.
2.2 Patient care quality

The study of quality in the contemporary health-care domain began with the work of Donabedian (1990) who categorized health care in terms of structure, process, and outcome. Outcome measures have become an important indicator of technical quality (Morrison and Heineken, 1992; Finison, 1992). The service quality elements are the functional service quality attributes of tangibles, reliability, responsiveness, assurance and empathy (Parasuraman et al., 1988). With regard to patient care in particular, there have been numerous instruments developed to assess the satisfaction of the patients within the various medical facilities (Meterko et al., 1990; Ervin, 1992; and Philips et al., 1900). However, there is no standardised instrument by which to measure such patient satisfaction variables.

Abu Naser et al. (2006) identified seventeen variables to measure the five dimension of service quality in the health care centres. Muslem (2008) compared the service quality of the public and the private hospitals with the help of 21 service quality variables. Chahal (2003) used sixteen variables to measure the quality of physicians, fifteen variables to measure the service quality of support staff, eighteen variables to measure the quality of atmospherics, ten variables to measure the overall performance. Rohini and Mahadevappa (2006) used 22 variables to measure the service quality gap in the health care centres. Williams et al. (2004) have used 22 variables to measure the long-term health care service quality in the USA and the UK.

The overall patient care quality in the hospital rests on the various tangible and intangible facilities at the hospitals (Chahal, 2003). It is related to the perception of the patients towards the doctors, the nurses, the support staff, administration, operational performance, follow-up actions and the medical facilities at the hospitals (Pakdil and Harwood, 2005).

2.2.1 Elements of patient care quality

Donabedian’s structure – process – outcome framework (1990) has provided a comprehensive outline of dimensions that have been used over time to analyse health care service quality (Table. 2.2). The matrix clarifies the interaction of structure, process and outcome with the technical, interpersonal and environmental / physical elements in health care service delivery. Structure includes the stable factors such as ownership, physical
facilities, personnel, etc. The process refers to the transactions between employees and customers. Outcomes focus on the end results of the structure/ process interaction.

Structural characteristics of the settings in which care takes place have a propensity to influence the process of care so that its quality is diminished or enhanced. Similarly, changes in the process of care including variations in its quality will influence the effect of care on health status. Quality measurement must include recognition of what is feasible, given the constraints of the current system, be it financial restrictions, medical knowledge limitations, or technological imprecision. Rendering high quality care necessarily includes recognizing one's limitations in terms of equipment, personnel, and financial resources (Donabedian, 1990).

There are three components of service quality: Institutional quality - corporate image, Physical quality - surroundings, equipment, food and process outcome, and Interactive quality - interaction between the medical contact person and the patient (Lehtinen and Laitamaki, 1985).

Patients' involvement in care such as maintaining their appearance, self-administration of medications, explicitly stating their expectations, seeking information and voicing their complaints can promote satisfaction. Patient involvement must be included as a dimension in studies of health care quality (Mac Stravic, 1988).

There are four components: the curing component, the caring component, the access component and the physical environment component. (John, 1989).
TABLE 2.2  
Structure – Process – Outcome framework of health care service quality

<table>
<thead>
<tr>
<th></th>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td>Equipment, staff (numbers, qualification, expertise), training, teaching affiliation.</td>
<td>Accuracy of diagnosis, appropriateness of treatment, skills, plans and sequencing, practice guidelines.</td>
<td>Morbidity, mortality, health status, palliation, frequency of adverse incidents, malpractices.</td>
</tr>
<tr>
<td>Inter-Personal</td>
<td>Technology impact on roles and responsibilities, building design, presence of patient advocates, social workers, translators, ethics committees</td>
<td>Collegiality communication, Honesty with patients and families, sensitivity and compassion in delivery of care.</td>
<td>Patient satisfaction, family satisfaction, referrals, compliance, returns for future care, malpractices.</td>
</tr>
<tr>
<td>Amenities</td>
<td>Cleanliness, convenience, ease of access, appearance of staff</td>
<td>Efficiency in patient flow, short waiting periods</td>
<td>Patient satisfaction, family satisfaction, referrals.</td>
</tr>
</tbody>
</table>

Source: Donabedian (1990)

2.2.2 Characteristics of health care services

Health care service has its own specific attributes which are as follows:

- **Intangibility**: Health services are highly intangible and cannot be stored and tested before consumption. Consumers cannot infer the exact quality of the service provided until the service is already consumed and no longer available. Plotted on the tangibility-intangibility continuum, health services are categorized at the highest levels of intangibility (Shostack, 1977).

- **Credence versus Search Attributes**: Health care services involve a higher proportion of experience and credence attributes relative to search attributes. While search attributes can be relatively easily assessed before purchase, experience attributes can only be inferred during or after consumption and credence attributes cannot be evaluated even after consumption has taken place. Affective rather than cognitive judgment is more likely to dominate the evaluation of the service delivery process if the number of experience and credence qualities increase relative to the number of search qualities, which is typically the case for healthcare services. However, to a large extent these more affective value judgments remain
based on concrete attributes and experiences with the service delivery process. This underscores the importance of the service delivery process in studies of service quality.

- **Variability:** Health services are characterised by a great degree of variability and the services offered are highly judgmental and individualised in a labour-intensive organisational framework. Variations in service performance can be expected across different providers, employees and even within an employee depending on skills, mood, gender of patient and provider, etc. Female healthcare workers are perceived to show more empathy, while males show more confidence. Even aspects of health care that could lend themselves to some standardisation (like diagnostic procedures) have no prescribed norms in India.

- **Inseparability and Customer Involvement:** Health services are characterised by inseparability or inter-relatedness and require the customer to play an active role in receiving service of good quality.

Health care providers have to put in some extra effort on effective customer management as it can produce significant value to the organisation in terms of reduced staffing requirements, lower costs, quicker recovery time, shorter length of hospital stay, and thus, better financial results (MacStravic, 1988).

There is more than cost at stake. The quality of care itself can be improved by enlisting the patient as an active partner in care, not merely as a passive recipient of a service. There are benefits to the care process by an informed, participatory patient. The maintenance of the patient's integrity as a self-confident person is essential in healing. Physicians diagnose and treat; if anyone heals, it is the patient (Boland, 1995).

Patient participation should, however be encouraged by doctors, as the power of doctors and patients working together greatly exceeds the sum of the power each has when acting alone (Boland, 1995).

### 2.2.3 Measuring health care service quality

Measuring service quality is indispensable for service providers aspiring to attract and retain customers. While the quality of goods can be measured objectively based on various parameters like durability, reliability etc, it is difficult to measure service quality in that way (Parasuraman et al., 1988). In the service industry, quality definitions tend to focus on
meeting customer requirements and how well service providers meet their expectations (Lewis and Booms, 1983).

Generally, SERVQUAL is considered to be a robust scale for measuring service quality across service sectors. The SERVQUAL developers initially identified ten service quality dimensions namely reliability, responsiveness, credibility, competence, courtesy, security, access, communication, tangibles and understanding the customer which they later collapsed into five: reliability, assurance, tangibility, empathy and responsiveness (Buttle, 1996; Parasuraman et al., 1988). To measure a particular industry’s service quality, one should carefully evaluate and modify the scale items to cater for the industry specific needs (Ramsaran-Fowdar, 2005). Healthcare service quality research, using the SERVQUAL model, brings mixed results. Few have found SERVQUAL a reliable instrument, while others suggest there are certain healthcare service dimensions that are not captured by the original SERVQUAL scale (Babakus and Mangold, 1992; Bowers et al., 1994). Therefore, it is important to tailor the SERVQUAL scale to a sector’s specific needs. The reliability dimension is concerned with the ability to perform promised services dependably and accurately. Assurance dimension of SERVQUAL parameter is concerned with knowledge and courtesy of employees and their ability to inspire trust and confidence. While tangibility parameter comprises of physical facilities, equipments and appearance of personnel, empathy refers to the caring individualised services provided to the customers and responsiveness refers to the willingness of staff to help customers and to provide prompt services (Parasuraman et al., 1988).

Babakus and Mangold (1992) identified SERVQUAL as a reliable and valid model in the hospital environment. O’Conner et al. (2001) found SERVQUAL instruments suitable to analyse the perceptual gap in understanding patient expectation among health care stakeholders. Pakdil and Harwood (2005) found SERVQUAL as a useful model to measure the differences between patients’ preferences and their actual experiences. According to Chunlaka (2010), SERVQUAL helps to understand what the customers’ value is all about and how well an organisation meets the needs and expectations of customers of hospitals. Qin and Prybutok (2009) mentioned all the five dimensions of the service quality in SERVQUAL instrument are significant and reliable in a health care setting.
Hence, in the present study, the perception of patients and bystanders regarding the quality of care provided at government hospitals was studied by grouping the variables based on SERVQUAL dimensions of reliability, assurance, tangibility, empathy and responsiveness.