

How Working Conditions Affect Quality Healthcare Delivery

Article by Adekunle Adekanmbi
Management, Texila American university
E-mail: upkunatom@gmail.com

Abstract

In Nigeria, incessant strike is prevalent among healthcare workers in public and civil service with workers asking for more remunerations and facilities so as function optimally. Each episode of disruption of service has an enormous effective on the citizen, economic implication, health parameters of the population. Healthcare workers suffer enormous injury ranging from biological, physical, psychological and economic as a consequence of our working conditions; sometimes healthcare workers even suffer death. Administrators of public and civil service need to be abreast with different classification of working conditions as explained by the International Labour organization (ILO) so as to affect the necessary standards in our healthcare facilities, hence, mitigating industrial strike actions, improving working condition in our facilities, translating to improved patient experience and health indices.

A literature review into the different effect of poor working condition on healthcare delivery; resulting in dissatisfaction among healthcare workers and support staff, most predictor of burn out syndrome, an increased risk of non-communicable disease in workers with overtime and extended schedules. It was also revealed that improvement in work environment can lead to higher productivity of employees and bad working conditions contribute to low productivity of employees (Taiwo, 2010).

The information in this report will assist clinicians, health system managers, policy makers and health services researchers to improve their understanding about how features of the work environment affect the quality of services rendered to the public.

Keyword: Working Condition and Quality Healthcare.

Introduction

The health sector in any country is recognized as an engine of growth and development and a major contributor to human capital development but it is disappointing that most states in Nigeria takes health sector as trivial. Nigeria operates a Federal System of Government with three levels; the federal, state, and Local Government Areas/Councils. There are 774 Local Government Areas (LGAs) within the 36 states and Federal Capital Territory (FCT) Abuja. The 774 LGAs are further sub-divided into 9,565 wards. The states and FCT are grouped into six geo-political zones: The South-South, South-East, South-West, North-East, North-West, and the North Central. The 774 LGAs are the constitutionally-designated provider of Primary Health Centres (PHC). However, they are the weakest arm of the health system. There are about 25,000 PHC facilities nationwide with a population to health facility ratio of about 5,600 residents to one. The Nigeria Ministry of Defense runs medical centers around the nation which provide mostly secondary and tertiary care to both military personnel and civilians.

In addition to the Federal Ministry of Health, the National Primary Health Care Development Agency (NPHCDA) - another centrally-funded agency - has the mandate to support the promotion and implementation of high quality and sustainable PHC at state and lower levels. The NPHCDA, in collaboration with state governments and LGAs, is active in development of community-based systems and functional infrastructure, as well as ensuring that women deliver in safe conditions and infants are fully immunized against vaccine-preventable diseases. The NPHCDA also implements the national campaign against polio and measles in collaboration with states. The National AIDS Control Agency (NACA), the National Malaria Control Program.

(NMCP) and numerous other health units at federal and state level have the lead in the development and implementation of policies, strategies, and high-impact programs that directly affect the survival and health of women and children.

The private health care system provides care for a substantial proportion of the population. The private sector consists of tertiary, secondary, PHC facilities, patent medicine vendors (PMVs), drug sellers, and traditional practitioners. More than 70 percent of all secondary facilities and about 35 percent of PHC facilities are private. About two-thirds of the population in rural areas lives within five kilometers of a public or private sector PHC clinic.

There are about 36,000 PMVs nationwide, fairly evenly distributed between urban and rural areas. However, despite all aforementioned sources of healthcare delivery, quality of care in Nigeria is still rated poor. Though many factors (poor infrastructural and mental development, poor remuneration, lack of equity in the distribution of resources) could be responsible but amongst is the poor working condition of health workers as evidenced by incessant strike been embarked upon by health workers so as to express their dissatisfaction to government and health policy makers. Quality of care in both the public and some private health sectors needs substantial improvement (in working condition, facility etc). Findings showed that health workers especially Doctors and Nurses are travelling out of the country for green pasture due to poor working condition within the country healthcare facilities. Hence, resulting in shortage of effective manpower, increase burnout syndrome, medical errors and ultimately worsening of healthcare indices.

The purpose of this article is to explore the relationship between working condition and quality healthcare provided which if addressed will contribute immensely to improvement in health indices of the populace.

Objectives

To provide an overview of the evidence from up-to-date systematic reviews about the effects of working condition on quality of care delivered in health systems. Secondary objectives include identifying needs and priorities for healthcare managers to identify improving working condition as a key in the improvement of quality of care provided.

Methodology

An internet-based search review of literature was done on the effect of different categories of working condition (workforce staffing, workflow design, personal and social factors, physical environment and social factors) on the quality of care provided in healthcare system.

Inclusion criteria for considering review

- Systematic reviews that had a Methods section with explicit selection criteria;
- Assessed the effects of working condition on quality of care in healthcare (as defined in Background);

Search methods for identification of review

A search was conducted using the Agency for Healthcare Research and Quality (AHRQ), Health system evidence, CINAHL, Medline and Embase databases. Key words used were quality of health care; workforce Staffing; personal/social – stress and burnout; workflow design; physical environment; organizational factors.

Classification of working conditions

International Labour Organization (ILO) defined working condition Working conditions are at the core of paid work and employment relationships. Generally speaking, working conditions cover a broad range of topics and issues, from working time (hours of work, rest periods, and work schedules) to remuneration, as well as the physical conditions and mental demands that exist in the workplace. A business dictionary defined it as the conditions in which an individual or staff works, including but not limited to such things as amenities, physical environment, stress and noise levels, degree of safety or danger, and the like. The

Agency for Healthcare Research and Quality (AHRQ), through its Evidence-based Practice Centers (EPCs) identified five distinct categories of working conditions, as follows:

- A. Workforce staffing
- B. Workflow design
- C. Personal/social
- D. Physical environment
- E. Organizational factors

A. Workforce staffing

Workforce staffing refers to the job assignments of healthcare workers. It includes four principal aspects of job duties:

1. The volume of work assigned to individuals. This has been defined in different ways depending on the nature of the job assignment. For pharmacists it has been defined as the number of prescription orders filled per day. For nursing staff, it has been defined as the number of patients cared for during a work shift. For physicians, it has been defined as the number of a certain procedure (such as coronary arteriography or resection of a gastric carcinoma) performed per year. The most common hypothesis is that higher workload is associated with a larger rate of errors and/or adverse outcomes. However, most research on physician performance has been based on the hypothesis that higher workload is associated with a lower error rate, due to differences in the unit of measurement and nature of clinical tasks.

2. The professional skills required for particular job assignments. This has usually been defined as attainment of advanced academic degrees or specialty certifications. However, some research has examined the effects of focused training programs for existing staff members. The usual hypothesis has been that higher levels of prior training are associated with lower error rates. Current concerns over the demographic trends toward a shrinking workforce for some

professional areas (particularly nursing) has also led to research on the effects of shifting some job duties to less highly trained personnel (such as using unlicensed personnel for performance of nursing tasks and using pharmacy technicians to provide pharmacy services as allowed by state/federal law).

3. The duration of experience in a particular job category. Duration is usually measured as the number of years an individual has worked in a particular job category. Some studies of physicians in academic settings have used faculty rank as a measure of experience. The most common hypothesis is that longer experience is associated with lower error rates.

4. Effects of work schedules, including length of shift, days of the week worked, and temporal cycle effects (such as influence of time of week or season of year). A common hypothesis is that longer work shifts are associated with a greater incidence of errors.

B. Workflow design

Workflow design focuses on the process of delivering health care. Healthcare facilities are complex collections of simpler units organized to support the workflow to deliver patient care. Workflow design encompasses the interactions among workers and also between workers and the workplace. It also includes the nature and scope of the work as tasks are completed. In health care, as in other industries, hazards to workers and patients can be evaluated by examining specific work processes. This allows for the analysis of risks in the system and the impact of those risks on the worker and patient. A useful framework for analyzing workflow design integrates approaches from several disciplines, including organizational psychology, industrial engineering, biomechanics and ergonomics.

For evaluating patient safety, workflow design includes task design and workplace design relevant to accomplishing the tasks. Task design includes such job characteristics as redundancy, complexity, distractions, and transfer of information and responsibility to others (“hand - offs”). Workplace design considers worker ergonomics for technology and equipment.

C. Personal/social

This category of working conditions is concerned with the personal, professional, and social aspects of the healthcare work environment. The personal factors include stress, burnout, dissatisfaction, motivation, and control over work. Social factors include interrelationships among workers, such as collectivism, role ambiguity, discord, and support. Professionalism includes the values that are cultivated within professional disciplines such as nursing or clinical pharmacy.

D. Physical environment

Physical environment working conditions include direct physical characteristics such as light, aesthetics, noise, air quality, toxic exposures, temperature, and humidity. This category also includes basic workplace design features, such as obstacles, physical layout, and distance from nursing stations.

E. Organizational factors

Organizational factors are structural and process aspects of the organization as a whole. For example, work structures such as the use of teams and the division of labor are organizational factors with potential influences on patient safety. Other organization-level factors include size, funding mechanisms (e.g., profit, not-for-profit), hospital type (e.g., teaching, private), and culture. Some aspects of the organization, such as size and funding base, are difficult to change. Other aspects, such as the use of team structures and culture, are more amenable to change.

Organizational culture is what employees throughout an organization perceive and how this perception creates a pattern of beliefs, values, and expectations. Specific characteristics of organizational culture include managerial style, evaluation and reward systems, economic effects, hierarchy, accountability, decision latitude, and employee feedback.

Result

Workforce staffing: the 2000 World Health Organization (WHO) report stated that Health care is a labour intensive making human resources one of the most important inputs in health care delivery. Hence, the need to manage human resources is imperative to the delivery of quality of healthcare to the population they serve. In health care, the problem of increasing performance and making the work environment more pleasant has been approached through the introduction of changes in working environment. Working conditions of staff in public hospitals in Nigeria had been appalling over the years. Tomic and Tomic reported that employees are said to experience a heavy workload when they experience difficulties in meeting the task requirements as delegated by the employer. Workload has been found to be the most important predictor of burnout, lack of involvement and dehumanization of patients by health care personnel. It is also a major cause of dissatisfaction among health care givers and support staff and has been found to have an influence on staff decisions as whether to leave or remain in their jobs (Shiron et al).

Hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes such as pneumonia, shock, cardiac arrest, and urinary tract infections, according to research funded by the Agency for Healthcare Research and Quality (AHRQ) and others (Mark W. Stanton, M.A.).

In relation to personal/social characteristics of working condition, Al-Momani found an increased risk of hypertension, cardiovascular diseases, fatigue, stress, depression, musculoskeletal disorders, chronic infections, diabetes and general health complaints in workers with overtime and extended schedules. Studies among nurses in Japan and in the United States indicated that irregular shifts impact negatively on the circadian rhythm and leads to failure of various physiological functions and metabolic syndromes. In addition to that, health problems such as obesity, gastrointestinal disorders, cardiovascular diseases, duodenal ulcers, infectious diseases and musculoskeletal complaints have been linked to shift work. Barger et al reported mental health problems such as depression and suicide have also been found to be associated with shift work. There is considerable evidence that irregular shifts and long working hours are the major risk factors for mental ill-health, particularly among young women. Hence, poor working conditions could

result in increased disability, non-communicable disease, psychological problems and even suicidal attempt.

Physical environment as a characteristic of working condition had been showed by several researches to have positive impact of workers satisfaction with work environment and increase productivity. Taiwo (2010) reported that Conducive work environment stimulates creativity of employees and enhance productivity. It was also concluded based on the T-test results that improvement in work environment can lead to higher productivity of employees and bad working conditions contribute to low productivity of employees. A survey conducted by Brill (1990) has suggested that improvements in the physical design of office buildings may result in a 5-10 percent increase in productivity and eventually increase performance. Scott, (2000) reported that working conditions associates with employees' job involvement and job satisfaction. Stall (1996) has also shown that when human needs are considered in office design, employees work more efficiently.

Discussion

The different research relating the working condition with quality of service delivery has positive impacts, meaning that health managers and policy makers improving working conditions in the various categories aforementioned viz a viz staffing, work design, physical environment, social/personal and organizational factors will improve the quality of services delivered in our healthcare system. The secondary effect is increase motivation, job satisfaction; reduce job turnover and brain drain within the health system.

Looking at the widespread localization of health facilities around local government within Nigeria, improvement of at least two (2) healthcare facilities within each local government to start because of enormous resources needed to effect this change; will result in an improvement in quality of healthcare provided within the state.

Conclusion

No doubt that the information in this report will assist clinicians, health system managers, policy makers and health services researchers to improve their understanding about how characteristics of the work environment affect the quality of services rendered to the public.

Policy makers can use the information to guide decisions about resource commitments for system changes and research priorities. Health services researchers can use the information to identify gaps in knowledge that can guide new research initiatives.

The findings thus far can have a positive impact if used to educate and inform interested parties on how quality of care is changing.

Finally, policymakers may want to monitor developments in staffing issues closely in order to determine if additional legislative changes are needed to increase employment rate and reduce adverse patient outcomes.

References

- [1].A.S TAIWO (2010), The influence of work environment on workers' productivity: A case of selected oil and gas industry in Lagos, Nigeria, African Journal of Business Management Vol. 4 (3), pp. 299-307, Available online at <http://www.academicjournals.org/>
- [2]. Barger, L. K., Lockley, S. W., Rajaratnam, S. M., & Landrigan, C. P. (2009). Neurobehavioral, health, and safety consequences associated with shift work in safety-sensitive professions. *Current Neurology and Neuroscience Reports*, 9 (2), 155–164.
- [3]. Brill, M.: Workspace design and productivity. *Journal of Healthcare Forum* 1990, 35 (5), pp. 51-3.
- [4]. Lehmann, U., Dieleman, M., & Martineau, T. (2008). Staffing remote rural areas in middle- and low-income countries: A literature review of attraction and retention. *BMC Health Services Research*, 8 (1), 19.
- [5]. Mark. W starton. Hospital Nurse Staffing and quality of care. Agency for healthcare research and quality, issue 14.

DOI: 10.21522/TIJMG.2015.05.01.Art013

ISSN: 2520-310X

- [6]. Scott, K. D., Jusanne, M., & Steven, M. E. Factors influencing employee benefits beliefs that, pay is tied to performance. *Journal of Business and Psychology*, 2000. 14, 553-562.
- [7]. Stallworth, J., Kleiner, B. Recent developments in office design. *Journal of Facilities* 1996, 14 (1/2), pp. 34-42.
- [8]. Tomic, W., & Tomic, E. (2008). Existential fulfillment and burnout among principals and teachers. *Journal of Beliefs & Values*, 29 (1), 11–27.
- [9]. Van der Colff, J., & Rothmann, S. (2009). Occupational stress, sense of coherence, coping, burnout and work engagement of registered nurses in South Africa. *SA Journal of Industrial Psychology*, 35(1), 1–10.
- [10]. World Health Organization, world Health Report, Health System: Improving performance 2000. Geneva Switzerland.