

# EXPLORING THE WORKING CONDITIONS AND PERFORMANCE OF HEALTHCARE PROVIDERS: THE EMERGING MARKET STUDY

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## Abstract

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The study examines the extent to which working conditions affect the performance of healthcare providers. The design was exploratory, using both quantitative and qualitative data. Data were obtained from 490 medical personnel at the University of Calabar Teaching Hospital (UCTH). The research used a multi-stage sampling technique. Data were analysed using descriptive statistics such as percentages and frequency tables, while the chi-square test was used to test the significance of the relationship between the two hypotheses stated. The findings of the study reveal that male respondents are less likely to perceive non-payment of hazard allowances as affecting their performance than female respondents. The study also reveals that younger healthcare providers perceive the work environment as affecting their performance more than their older colleagues (Aduo-Adjei et al., 2016). As a result, the study recommends specific interventions to address the unique working conditions and challenges that various groups of medical personnel face. This will ensure that each category of medical personnel is given favourable conditions to improve their performance, which, in the long run, will ensure effective healthcare delivery.

**Keywords:** Working Conditions, Performance, Health Workers, Nigeria

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## 1. INTRODUCTION

Working conditions in teaching and public hospitals have been of great concern to healthcare practitioners worldwide in their bid to provide adequate healthcare services (Yusefzadeh & Nabilou, 2020). This is because employees view working conditions as the essential ingredients to their satisfaction at the workplace. Accordingly, Llop-Gironés et al. (2021) posit that the nature of working conditions workers is exposed to is crucial to the overall performance and productivity of workers in an organization. It is such that, where the working conditions are favourable, workers naturally work with less concern about their welfare, but if it is the contrary, the productivity of the workers cannot be guaranteed (Edem et al., 2017; Okpa, 2022). Working conditions at teaching hospitals have recently been under scrutiny in the press and medical publications, with understaffing, excessive workload, inadequate supervision or support, long working hours, lack of essential equipment, and lack of sufficient consumables to work with, among others; being described as factors that compromise the performance of medical personnel at teaching hospitals worldwide (Bataineh, 2019; Korang-Yeboah & Buobi, 2021). This disturbing scenario causes a high rate of attrition among health workers in the hospital.

Across the world, medical practitioners at most teaching hospitals are unable to perform their duties satisfactorily due to a lack of equipment, drugs, and unsupportive management systems (Alfayad & Arif, 2017; Aliyu et al., 2018). Lack of a career structure, poor housing, inadequate clinical facilities, inadequate pay, lack of recreational facilities, limited schooling opportunities for children, academic isolation, and bureaucratic problems have also been identified as factors that affect the performance of medical personnel (Ousman & Worku, 2022). In Pakistan, numerous factors influence medical employees' low satisfaction, and these are associated with working with unskilled or inappropriately trained staff, laborious tasks such as monotonous documentation, feeling overloaded, being available for overtime, tensions within role expectations, repetition of duties, overlapping of duties, role conflict, and role ambiguity, the increasing need to be in good relations with co-workers, personal factors, and organisational factors (Hailu et al., 2019).

Research evidence suggests that across Africa, healthcare personnel in teaching and public hospitals work under appalling conditions (Opiah et al., 2022). In Tanzania, less than half of the required staff is available to serve rural populations, and healthcare is sometimes provided by unqualified personnel. This situation seriously compromises the health status of the communities. The poor performance has been attributed to poor diagnosis and even death of sick people (Ipole et al., 2018; Oyira et al., 2019). In South Africa, working conditions in the district hospitals are causing frustration, and hindering optimal service. The lack of resources, both in terms of equipment and specialist backup, emerged as sub-themes of frustration. The full-time medical officers felt that the excessive workload, especially after-hours' duties and coping with large numbers of primary healthcare problems, assaults, and trauma, were problems (Igbe et al., 2017; Carbajal et al., 2020). In Ghana, working conditions,

including understaffing in health facilities, inequitable distribution of health sector human resources (HR), de-motivated staff, and inadequate healthcare infrastructure, among others, are hindering effective and efficient health service delivery to the users (Zhang et al., 2020). In Malawi, the most commonly cited factors leading to a poor working environment include poor compensation, lack of continuing education and training opportunities, lack of social and retirement benefits, lack of proper equipment, and poor HR management (Akinwale & George, 2020).

In Nigeria, medical personnel work under unsafe and unfriendly conditions. According to Akinwale (2019), workers are often exposed to poor working conditions, unsatisfactory hygiene facilities, and a poor reward system. Other prevalent problems with regard to working conditions in Nigeria are insufficient working space, inadequate lighting, poor and epileptic power supply, lack of sufficient ventilation, shortage of working apparatus, routine refusal to pay overtime benefits, unfriendly welfare packages, and poor health insurance schemes, which have left most teaching hospitals in deplorable states. It is sad to note that African countries, including Nigeria, are losing experienced health workers to developed countries as a result of neglect of their health sectors. Particularly in Nigeria, mismanagement of resources, lack of priority, lack of respect for human lives by leaders, low wages, poor motivation, persistent shortages of basic medical supplies, poor working conditions, outdated equipment, lack of efficient and effective coordination, limited career opportunities and, above all, economic reasons are among the most important factors responsible for this brain drain (Blomberg & Welander, 2019; Alhassan et al., 2013). The treatment of health workers at the University of Calabar Teaching Hospital (UCTH) is a reflection of the national attitude towards the provision of fair working conditions. The working conditions at the UCTH are not remarkably different from those of other health institutions across Nigeria.

Since the Alma-Ata Declaration, countries around the world are making efforts in trying to bring health to all through national health policies and plans which have been formulated and implemented by governments of various countries based on the Primary Healthcare (PHC) Principle. In a bid to make basic health services accessible to its citizenry, Nigeria fully joined the worldwide movement to adopt and implement a national primary healthcare programme in 1986 (Sanjeewa & Herath, 2018; Ali & Howaidee, 2018; Iji et al., 2019). The national primary healthcare policy essentially is to ensure no one is left behind in accessing healthcare. Therefore, it was an inclusive healthcare plan. Bearing in mind the interplay between friendly work conditions and job satisfaction, the implementation of the PHC Policy/Programme or any other health programme will be defective if a quality work environment and a committed and satisfied team are not developed, and placed in their right context for efficient service delivery; as the provision of these will make for a situation where everyone feels that he or she is an important stakeholder who must make significant contributions that aim to improve the quality of health of Nigerians (Edem et al., 2017; Bonenberger et al., 2014). The extent to which

an organization's environment influences a worker's performance has long been a source of contention in labour relations (Pawirosumarto et al., 2017; Ukwai et al., 2018). Progress recorded in this area has recently been extrapolated by medical experts focusing on public health sectors to ascertain how the nature of hospital environments could influence the performance of medical personnel and, in turn, the effectiveness of healthcare delivery (Daneshkohan et al., 2015; Mossburg et al., 2019). The hospital environment, when placed and supported by appropriate resources (both financial and human), is believed to go a long way in ensuring the establishment and maintenance of an effective healthcare professional workforce and, ultimately, the overall quality of health systems (Bloxsome et al., 2019).

Previous studies have failed to provide sufficient evidence of how different areas of working conditions like working equipment/tools, power supply, consumables, payment of hazards, and other monetary benefits are perceived by distinct medical personnel categories as affecting their performance (Kaur & Malhotra, 2018). In circumstances where such studies exist, there have been inconsistent results regarding the relationship between working conditions variables and health workers' performance at teaching hospitals. In the absence of such information, government or management intervention programmes directed at improving the working conditions of medical personnel to boost effective public sector healthcare delivery may have advanced from such an inclusive assumption. This presupposes that all medical personnel are similarly affected by their working conditions (Agyepong et al., 2018). To this end, this study, therefore, sets out to bridge this gap by ascertaining essentially medical personnel's perception of the effect of working conditions on their job performance and to equally find out how certain categories of medical personnel (professional affiliations, years in active service) relate to the perception that certain working conditions affect job performance. The study adopted a survey approach in analysing the perception of medical personnel with respect to their working conditions. Both qualitative and quantitative data were used in this study. The findings of this study will assist the UCTH's management in developing appropriate strategies and programmes that will not only lead to improved job performance and satisfaction among medical personnel, but will also increase the UCTH's productivity, efficiency, and quality of healthcare delivery. The study will also help in broadening the understanding of medical personnel at the UCTH and other teaching hospitals about the dynamics of suitable working conditions in the field of medical practice and the healthcare industry. The specific objectives are to:

- 1) examine whether the working conditions at the UCTH are satisfactory;
- 2) determine workers' perception of the characteristics of good working conditions.

The following research questions were raised:

*RQ1: To what extent are the working conditions at the UCTH satisfactory?*

*RQ2: What are the workers' perceptions of the characteristics of good working conditions?*

The paper is divided into six major sections. First is the introduction. Section 2 is the literature

review. Section 3 is the methodology, while Sections 4, 5, and 6 cover the result, discussion, and conclusion.

## 2. LITERATURE REVIEW

The following theories are reviewed as they are considered relevant to the study; they include the human relations theory, Abraham Maslow's theory of motivation (Maslow, 1943), and Herzberg's two-factor theory of motivation (Herzberg et al., 1959).

### 2.1. Human relations theory

The human relations theory is attributed to the outcome of the studies, referred to as the Hawthorne experiments, carried out by Elton Mayo (1927-1932) (Mayo, 1933). and his colleagues in the Western Electric Company in Chicago. The tenets of the theory are as follows: firstly, a worker's need for recognition, consultation and a sense of belonging is more important in determining his morals and productivity than physical ability or stamina. Secondly, non-economic factors (social rewards and sanctions) are significant determinants of workers' motivation and their levels of job satisfaction (Arefi et al., 2020; Heidarian et al., 2015). In other words, productivity is strongly affected by social and psychological factors, not simply by the conditions of work. Thirdly, informal groups within an organization strongly influence the work habits and attitudes of the individual workers. Lastly, an effective style of supervision is created when the managers consult the work groups and their informal leaders before introducing every change in the work schedule.

By application to this study, the workers at the health facility will appreciate and value attention, recognition, good remuneration, and consultation as much as an improvement in physical working conditions in the establishment. The life of the workers outside the organization is also as important as that within the organization, as they belong to other groups other than the formal organization, as these all will contribute to their optimal or dismal performance. Therefore, there must be a work-life balance to enhance organisational productivity, while maintaining other extrinsic factors that affect staff performance. Those in management should also be conversant with the reality that man's major motivation for greater output is not only money or economic rewards, but other things like social rewards and sanctions can also be considered (Karan, 2019; Wu et al., 2020). Where all these factors among others are in place, the workers have a sense of belonging, and are treated as critical stakeholders in progress (with their own welfare adequately taken care of), then, there is a guarantee that they will put in their best for optimal performance and organizational growth.

### 2.2. Abraham Maslow's theory of motivation

The theory of motivation is attributed to Abraham Maslow in his famous article "A Theory of Human Motivation" (Maslow, 1943); wherein he propounded the hierarchy of needs theory. The theory proposes that people are motivated by multiple needs and that these needs exist in a hierarchical order, namely:

the physiological needs (food, shelter, sex, and clothing), the safety needs (physical, emotional, and economic protection), the social needs (love, status, sense of belonging, friendship, etc.), the esteem needs (self-confidence, achievement, self-respect, recognition and respect from others), and the self-actualization needs (the desire for self-fulfilment, to be one's best) (Dieleman et al., 2006). The tenets of the theory include: firstly, that human motivation to action arises from certain driving needs common to all; secondly, the lower needs must be satisfied for an individual to be fundamentally comfortable; thirdly, that the lower level needs must be fairly satisfied before higher level needs emerge; fourthly, that a satisfied need no longer motivates behaviour, while an unsatisfied need motivates; and lastly, that higher level needs can be satisfied in many more ways than the lower level needs (Franco et al., 2004).

Applying the theory to this study, it will be pertinent for the management of the health facility/organization to be abreast with the tenets of the theory, so as to know the categories of staff, their state of needs and to know what to do to meet those needs as they manifest. The workers, being human beings, are wanting beings; they always want more, and what they want depends on what they have already (Anyim et al., 2012). In the life of each worker, the urgency of these needs varies. However, safety constitutes one of the essential human needs, as postulated by Maslow (1943) in his theory of needs hierarchy. The feeling of safety at work ranks as an important factor that influences optimal performance and job satisfaction (Okpa, 2022; de Oliveira et al., 2019). In an attempt to satisfy this level of needs, certain organizations tend to incorporate into their policy thrusts, measures that guarantee workers' safety under a climate capable of enhancing the physical, mental, and emotional conditions, with the intent to improve the individual worker's optimal performance and the organizational overall productivity and profitability. According to Wihardja et al. (2019), motivation has a positive correlation with productivity, and pressure results in increased productivity.

### 2.3. Hypotheses development

The two hypotheses were presented in the null and alternative form as follows:

*H1 (substantive hypothesis): Male respondents are more likely to perceive non-payment of hazard allowances as affecting the performance of healthcare providers than female respondents.*

*H1<sub>0</sub> (null hypothesis): Male respondents are not likely to perceive non-payment of hazard allowances as affecting the performance of healthcare providers more than female respondents.*

*H2 (substantive hypothesis): Younger healthcare providers are more likely to perceive the availability of working tools as affecting their performance than older healthcare providers.*

*H2<sub>0</sub> (null hypothesis): Younger medical healthcare providers are less likely to perceive the availability of working tools as affecting their performance than older medical personnel.*

## 3. METHODS

### 3.1. Participants/settings

Five hundred and one (501) health workers from five major departments that are directly involved in healthcare delivery at the University of Calabar, Teaching Hospital participated in the cross-sectional survey design with 247 males (50.4%), and 243 females (49.6%) ages ranging from 18 to 51 years. The sample size was determined through a proportionate method where 10% derivation was applied in each department to select only 10% of the total number of staff working in each of the five major departments/professional units. This was to ensure even representation of the major affiliations that are directly involved in healthcare services, *vis-à-vis* attending directly to patients. Participants were purposively selected in the study with the aid of a trained research assistant. Purposive sampling is adopted because it prevents unnecessary and irrelevant elements from entering the sample by chance. A total of 156 medical doctors, 280 nurses, 23 laboratory scientists, 17 ophthalmologists, and 25 dentists were selected. It should be noted that specialist units, such as general medicine, paediatrics, gynaecology, resident doctors, and others were grouped as doctors with exception of dentists and ophthalmologists. Also, one head of each of the departments was interviewed using an in-depth interview (IDI) schedule while eight representatives of the various departments (Departments of Nursing, Laboratory Science, Ophthalmology, Medicine, and Dentistry) participated in a focus group discussion (FGD) session. This is different from the 501 respondents for the questionnaire, which brought the total number of respondents for the study to 514. Five hundred and one (501) questionnaires were distributed out of which four hundred and ninety (490) were retrieved and used for the analysis. The use of both quantitative and qualitative methods ensured complementarities of data and triangulation, which is emphasised in modern research.

### 3.2. Procedure

A consent letter was attached to each of the questionnaires, with highlights on such research ethical principles as the purpose of the study, risks, and benefits, compensation, confidentiality, voluntary and anonymity, which the participants read and understood before granting their free and informed consent to complete the survey. The anonymity of the respondents and confidentiality of the data provided was guaranteed as requested by the health workers. To achieve this, we asked the respondent not to write their names, staff number, or other personal information on the questionnaires. They filled out the questionnaires in their respective offices and laboratories; the exercise usually took place in the morning for staff who are on the morning shift and/or in the afternoon for staff who are on the afternoon shift. The data were collected from June to August 2021. For the qualitative data, five IDI sessions were conducted with 5 heads of department as participants each in their offices or wherever they deem convenient to participate in

the interview session. While one FGD session with eight staff that were unit heads of different units in the hospital. The FGD was held in the conference room at a scheduled time, negotiated with, and agreed upon by all the participants. These participants are selected due to the fact that they are considered to be in privileged positions, and able to offer relevant information on the subject matter. The interview guide and the FGD guide were prepared with specific themes or domains spelled out but ensured that the instrument remained flexible during the interview process. The essence of the interview and FGD guide was to rely on sequential probes to pursue leads provided by the study respondents. Both interviews and FGD sessions focused on participants' perceptions, feelings, and thoughts on the issues surrounding working conditions and their implications on job performance. The sessions were interactive and were interlaced with word association or sentence completion, where certain statements were made halfway and the respondents were invited to respond, complete the sentence, or take it up from there. Each session lasted for about 25 to 30 minutes. The participants during the session requested that they should not be recorded to avoid any uncertainty in the future. Thus, the research assistants took extensive notes on all the subjects that were discussed during the IDI and FGD sessions.

### 3.3. Instruments

The main instrument for data collection consisted of three sections: A, B, and C. Section A served to obtain respondents' background data such as sex, age (measured as a continuous variable), years of service, occupation, (doctors, nurses, laboratory scientists, ophthalmologists, and dentists), and marital status (single, married, separated, and divorced), educational qualification (registered nurse, B.Sc., Ph.D., MBBCH, MDS, BDS). Section B, dealt with questions and views of respondents on the specific issues of the study, while Section C took care of the dependent variable. The qualitative data were

collected through an in-depth interview guide and FGD guide which contained unstructured questions.

The pilot test was conducted with 21 copies of the questionnaire which were distributed two different times within two weeks to participants who were selected from a population who shared similar characteristics but worked in units in the hospital. Two separate scores were obtained and statistically analysed using Pearson product moment correlation (PPMC). The reliability coefficient shows an r-value of 0.86, implying that the method used was suitable for the study. To ensure face and content validity the instruments were validated by three sociologists who are experts in industrial relations at the Department of Sociology and Anthropology, University of Nigeria, Nsukka.

### 3.4. Analytic strategy

This study applied qualitative as well as quantitative methods of data analysis. The Statistical Package for Social Science (SPSS) version 21 was used to code and analyze the responses from the questionnaires distributed. Frequency tables and simple percentages were used in presenting the outcomes. The chi-square ( $\chi^2$ ) test was used to test the significance of the relationship in the stated hypotheses. The qualitative data collected was transcribed, reviewed, organized, coded, and analyzed into common themes. Careful interpretation of the responses obtained was ensured in order to use the points generated to relate to the themes developed. Verbatim quotes from the transcription were used to support the quantitative data.

## 4. RESULTS

### 4.1. Socio-demographic characteristics of respondents for IDIs and FGD

The socio-demographic characteristics of respondents who participated in IDIs are shown in Table 1.

**Table 1.** Socio-demographic characteristics of respondents that participated in the IDI for heads of department in UCTH (N = 5)

Categories	1	2	3	4	5
Sex	Male	Female	Female	Male	Male
Occupation	Medical doctor	Dentist	Nurse	Laboratory scientist	Ophthalmologist
Age	45 years old	51 years old	49 years old	42 years old	47 years old
Religion	Christianity	Christianity	Christianity	Christianity	Christianity
Marital status	Married	Divorced	Married	Married	Married

Source: Author's elaboration.

The socio-demographic characteristics of the respondents from the in-depth interview conducted with five heads of department as displayed in Table 1 revealed that out of the 5 participants, 60% were males and 40% were females. In terms of occupation and age, one (20%) head of department represented: medicine (45 years), dentistry (51 years old), nursing (49 years old) laboratory science (42 years old), and ophthalmology (47 years old). 100% of the participants were

Christians. Also, in terms of marriage, 20% were divorced and 80% were married.

### 4.2. Socio-demographic characteristics of respondents for FGD among staff of UCTH

The socio-demographic characteristics of respondents who participated in FGD are shown in Table 2.

**Table 2.** Socio-demographic characteristics of respondents that participated in the FGD for staff of UCTH (N = 4)

Categories	1	2	3	4	5	6	7	8
Sex	Male	Male	Female	Female	Male	Male	Female	Female
Marital status	Married	Married	Married	Divorced	Separated	Single	Separated	Single
Occupation	Ophthalmologist	Dentist	Nurse	Laboratory scientist	Medical doctor	Nurse	Dentist	Medical doctor
Age	28 years old	29 years old	26 years old	29 years old	28 years old	26 years old	31 years old	31 years old
Religion	Atheism	Christianity	Christianity	Christianity	Christianity	Christianity	Atheism	Christianity

Source: Author's elaboration.

Table 3 showed the socio-demographic characteristics of the respondents from the FGD session conducted with staff of departments at the UCTH. Out of the 4 participants, four (4) were males and four (4) were females. In terms of occupation, one (1) was an ophthalmologist, two (2) were dentists, two (2) were nurses, one (1) was a laboratory scientist and two (2) were medical doctors. For age: two (2) were aged 28 years old, two (2) were aged 29 years old, two (2) were 26 years old and two (2) were 31 years old. Six (6) participants were Christians while two others (2) were atheists. Also, in terms of marriage, three (3) were married, one (1) was divorced, two (2) were separated and two (2) were single.

#### 4.3. Responses on whether working conditions at UCTH are satisfactory

Responses on whether UCTH has good working conditions showed that the majority (80%) of the respondents indicated that UCTH has good working conditions, while 20% stated that UCTH lacked a good working environment/condition.

**Table 3.** Distribution of the respondents on whether the working conditions at UCTH are satisfactory

Satisfactory working condition	Frequency	Percentage (%)
Yes	392	80
No	98	20
Total	490	100

Source: Author's elaboration.

The Head of the Nursing Department who shared the view on the perception of the working conditions explained: "Generally, Nigeria is suffering from lack of equipment in all its hospitals, but to the best of my knowledge, amidst these issues, we have strived over the years to give our best to patients. So yes, I can say we have a fair working condition, it's not perfect though".

According to the Heading of the Nursing Department who shared the view on the perception of the working conditions explained that: "The working conditions at the UCTH are in very good shape. At least what we see here is presently okay. The challenge we have in UCTH is inadequate equipment which most patients usually or normally complain about. But we are working on this already and I'm certain that in no distance time, everything will be okay" (IDI participant with a nursing officer in UCTH).

#### 4.4. Workers' perception of the characteristics of good working conditions

Respondents were asked to describe what they perceive as good working conditions. The information

presented in Table 4 showed that the majority (35.7%) of the respondents mentioned a conducive environment. This was followed by 22.7% who said improved staff welfare. Next were 22.4% of the respondents who mentioned the availability of working equipment. 14.5% mentioned cooperating with colleagues, while 4.7% said constant power supply indicated good working conditions.

**Table 4.** Distribution of the respondents on characteristics of good working conditions

Characteristics	Frequency	Percentage (%)
Conducive environment	175	35.7
Co-operating colleagues	71	14.5
Improved staff welfare	111	22.7
Availability of working equipment	110	22.4
Constant power supply	23	4.7
Total	490	100.0

Source: Author's elaboration.

Additionally, data from the FGD excerpt complemented this finding. The opinion of the FGD participant who is a nurse in the hospital shows that: "There are various factors to consider when we talk about the good working condition in the hospital. These factors are light, water, good equipment, information management, cordial relationship, good remuneration, the safety of the job, steady pay, and good security just to mention a few. When these things mentioned are available in a hospital, one can say there is a good working conditions for both staff and these positively affect their performance" (FGD with a 44-year-old nurse in UCTH).

#### 4.5. Responses on why some respondents perceived that UCTH working conditions are not satisfactory

Data in Table 5 revealed responses of the respondents on the reasons why they indicated that the working conditions at the UCTH are not satisfactory. The majority of the respondents (25.5%) said there is inadequate security personnel at the UCTH, 20.4% mentioned non-payment of allowances, 9.2% said there are poor equipment and poor power supply, 8.1% reported non-availability of insurance policy at the UCTH, while 36.7% reported inadequate clinical facilities.

**Table 5.** Distribution of the respondents on why they feel that UCTH working conditions are not satisfactory

<i>Reasons for no safety</i>	<i>Frequency</i>	<i>Percentage (%)</i>
Inadequate security personnel in UCTH	25	25.5
Non-payment of allowances	20	20.4
Poor equipment and poor power supply	9	9.2
Non-availability of an insurance policy	8	8.1
Inadequate clinical facilities	36	36.7
Total	98	100.0

Source: Author's elaboration.

Additionally, data from IDI with a medical doctor also revealed thus: "We lack the right tools and equipment to handle our patients. You know we attend to a good number of sick people and these people are affected with various kinds of infectious diseases and one has to attend to them. Some basic things such as gloves may not be available for you to

attend to patients and all that. A good number of personnel have died in course of discharging their duties. I think is an opportunity for the government to look into this hazard and do something positive about it because medical personnel are not immune to these diseases" (IDI, head of Department of Medicine, UCTH).

#### 4.6. Occupational standing of the respondent with respect to their views on satisfactory working conditions in UCT

Data in Table 6 showed that out of all the respondents who indicated that UCTH had satisfactory working conditions, 28.1% were doctors, 32.4% were nurses, 18.4% were laboratory scientists, 5.6% were ophthalmologists and 15.6% were dentists. Amongst those who are not satisfied with the existing working conditions at the UCTH, 32.7% were doctors, 24.5% were nurses, 15.5% were laboratory scientists, 7.1% were ophthalmologists and 20.4% were dentists.

**Table 6.** Distribution of respondents on views with respect to working conditions at the UCTH

<i>Satisfactory working conditions</i>	<i>Doctors</i>	<i>Nurses</i>	<i>Laboratory scientists</i>	<i>Ophthalmologists</i>	<i>Dentists</i>	<i>Total</i>
Yes	110 (28.1%)	127 (32.4%)	72 (18.4%)	22 (5.6%)	61 (15.6%)	392 (100.0%)
No	32 (32.7%)	24 (24.5%)	15 (15.3%)	7 (7.1%)	20 (20.4%)	98 (100.0%)
Total	142 (29.0%)	151 (30.8%)	87 (17.8%)	29 (5.9%)	81 (16.5%)	490 (100.0%)

Source: Author's elaboration.

#### 4.7. Implications of working conditions on the performance of healthcare providers

To determine the implications of working conditions on the performance of healthcare providers at

the UCTH, respondents were asked to indicate whether they agree or disagree with the following statements as contained in Table 7.

**Table 7.** Distribution of the respondents on the implications of work conditions on healthcare providers

<i>Implications on the performance of healthcare providers</i>	<i>Agree</i>	<i>Disagree</i>	<i>Total</i>
Prompt payment of hazard allowance cannot influence the satisfaction of healthcare providers	178 (36.3%)	312 (63.7%)	490 (100.0%)
Healthcare providers who work in unsatisfactory environments hardly satisfy their patients	323 (66.0%)	167 (34.0%)	490 (100.0%)
Non-payment of hazard allowances to healthcare providers affects their productivity	428 (87.3%)	62 (12.6%)	490 (100.0%)
Access to functional equipment in the hospital enhances the efficiency and profitability of healthcare providers	458 (93.5%)	32 (6.5%)	490 (100.0%)
Long working hours effectiveness of healthcare providers	273 (55.7%)	217 (44.3%)	490 (100.0%)
Poor remuneration does not affect the commitment of healthcare providers	275 (56.1%)	215 (43.9%)	490 (100.0%)
Commensurate pay for long working hours encourages creativeness and innovativeness	454 (92.7%)	36 (7.3%)	490 (100.0%)
Improved power supply affects the quality and output of healthcare providers	304 (62.0%)	186 (37.9%)	490 (100.0%)

Source: Author's elaboration.

Measuring the performance of healthcare providers, at the UCTH, eight identifiable impacts are scaled to enable the respondents "agree", "strongly agree", "disagree" or "strongly disagree" on whether the impact is obtainable in their departments. In presenting the responses, "strongly agree" and "agree" options were merged and recoded as "agree", while "strongly disagree" and "disagree" responses were merged and presented as "disagree". The merging is to enable ease and meaningful descriptive interpretation and analysis. As can be deduced from the first row, 178 (36.3%) of the respondents agreed that prompt payment of hazard allowance cannot influence the satisfaction of healthcare providers, while 312 (63.7%) disagreed.

In the second row, 323 (66.0%) point out that, healthcare providers who work in unsatisfactory environments hardly satisfy their patients. This was however disagreed with by 167 (34.0%). This implies that the majority of the respondents acknowledged that an unsatisfactory work environment negatively affects the performance of healthcare providers toward their patients. This was also the case with data presented in the third row in which 428 (87.3%) of the respondents agree that non-payment of hazard allowances to healthcare providers affects their productivity. However, this was not upheld by 62 (12.6%) of the respondents who disagree that non-payment of hazard allowances does not affect the productivity of healthcare providers in their unit.

In the fourth row, 458 (93.5%) of the respondents agree that access to functional equipment in the hospital enhances the efficiency and profitability of healthcare providers. On the contrary, 32 (6.5%) of the respondents disagree, noting that such is not applicable in their departments. In the fifth row, 273 (55.7%) of the respondents agreed that long working hours affect the effectiveness of healthcare providers. On the contrary, 217 (44.3%) of the respondents disagree with that submission. The sixth row equally shows that the majority of the respondents 275 (56.1%) agree that poor remuneration affects the commitment of healthcare providers. As can be deduced from the seventh row, 454 (92.7%) of the respondents agreed that commensurate pay for long working hours encourages creativeness and innovativeness, while 36 (7.3%)

disagreed. Also, from the eighth row, 304 (62.0%) of the respondents agreed that improved power supply affects the quality and output of healthcare providers, while 186 (37.9%) disagreed. A summation of all data presented in this section showed that the majority of the respondents are of the view that unsatisfactory working conditions have many negative implications on the performance of healthcare providers.

#### 4.8. Test of hypotheses

The following hypotheses were tested to help organize the research and guide its efforts by providing a clear focus and direction.

**Table 8.** Gender and perceived effects of non-payment of hazard on performance

Non-payment of hazard allowances affects performance	Sex		Total
	Male	Female	
Affirmative	212 (85.8%)	216 (88.9%)	428 (87.3.0%)
Denial	35 (14.2%)	27 (11.1%)	62 (12.7%)
Total	247 (100%)	243 (100%)	490 (100.0%)

Note:  $\chi^2$  (N = 490), 1.037; df = 1,  $p > 0.308$  N/B: critical  $\chi^2 = 3.841$ .  
Source: Author's elaboration.

The result in Table 8 shows that 85.8% of the male respondents were affirmative that non-payment of hazards affects the performance of healthcare providers, while 88.9% of the females were affirmative that non-payment of hazards affects the performance of healthcare providers. This shows that the difference between male and female healthcare providers' perceptions of how non-payment of hazard allowances affects their performance is less than 5%. It was further evident from Table 8 that the computed chi-square ( $\chi^2 = 1.037$ ) is less than the critical chi-square

( $\chi^2 = 3.841$ ) at df (1), showing that there is no statistically significant relationship ( $p > 0.308$ ) between gender and perceived effect of non-payment of hazard on performance. As a result, the substantive hypothesis which states that male respondents are more likely to perceive non-payment of hazard allowances as affecting their performance more than female respondents is rejected. As a result, the study concludes that male respondents are not likely to perceive non-payment of hazard allowances as affecting their performance more than female respondents.

**Table 9.** Years of service and perceived effect of working tools availability on performance

Availability of working tools affects performance	Years of services		Total
	Younger	Older	
Affirmative	248 (73.8%)	56 (36.4%)	304 (62.0%)
Denial	88 (26.2%)	98 (63.6%)	186 (38.0%)
Total	336 (100%)	154 (100%)	490 (100.0%)

Note:  $\chi^2$  (N = 490), 62.875; df = 1,  $p < 0.001$  N/B: critical  $\chi^2 = 3.841$ .  
Source: Author's elaboration.

The result in Table 9 indicated that 73.8% of younger respondents (healthcare providers who have been in active service for less than ten years) perceived the availability of working tools as affecting the performance of members, while only 36.4% of older respondents (healthcare providers who have been in active service for more than ten years) held a similar opinion. Also, given that the computed chi-square ( $\chi^2 = 62.875$ ) is greater than the critical chi-square ( $\chi^2 = 3.841$ ) at df (1), it shows that there is a statistically significant relationship ( $p < 0.001$ ) between years in active service and perceived effect of availability of working tools on the performance of healthcare providers. As a result of this, the substantive hypothesis which states that younger healthcare providers are more likely to perceive the availability of working tools as affecting their performance than older healthcare providers are upheld. The study thus concludes that younger healthcare providers perceive work

environments whereby working tools are inaccessible as affecting the level of healthcare services more than the older ones. While this could be a result of the experience differences between the two groups, it also shows the nature of technological reliance of modern-day medical personnel that makes it almost impossible for them to provide adequate healthcare services in the absence of such technologies; a condition that some of the long-serving medical personnel may not find difficult to grapple with.

## 5. DISCUSSION OF THE FINDINGS

Globally, there is a desire for organizations to have employees who are competent in discharging their duties, especially, those in the health sector. Such amounts to a quest for effective healthcare delivery. Hence, organizations generally and hospitals specifically in a bid to have the best employees that will ensure such efficiency, need to do something to



attract competent employees and make consistent efforts to retain them. One of the things that can be done to attract competent employees is to establish a pleasant working environment (Zhan et al., 2020; Omang et al., 2020). Findings from this study revealed that a conducive environment (35.7%), cooperating colleagues (14.5%), improved staff welfare (22.7%), availability of working equipment (22.4%), and constant power supply (4.7%) were all characteristics of good working conditions. Also, the finding also found that UCTH had good working conditions as was affirmed by the majority (80.0%) of the respondents. This finding however contradicts the finding of Akwash (2016) which is probably based on the disparities of hospitals under study. Akwash's own position is that in Nigeria, medical personnel work under unsafe and unfriendly conditions, as they are often exposed to poor working conditions, unsatisfactory hygiene facilities, and poor reward system (Akwash, 2016; Okpa et al., 2020). As regards reasons for non-existing working conditions, poor facilities, poor security, no conducive environment, and poor treatment meted on nurses were options indicated to give a clear picture of poor working conditions. This study is congruent with the findings by Alcaraz-Mor et al. (2019), Okpa et al. (2022), Singh et al. (2019), Kowalczyk et al. (2019). They highlight that in Iran, factors like unfair treatment, poor management, and lack of appreciation were the main demotivating factors. Also, Mengistu and Bali (2015) reveal that in the Oromia Region of Ethiopia, the major factors reported for affecting working conditions included poor payment schemes, lack of training opportunities, lack of incentives, bureaucratic management style, poor performance evaluation system, and poor working conditions (Rostami et al., 2021; Omang et al., 2022). The finding also agrees with Maslow's (1943) theory that a good working environment and better remuneration act as motivating factors for increased productivity.

The descriptive analysis revealed that the difference between male and female healthcare providers' perceptions of how non-payment of hazard allowances affects their performance is less than 5%. It was further evident as presented in Table 8 that the computed chi-square ( $\chi^2 = 1.037$ ) is less than the critical chi-square ( $\chi^2 = 3.841$ ) at df (1), showing that there is no statistically significant relationship ( $p > 0.308$ ) between gender and perceived effect of non-payment of hazard on performance. The findings of this study are in tandem with the findings of Babarinde et al. (2022). They reveal in their study that when gender balance practices are present, employees are more motivated regardless of gender. Similarly, Ogunleye and Osekita (2016) report in their study that there is no significant interaction effect that exists between gender, job status, and the level of achievement motivation behaviour on work performance ( $F(2,206) = 0.217, p > 0.05$ ). The descriptive data from hypothesis two revealed that the computed chi-square ( $\chi^2 = 62.875$ ) is greater than the critical chi-square ( $\chi^2 = 3.841$ ) at df (1), suggesting that there is a statistically significant relationship ( $p < 0.001$ ) between years in active service and perceived effect of availability of working tools on the performance of healthcare providers. This result is validated by recent studies conducted by Ghasi et al. (2020) and Arogundade and Momoh (2021).

## 6. CONCLUSION

The current study explored the existing working conditions of personnel at the UCTH, Calabar, Cross River state of Nigeria, and their perceived impacts on the performance of medical personnel in the hospital *vis-à-vis* healthcare delivery. The work is built on the debate that the nature of working conditions exposed to workers is vital to their general performance, and that the case of medical personnel in hospitals might not be an exception. Makinde et al. (2014) shares a similar opinion by noting that where the working conditions of medical personnel are favourable, then adequate healthcare delivery is guaranteed. But, unlike previous studies with the same objective, the current study dichotomized medical personnel using variables like gender, years of services, and professional affiliations in a bid to provide insight into how distinct aspects of work environments like availability of medical equipment, payments of hazard allowances and other monetary benefits affect the performance of certain medical personnel.

Contrary to dominant literature evidence on the working conditions of the medical staff at the Nigerian teaching hospitals, the study found that the majority of the respondents perceived the working conditions at the UCTH as good; though need to be further improved for robust healthcare services. This could be attributed to some recent infrastructural and equipment changes in the hospital as evident in the qualitative data. It was also revealed that there is perceived safety for effective output/performance at the UCTH which further calls for actions and improvement to ensure the safety of medical personnel. The study also found that non-payment of hazard allowance hinders the performance of medical personnel. When hazard allowances are not paid, it kills the morale to work, and this feeling is not subject to the gender of the medical personnel as no statistical relationship was found between gender and the perceived effect of non-payment of hazard allowance on the performance of medical personnel.

In the same light, the study found that commensurate pay for long working hours encourages performance. Hence, there is a need to improve the remuneration and reward system existing in hospitals. However, with regard to how monetary benefit affects the performance of medical personnel, the study found that medical doctors are less affected in such regard when compared to other medical personnel like nurses, laboratory scientists, and so on. This was evident in the third hypothesis which affirmed that health workers are more likely to perceive monetary benefits as affecting their performance than doctors. The reason for this could be due to the disparity in the monetary benefits to doctors as a professional group, compared to those of health workers.

Another key finding of this study as indicated by the few respondents that perceived the UCTH as having a poor working environment is the lack of sufficient equipment. Although the accessibility of such tools is perceived more by younger medical personnel (those that are yet to work for 10 years) as affecting their performance than older medical personnel (those that have worked for 10 years and above). The general conception as demonstrated

by 62% of the respondents is that the availability of working equipment affects their performance. It is thus evident that when these pieces of equipment are not available, healthcare delivery becomes poor and patients suffer. The finding implies that older medical personnel by the virtue of their years of experience could, to an extent, function under the prevailing circumstance of inadequate equipment than the younger ones. It should also be noted, based on the sample distribution, medical personnel who have worked for less than 6 years constituted the majority of the respondents. Since the study made use of personnel on duty during the one-month period, the fieldwork lasted; it indicated that respondents who have worked for 6-28 years and above were rarely on the ground. Since these persons have stayed longer on the job, there is a need for them to be on the ground to attend to the needs of patients and other colleagues who may need their wealth of knowledge and experience. This could be achieved through an improved work environment that will limit the exodus of medical personnel and their preoccupation with private consultancy.

Thus, the study suggests that adequate facilities should be provided in hospitals to aid performance, and regular payment of hazard allowances and salary increments should be considered. Also, there is a need for adequate funding of the hospital by the government to enable them to acquire adequate equipment in the hospital. Finally, regular supervision should be carried out to ensure that these facilities are utilized extensively. To this end, the government, organizations, medical

personnel, institutions, sociologists, social workers, and the general public should quickly rise to their distinct responsibilities in providing positive help to improve the working conditions of medical personnel which in turn enhances effective healthcare delivery. Particularly, there is a need to establish effective collaboration between social work practitioners and academics to assess the institutional needs and opportunities of healthcare institutions with the goal of making recommendations aimed at improving service delivery in these facilities.

This paper is important for future study in the sense that it adds to the body of existing knowledge, and provides insights into how working conditions affect the performance of health workers at the UCTH. Using both quantitative and qualitative approaches to gather information is the study's greatest strength. Using this method makes it easier to verify study results with two independent parties, leading to more credible conclusions. However, the major limitation of this study is that the study focuses only on one state in Nigeria. Consequently, data gleaned only relies on information gathered from staff selected from one teaching hospital in Cross River State, Nigeria, and supported by secondary sources such as internet-based materials, textbooks, and journal articles. Since respondents are selected from one teaching hospital in Cross River State, caution should be applied in generalizing the findings of this study to other teaching hospitals and corporate organisations in Nigeria and beyond.

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