

FROM A CLINIC TO A HOSPITAL

More than we bargained for: Public health nurses' report of day-to-day-work conditions after an upgrade

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SUMMARY

A number of organizations in recent times have undergone changes which have been motivated by the need to satisfy customer preferences. In the health sector, reforms were and still are motivated by the need to provide patient focused care thus organizing health services to meet patient needs and preferences; protecting patients' rights, improving efficiency, the need for adopting new technology, reducing medical errors and minimizing overall total health cost.

In Ghana however, reforms in the health sector had been motivated by the need to improve accessibility, reduce government cost and control and to improve efficiency of health care services in the country. Many studies in recent times have attempted to evaluate the impact of such reforms on health services management and organization and on how patient outcomes have been affected by these changes. This thesis attempted to investigate how one of such reforms, upgrading a clinic to a hospital, has affected the general competencies of nurses who stay at the post after the upgrade has been completed.

The findings in this thesis suggest that most nurses maintained their previous positions after the upgrade. Some nurses had been promoted to higher levels of responsibilities which meant new job demands. This was resolved by the training and development of the skills necessary for performance. Secondly, the interviews showed that nurses' workload had increased as a result of the upgrade and it was evident that nurses worked overtime and complained of lack of adequate health personnel at the hospital. All in all, the goal of the upgrade was achieved but new problems arose and uncertainties still linger in the minds of both nurses and management. Further exposition and a more robust assessment of the job demands and control model within this setting are warranted.

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CHAPTER 1

1.0 INTRODUCTION

Many companies today are undergoing changes and transformations of various degrees and magnitudes (Beer & Nohria, 2000). These changes may range from relatively small internal restructuring involving the integration of smaller units and departments, to complete organizational mergers and takeovers. Most organizational changes, including those that occur in hospitals are usually carried out in response to changes in the company's environment, precipitated either by state regulation for reforms or by the organization's desire to deliver more customer friendly services, the desire to achieve efficiency and save on cost and the organization's desire to strategically position itself in relation to its competitors (Jespersen & Wrede, 2009; Doherty, 2009 ; Shortell & Kaluzny, 2005) as well as the need to adopt new technology and the demand for new competencies and skills.

While there is a lot of literature on organizational development, hospital restructuring and nurse' competencies, most of these have been descriptive. Some research has established a relationship between hospital restructuring and social work services (Michalski, Creighton, & Jackson, 2000). There is also a lot of research on competencies that nurses need in order to effectively do their jobs (Watson, R., Simpson A., Topping A., & Porock D. 2002). Research into, how hospital restructuring impacts on nurses in general has focused on themes such: how restructuring affects nurses job satisfaction, how it impacts upon their nursing work groups and collaborations, its impacts on nurses' satisfaction with time spent on patients, job security issues among others. (Cummings & Estabrooks, 2005)

However, data on how these restructuring efforts or transformations impacts on the existing competencies and workload of nurses who choose to stay at post after the transformation has occurred is limited. Moreover, the published data describes the situation of nurses in the USA and some other Western countries rather than the Ghanaian situation. Thus, this study therefore seeks to contribute to our understanding of this situation with data from Ghana.

1.1 Relevance of this study

The idea to carry out this study comes from my personal motivation. It is common practice for politicians in my country to undertake projects and later use it to win political votes. The truth is that, majority of these projects usually end up not serving the purpose for which they are meant for. This study is therefore, necessary to be undertaken because ever since the upgrade, the government has been taunting their achievement for political capital. However, it is important to pause and ask ourselves, whether the nurses who manage the facility from day – to- day are praising this upgrading effort. It is the health personnel especially the nurses who can ensure that the facility serves its purposes, and their attitude towards the upgrade shall shed light on how the facility is serving the community efficiently. It can aptly be phrased that a satisfied employee ensures satisfied customer delivery. The aim of this present study is to evaluate how, an upgrade has affected the competencies and workload of public health nurses who remain at the post after the change has taken place.

1.2 Presentation of the research question

Though there are controversies surrounding the definition of competencies, (Watson et al 2002) the writer of this essay adopts Gonzci's (1994) definition of competencies which I think is relevant for this study. He defined competencies as pertaining to 'general attributes of the practitioners that are crucial to effective performance' (Gonzci, 1994. P. 29)

The current research question is:

How does upgrading a clinic to a hospital level, affect the competencies or general attributes and subsequent workload, of the public health nurses who decide to stay at the post after the upgrade?

How will their perceptions of their workload differ from those health professionals who came after the hospital has been established? What demand for specific competencies proves a challenge for them?

Specific objectives are as follows:

To find out;

- ✓ The reason for the upgrade from a clinic to a hospital
- ✓ Whether the source of funding affects nurses feeling of ownership over the upgrade
- ✓ Whether there has been an increase or a decrease in Nurses workload
- ✓ Whether nurses' perceive their former competencies as relevant for their new work roles
- ✓ Whether nurses underwent additional training to help them in their new work roles

By making use of qualitative interview, questionnaires and a review of government documents in conjunction with discussions of theoretical perspectives, I will try to answer these questions in the hope of contributing to the ongoing debate about hospital restructuring and its effects on nurses' in general and on nurses' competencies in particular.

1.3 Operational definition of terms

1.3.1 Restructuring

According to the Webster's dictionary, restructuring refers to the process of changing the make-up, organization or pattern of something. In this thesis, restructuring refers to the changes in the physical infrastructure, changes in work designs, changes in management etc.

1.3.2 Upgrade

The word upgrade has so many meaning. Upgrade in my thesis refers to the act of raising the value of a clinic to a hospital. In essence, the value of the clinic had risen by a number of factors including increased human resource, increased technology, increased in infrastructure increased in logistics and materials.

1.3.3 Competencies

In my thesis, competency refers to the skills, knowledge, abilities and general attributes of nurses that enable them perform their duties as nurses properly.

1.3.4 Workload

In my thesis, workload refers to the number of tasks that a nurse usually performs at work and during working hour. These may include registering patients, taking blood pressure readings, carrying out tests, giving out drugs to patients, wheeling patients from one department to the other etc.

CHAPTER 2

2.0 BACKGROUND / PROFILE OF GHANA

In this section, I try to give a description of Ghana. Focus is placed on geographical location and the health status of Ghanaians. These statements are not absolute as the determinants and dynamics of health keep changing. I talk about common diseases afflicting Ghanaians so that, the reader can have an idea about the ailments that the nurses are most likely to be dealing with on daily bases.

2.1 Geography

Ghana is located on the Gulf of Guinea in the south of the West African sub –region. It is a coastal country bordered in the North by Burkina Faso, to the East lies Togo, and to the West is Ivory Coast. For administrative purposes, the country is divided into 10 regions and 170 districts. Total land area is estimated at 239,460km². The vast majority of the country’s land is tropical and partly savannah (Salisu & Prinz, 2009). According to the 2010 Ghana Population and Housing census, Ghana’s population is estimated to be 24.6 million with the majority of the population being below the age of 14. Population growth rate is currently estimated at 2.2%.

2.2 Access to health care facilities

For a population of 24.6 million people in Ghana, there are only 1,439 health care facilities (Health Care in Ghana, 2009). A study by van den Boom and colleagues compiled in 2004 noted that access to these facilities remained a problem: medical facilities were not evenly distributed across the country, with most rural areas lacking basic facilities such as hospitals and clinics as well as doctors and nurses. The study further said that “Ghanaians on average live about 16 km from a healthcare facility where they can consult a doctor, but half of the population live within a 5 km radius. By the same token, the other half cannot consult a doctor within 5 km, which corresponds to a 1 hour walking distance, and one quarter even

live more than 15 km from a facility where a doctor can be consulted.“ The Government of Ghana embarked on a health sector reform in the early 1990s to improve the accessibility and quality of services. However, “the health situation in Ghana is still far from satisfactory.” Many people in the country still rely on self-medication (Van den Boom et al., 2004, p. 1, 4, 20, and 21). Projects to raise accessibility, however, are underway: The Minister of Health told Parliament in December 2007 “that the Ministry has established 176 health infrastructure projects within a period of five years. This included 50 Health Centers comprising 22 District Hospitals and 26 Community Health Planning Schemes (CHPS)” (Ghana Parliament, 18 December 2007).

2.3 Common diseases

The health sector delivers services to address both communicable and non-communicable diseases which are found among the populace. Common diseases that afflict people in Ghana include communicable diseases such as

2.3.1 Malaria

According to a 2009 report by the Australian Red Cross, malaria, a curable disease is still claiming the life of many people in Ghana, followed by lower respiratory infections, diarrheal diseases, and prenatal conditions. Furthermore, these five diseases account for 50 % of all deaths in Ghana and 68% of deaths among children.

2.3.2 Tuberculosis (TB)

Tuberculosis is one of the six diseases killer listed by the ministry of health. Ghana is therefore, a member of the W.H.O’s Directly Observed Treatment Short course (DOTS) which was implemented in 1994 nationwide. Treatment of TB is free at all levels of health care delivery. According to 2010 annual report of the ministry of health, there has been an improvement in the treatment of TB cases as compared to previous years.

2.3.3 Hepatitis

Treatment of viral hepatitis is currently not covered by the NHIS. According to Sarkodie et al, 2001, prevalence rate of hepatitis B among blood donors in Ghana is 15.3%, and 20.9% among children (Martinson et al., 1996) and the general population (Martinson et al., 1998), respectively, in a rural district in Ghana. The prevalence rate of HB among pregnant women

in Accra, Ghana, increased from 6.4% in 1994 (Acquaye & Mingle, 1994) to 10.5% in 2005 (Damale et al., 2005). As shown by current research, hepatitis is common in Ghana. Despite its long history in Ghana, initiatives to tackle the disease are relatively small. The Ghana Hepatitis B Foundation (GHBF) which focuses on, information dissemination on preventive measures and immunizations is yet to lobby government to include the disease on the list for treatment under the NHIS.

2.4 Non communicable diseases

2.4.1 Cancer

According to Ohene- Yeboah et al., 2012, breast and cervical cancers are a primary cause of death among Ghanaian women while prostate cancer is also common among men. Shortage of health personnel and lack of awareness are huge problems facing the management of the disease. Most cancer cases presented at the hospital are usually at an advanced stage with limited treatment options. Patients inevitably die from the disease.

2.4.2 Kidney disease

Chronic and acute renal failures are not covered under the NHIS. Sufferers pay out of pocket and treatment is expensive (GNA, 22 June 2005). According to Plange-Rhule et al 1999, renal disease is a significant contributor of morbidity and mortality among acute admissions in a large hospital in Kumasi, Ghana.

2.4.3 Diabetes

The Ghana diabetes association says that diabetes has been recognized as a cause of prolonged illness in about 2.2 million Ghanaians and threatens 50% of all Ghanaian patients. Intensive therapy directed at the control of blood glucose and blood pressure form the main treatment strategies in the country.

2.4.4 Reproductive health

Reproductive health remains a serious health issue in Ghana. Evidence from the literature is inconclusive. While some report a reduction in maternal deaths as a result of the introduction of the TBA strategy in the rural areas, others argue that neglect and unprofessional attitudes of nurses at some health facilities has led to an increase in maternal mortality.

2.4.5 Mental health

Mental illness in Ghana is stigmatized, so sufferers rarely seek medical attention. Usually relative of the patient would prefer to seek help from traditional healers, at spiritual churches and other unorthodox institutions. A director of the Pantang psychiatric hospital laments that more often; mental patients are kept in police custody for prolonged periods of time without any legal reason before being brought to the hospital for evaluations and treatment. (Public Agenda, 7 April, 2008)

It should be observed that the incidence of any of these ailments differ from region to region. From the above description of the health needs of the country, it is self-evident that the health sector must constantly undertake improvements and readjustments where necessary so that health services that are of utmost importance for each region is provided. For this reason, as well as part of the government's aim to restructure and upgrade some of the clinics in order to be able to deliver specialized care where possible. The Dodowa clinic was among the clinics which were upgraded with this purpose in mind.

2.5 The hospital of interest / case study setting

Dodowa District Hospital was originally a clinic which was established in 1985 to provide health services for the inhabitants of a small community in the Dangme East District of the Greater Accra Region of Ghana. Originally among the least populated areas of the region, it has begun to act as one of the satellite towns for the capital city because of its proximity to the city (30mins by road) and also the relatively cheaper cost of living in the area. The facility was upgraded to a district hospital in 2009 in response to Government's goal to increase people's access to health care facilities and the creation of new districts. The project was financed with money from the Global Fund and support from the Ministry of Health of Ghana. There are roughly 25 doctors working in various departments of the hospital. It is the only public hospital in the whole Dangme West districts providing a wide range of health services to about one hundred and forty eight thousand inhabitants (148,000). The services include General Out Patient Department (OPD) providing antenatal care, post natal and emergency services. In-Patient services (medical), Gynecological services with a full time obstetrician-gynecologist, a Radiology department which provides ultra sound, scanning, and X-ray services, a Dental department, an Eye department, a pharmacy, a Laboratory and a blood bank, a comprehensive reproduction health service department, testing and counseling

for HIV/AIDS patients, Child health services, community Psychiatry services, Tuberculosis testing and treatment and Nutrition services. Using the rough estimate that the inhabitants in the area are around 148000 (the author used the hospital figures because census figures are often unreliable in these settings because of the extreme mobility of the population); it suggests that with 25 doctors working at the hospital, the patient: doctor ratio stands at 5920 patients to each doctor. This figure does not even factor in other patients as a result of referrals and the rapid increases in the number of inhabitants in the area because of its nearness to the capital city.

CHAPTER 3

3.0 GHANA HEALTH SECTOR REFORMS

The health sector in Ghana like other developing countries has undergone changes over the years. Reforms have been initiated by government and donor agencies aimed at curbing health cost and improving health care delivery and accessibility through the years. This section will be devoted to a short narration of the significant reforms that the health sector has undergone over the years. These reforms have mainly been of administrative and financial nature.

3.1 Administrative reforms (decentralization)

Decentralization initiatives in most developing countries are to address political, economic and managerial problems. However, (Cassel, 1995) argues that these objectives are usually incompatible even though decentralizations aims at reducing government expenditure and improving the quality of health service delivery through the devolution of power and authority to many smaller districts and reducing the power of national and regional authorities. Evidence from published sources is to the contrary and Ghana's situation is not different.

Until the introduction of decentralization policy in public health services in Ghana, the Ministry of Health (MOH) was the largest provider of health services owning 63% of hospitals and 70% of all hospital beds in the country (Agbola, 1998). Health services were organized at three main levels; national, regional and district levels. However, in the reorganization, health administration is carried out in five levels namely; national, regional, district, sub-district and community levels. This reorganization program is contained in the Medium Term Health Strategy (MTHS) document which spells out government's goals and programs for health care development towards year 2020.

3.1.1 National Health Administration

The Ministry of health (MOH) at the national level is responsible for the formulation of national health policies, planning, training, monitoring and evaluation of all aspects of the

ministry's activities. It is also responsible for resource allocation and medical research, the enactment of conventions and legislations with respect to health matters including international co-operations and activities regarding health. The ministry is assisted by a National Health Policy Coordinating Committee, and a National Health Advisory Council which advises the minister and the MOH on matters affecting the development and administration of health in Ghana.

3.1.2 Regional Health Administration

As the name implies, the regional health administration is to ensure health care delivery in the regions. This is overseen by the Regional Health Management Team (RHMT) consisting of representatives from the various health departments and divisions. The RHMT is responsible for health policies at the regional level. The team is expected to co-ordinate health program planning, personal training, both professional and technical and administrative services in the region. They also offer technical assistance and advice to the districts, as well as supervise, monitor and evaluate all health activities in the region.

3.1.3 District Health Administration

One of the important steps in the decentralization process in Ghana is the creation of the District Health Management Teams (DHMT), Sub-District Management Teams (SDMT), and Hospital Management Boards. Each district is equipped with at least one district hospital which is the first referral point for sub-district and community facilities. The District Medical Officer (DMO) is in charge and his/duty is to supervise the provision and delivery of health services in the district. He is also the leader of the DHMT.

The District Health Management Team (DHMT) plans, implements, and evaluate health services for the entire district. Other functions include "training needs assessment, operation research, capacity building at the sub-district level and the provision of technical and administrative support required for implementations of policies" (MTHS 1995: p.13).

Also, a member of the DHMT is selected as a 'Parent' to a district essentially representing the district and acting as liaisons between the district and the regions. They also attend periodic

meeting where problems are discussed, progress reports are presented and future plans are made.

In line with government's policy, all hospitals are made semi-autonomous to ensure efficient administration and effective service delivery. Although hospitals are semi-autonomous, they have management boards that have the power to employ and terminate appointments, supervise the collection of hospital fees and retain part of the fees for internal use. Okomfo Anokye Teaching Hospital and Korlebu Teaching Hospital have complete autonomy from both the regional and district directors.

3.1.4 Sub- district health administration

Under the new health organization, each district is divided into five or six administrative units known as sub-districts. A sub- district is a geographical area with a population of between 15,000 and 30,000 inhabitants. The sub-district is managed by a sub-district Health Team (SDHT) which reports to the DHMT and performs duties delegated to them by the district. Each sub-district has at least one health center or a clinic. The center serves as a base from which services to the community in its catchment area is being organized. Each health center has a management team (HCMT) with the responsibility to forge close partnership with communities, local leaders, village based health workers and other health related institutions in the catchment area.

3.1.5 Community health care development

The guiding principles for the organization of community level services according to the Medium Term Health Strategy (MTHS) include the following:

'the need for a transformation within communities and households to enable them make decisions and take positive steps regarding their health through the acquisition of appropriate knowledge and skills ... the need for sub-districts staff to acquire the skills, methodology and incentives to work effectively with communities. The need for health services to be accountable to the communities and the need to explore new avenues and options of community care'' (MTHS: p. 9).

Currently, community based services are few and some of the services are delivered through outreach activities by the ministry of health. Herbalists, Traditional Birth Attendants (TBA) and licensed chemical sellers serve as the first point and main source of health for most community members. Furthermore, the TBA initiative has help to drastically reduce maternal deaths in most communities throughout the country.

3.2 Financial reforms

The introduction of cost sharing and cost recovery measures for the use of health facilities was initiated by the then Provisional National Defense council (PNDC) administration led by Lt. Gen. JJ Rawlings chiefly because the government could no longer bear the rising cost of care. In order to control cost, government raised user fees for all public health facilities and full- cost pricing of all drugs and pharmaceuticals. By so doing, the ministry of health, (MOH) hoped to raise 15 % of its recurrent expenditure through user fees.

The medium Term Health Strategy was also aimed at regulating donor financing and formed active partnership with the private sector. The goal of the financial reform was stated as

‘to harness and co-ordinate all sources of health care financing including private, governmental and non-governmental sources of finance to promote the development of sustainable health care system’ (MOH: Nov. 1995:4)

Specifically, the objective of the reform was to:

- Recover at least 15 % of government’s recurrent expenditure on health.
- Promote efficient management of resources
- Develop an effective health care delivery system that can be affordable to majority of Ghanaians
- Ensure an adequate supply of drugs equipment and consumables at all levels.

3.2.1 Pharmaceuticals and the cash and carry system

The hospital fee regulation policy indicated that ‘all drugs were to be supplied to patients at full cost’ (LI 1313, 1985). The objective was to raise revenue and to prevent wastage of scarce resources. Patients paid the full cost of drugs and services while health facilities collected free drugs from the central and regional medical stores until 1992 when all health institutions were asked to pay for all drugs from the central stores under a scheme which was known as ‘cash and carry’. This system was to force health institutions to take better management of the drugs in their stores and to eliminate waste that was caused by over prescription of drugs and drugs left to expire in the stores. Health institutions are now accountable for the use of drugs and other pharmaceutical products in contrast to the formally when all these were put freely at their disposal.

3.2.2 Donor participation

Until the reform, donor agencies played a significant role in financing health care in Ghana. They determine which initiative they were interested in and made funds available for such intervention. This led to fragmentations in the implementations of health strategies. However under the reforms, the MOH actively requested donor agencies to support rather than dictate the whole framework of strategic plans and interventions.

3.2.3 Private sector collaboration

Private medical practice was banned under the Kwame Nkrumah regime but it was later allowed under other regimes. Private practice was however still not popular and attractive. Under the new reforms, government formed collaborations with the private sector in the areas of health provisions and supply of consumables. Religious and missions organizations which provide about 30-40 % of health services in mostly remote parts of the country are supported financially by the ministry of health through the provision of subventions (Agbola, 1998).

3.2.4 Establishment of an insurance scheme

Insurance is another way of financing health costs in Ghana. The Medium Term Health Strategy (MTHS, 1995 p34) states that a health insurance scheme is ‘a new major source of

financing to be explored during the medium term (MTHS, 1995 p. 34). This has led to the introduction of the Nation Health Insurance Scheme (NHIS) in 2003 under the Kufour Administration. Its primary aim was to abolish the cash and carry system where payment had to be made at every service point before patients could obtain health services.

3.3 Structure of the health system organization in Ghana

There are “four main categories of health care delivery systems in Ghana – the Public, private-for-profit, private-not-for-profit, and traditional systems” (Ghana Medium Term Health Strategy [GMTHS], 1995) The public health system, centered on the ministry of health (MOH), has a hierarchical organizational structure from the central headquarters in Accra to the regions, districts, and sub-districts. According to (Osei et al., 2005), the country's health services are organized at the following levels:

3.3.1 Community

Health services are delivered through outreach programs, resident or itinerant herbalists, traditional birth attendants and/or retail drug peddlers.

3.3.2 Sub-district

A health center serves a geographical area with 15 000 to 30 000 population. It provides basic curative care, disease prevention services and maternity services (primary health care). A health center constitutes an essential component of the close-to-client health services.

3.3.3 District

A district hospital provides support to sub-districts in disease prevention and control, health promotion and public health education; referral outpatient and inpatient care, training and supervision of health centers; maternity services, especially the management of complications and emergencies and surgical contraception.

3.3.4 Regional

A regional hospital provides specialized clinical and diagnostic care; management of high-risk pregnancies and complications of pregnancy; technical and logistical back up for epidemiological surveillance; and research and training.

3.3.5 Tertiary

At the apex of the referral system, there are two government-owned teaching hospitals that offer specialized services, undertake research, and provide undergraduate and postgraduate training in health and allied science areas.

In terms of coverage, as well as expenditures on health, the public health system has a marginal lead over the other sectors, although the contributions of the mission sector and the for-profit providers are very significant. In terms of tertiary level services, however, the public sector is clearly dominant, and has a virtual monopoly over some services (Govindaraj et al., 1996). I did not talk about the other sectors because I think they do not form part of my research project.

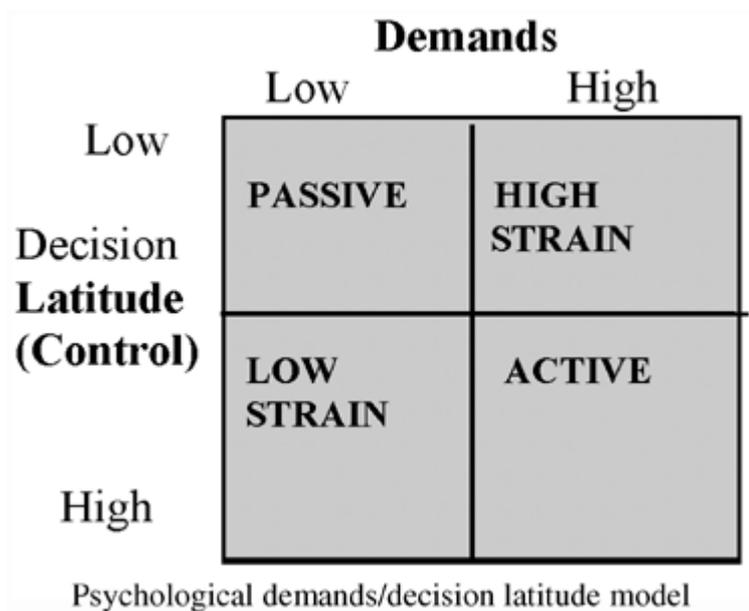
CHAPTER 4

4.0 THEORETICAL FRAMEWORK

Upgrading a clinic to a hospital will demand changes in the job characteristics and competencies of the nurses at the post. It means that the nurses may be asked to perform varied tasks than they normally would do, and it is important that they have enough decision making autonomy over their tasks. Therefore I base this study under the umbrella of job demand-job control model of job satisfaction (Karasek 1979).

The Job Demand-Control (JDC) model is among the most widely used theoretical frameworks that relate the characteristics of a job to health and wellbeing (Aida, Ibrahim, & Ohtsuka, 2012, p10). Karasek proposed his theory of demand-control to explain workplace stress as dependent on the demands of a job as compared to the control in decision making and authority which the worker has over his/her assigned job. Job demands are the sources of stress in the workplace, and there are psychological stressors involved in accomplishing workload, stressors related to unexpected tasks, and stressors of job-related personal conflict (Karasek, 1979, p.291). Job control, also referred to as decision latitude, is defined as a:” working individual’s potential control over his task and his conduct during the working day” (Karasek 1979, pp. 289-290). Later revision of this theory have included social support as important in the direct and indirect effect of job demands and control model, but for purposes of this study, the focus will be on the job demands and control formulation.

Thus there could be high/low demand jobs interacting with high/low control jobs, creating 2 X 2 possible outcomes as illustrated in the grid below.



Figur 1: The job demands-control model of Karasek

On the top left of the grid will be jobs where both the demands of the job and the decision making on the part of the worker are low. This creates passivity and the job lacks any learning or motivational capacity for the worker. On the top right of the grid are jobs which are highly demanding but the worker lacks any control over the conditions of their work because they possess little decision making authority. These are the jobs which will cause the most strain and stressors and the empirical evidence suggests that workers report the most burnout and reduced morale under this scenario. The third possible outcome of the job demands-control interaction is located on the bottom left of the grid. These are jobs with low demands over which the worker has high decision making authority and this will cause the least strain for the worker, according to Karasek (1979). Finally, there are jobs which are designed with high demands but are matched with high control. This is the condition which will lead to the most beneficial learning outcomes and stimulation for the worker. Workers are therefore challenged to go beyond just what they have to do but to seek growth opportunities to improve themselves in order to perform their jobs.

Empirical work on the job demands-control model within the health sector is abundant (e.g. Chungkham, Ingre, Karasek, Westerlund, & Theorell, 2013; Luchman & Gonzalez-Morales, 2013). Since the formulation of the model, it has been found in several studies that job with high demands but without the associated control leads to high strain and burnout at work. In

the 80's, Landsbergis conducted a survey among nursing and care home employees within 771 hospitals in the New Jersey area. His results from that period suggests that job dissatisfaction, depression, psychosomatic symptoms and burnout increases significantly in jobs that have high workload demands and low decision latitude. His results remained the same even when other control factors such as work shift hours and background characteristics were accounted for. Recent meta-analysis of the literature though suggests that various factors come into play when looking at the influence of job demands, control, and support on job outcomes.

However, the influence of the job characteristics model shows that demands and control have unique influences depending on the setting (Pisljar, Van der Lippe, & Den Dulk, 2011). The idea is that the institutional setting can affect the manner in which the demands and control of the job influences worker outcomes. In a comparative study in Europe, Pisljar and colleagues explored how work stress and work control influenced the health of hospital employees across selected Eastern and Western European countries. With data on over 1500 hospital employees from the study, 'Quality of work and life in a changing Europe' they obtained results which demonstrated that work stress has a deleterious effect on the health of hospital employees. Job control, however, did not have any effect on their health. Further comparative analyses revealed the effects of working conditions on health vary across European countries. Job control such as working overtime is more closely related to poorer health in Eastern European countries, while the evidence in Western Europe is that, there is a positive relationship between deciding to work overtime and positive report of health (Pisljar, Van der Lippe, & den Dulk, 2011). There is thus an important contribution of the institutional environment on the effect of the job demand and control model.

4.1 Review of relevant literature

4.1.1 The nature of hospital restructuring

Hospitals all over the world have been subject to some kind of reform in recent times as several countries try to curb the rising costs of health care (Duffield et al, 2006). The United States of America has experienced three different waves of hospital restructuring. The first wave of restructuring was aimed at making maximum use of nurses' time and professionalism by introducing health plans such as primary nursing and professional decision making structures such as shared governance. There was also a growing recognition that nurses can and should have responsibility of a particular patient from the time of admission till the time of discharge. This then resulted *in primary nursing* rather than the traditional team nursing (Cummings & Estabrooks, 2003). The second wave started in the 1990's with the birth of the *patient focused* paradigm. In trying to implement the patient focused care, many hospitals redesigned their clinical processes and support services to take place at the patient bedside rather than have the patient transported around the hospital for care services (Michalski et al, 2000). This was based on the idea that hospital resources should be spent on patients rather than on support services while tremendously improving the patient experience. The third wave of transformation came as a response to rising costs and inefficiencies in hospital management, prompting governments around the world to get involved in hospital management in order to curb rising costs and to ensure efficiency and quality of service in the health care sector (Scally & Donaldson, 1998; Norrish & Rundall, 2001 cited by Cummings & Estabrooks, 2003).

4.1.2 Perceptions and experiences of health workers after restructuring

The general effects of all these restructuring processes are enormous although research is still on-going.

In Duffield and colleagues study, they found that nurses lost a lot of key management positions as a result of hospital restructuring as did Michalski and colleagues study (2000). Duffield et al., explain that this situation, may adversely affect nurses' ability to ensure that safe and appropriate care is provided at the ward level and their ability to influence organizational decisions to create a positive work environment for their colleagues (Duffield et al, 2006).

In another study by Burke, nurses complained that hospital restructuring which included layoffs, often resulted in lesser – trained or untrained staff replacing registered nurses. This resulted in additional stress on those remaining at post (Burke, 2005, cited by Duffield et al, 2006) Since fewer qualified nurses are available to care for patients, higher patient acuity and shorter length of stay significantly increased nurses workload (Cumming et al, 2003). Michalski and colleagues also found a significant increase in nurses' workload as well.

Duffield and O'Brien- Pallas' study found out that nurses who stayed at the post after restructuring had low morale and motivation to work due to issues of distrust, job insecurity and anger at the way the process was carried out which may lead to poor patient outcome (Duffield & O'Brien-Pallas, 2002, Michalski et al, 2000).

Wynne's study of Australian Intensive care unit (ICU) nurses concerning their perception of organizational restructuring revealed among other things, that nurses felt they were always working under pressure. This pressure emanates from the fact that, they had to be constantly mindful of the financial constraints faced by the hospital when providing care to patients. They had to be frugal with regards to basic wound dressing materials and other consumables needed for patient care which ultimately affected their ability to provide appropriate patient care. The nurses also complained about the way the change was communicated to them. Majority of respondents felt the change was initiated by the top level of hospital hierarchy without adequate consultations and negotiations. They said they had heard about the upcoming restructuring in the media and they were only informed of the change and did not have the opportunity to either make contributions to or object to the change. Nurses ultimately had to accept the change and deal with the consequences (Wynne, 2004).

Doherty (2009) also looked at how the reforms in Britain's NHS had affected nurse's day-to-day working lives. She argued that changes in nurses' skill mix had resulted in staff nurses and ward sisters perceiving that they were 'losing nursing'; thus properly 'caring' for the patient. However, Specialist nurses in particular thought that the reforms in the NHS had given them greater empowerment by increasing their authority in clinical decision- making.

Although the picture looks gloomy, there are some success stories involving hospital restructuring. Michalski and colleagues study of nurses in a Canadian social work department of a hospital suggest some positive results. The nurses in this department felt they had spent more time with their clients after the restructuring than before. In Wynne's study too, nurses

felt that the decision to decentralize nursing services as a result of the restructuring process was a positive move.

Summing up, its clear research into hospital restructuring is relatively few and still ongoing. Evidence available on impact of restructuring on other components of the hospital organization is mixed. This thesis therefore seeks to contribute to this ongoing debate.

CHAPTER 5

5.0 METHODOLOGY

This chapter outlines the methods, materials and strategies that I used in collecting data for this research.

5.1 Design of the study

In trying to study and understand the perception and meanings that public health nurses attach to the changes going on around them, the writer decided to utilize the qualitative research methodology which enables respondents to freely express their own views and feelings concerning a particular subject (Silverman, 2010). I also wanted the nurses to tell me what they think about changes in their workload and how this has proved as a challenge to their ability to deliver safe health care services to their patients.

5.2 Data collection strategies

5.2.1 Sample / respondents

Malterud (2003) described a strategic (purposive) sample of informants as being picked on the basis of the knowledge that one possesses. She argues that in qualitative research, the mode of data collection is not driven by the principle of sample representativeness, but rather on the basis of who can shed light on the questions being investigated. For this reason, I sent a request to the hospital administrator asking her to help me identify informants that suited my criteria.

The Dodowa Hospital is part of a population of clinics which have recently been upgraded to become a hospital. Since the aim of my research is **to investigate how changes in nurses workload serve as a challenge to their competences**, a purposive sampling technique seemed more appropriate and was therefore, used to select the respondents who were mainly those public health nurses who remained at the post after the upgrade was completed. In other words, this group of nurses has had the opportunity to experience the work environment of the

clinic era and is now experiencing the work environment of a hospital setting. This group of nurses therefore, possesses the information I needed to answer my research question.

There were 25 of such nurses or respondents who held various positions in various departments of the hospital. All respondents were female which is typical because most nurses in Ghana are women. Their ages ranged from 27 to 59 years.

The researcher conducted 3 semi-structured interviews with some of the nurses whose position and history at the organization gives them privileged access to information about all the changes that have happened at the hospital. This was transcribed and condensed into meaningful themes with reference to the objectives. Due to large numbers of patients and the fact that some nurses did not want their views to be recorded, the researcher had to adopt other means of collecting data. Some of the respondents were given questionnaires to be filled at home and return them the following day when coming to work. Majority of the nurses (20) returned the answered questionnaires the following day. The others said they had forgotten the questionnaires at home. The researcher sent them a text message as a reminder on their mobile phones and the rest of the questionnaires (2) were received after 3 days.

5.2.2 Data collection

The method of data collection was by means of a survey and a follow up with a semi-structured interview. The survey was completed by 20 nurses. The researcher interviewed 3 nurses. The interview took place at the hospital and I was given an office which I could use. In each case, the purpose of the research study was stated at the beginning namely; that this is an individual research study purely for educational purposes and that I do not represent any office or authority. I then exchanged greeting with each informant, offered her a seat and then gave her the consent form. I explained to each informant that, it was voluntary to participate and that if at any point during the interview they felt uncomfortable; each had the right to inform me and subsequently withdraw from the interview process. I also explained that I need to audiotape the interview so as to enable me do the analysis. Issues of confidentiality were also explained and addressed. Each of the informants understood well. Each signed the consent form and carried through the interview to the end. Each interview lasted approximately 30 minutes. There were no breaks.

A set of questions was developed to elicit informant's views and experience with the upgrade of the hospital. The questions in the interview guide were prepared with a set of themes relevant to the research question and suited to the respondent. These questions served to guide the interview process rather than dictate it. The interviews were conducted in English. The results were analyzed and summarized by the researcher.

5.2.3 Transcription of interviews

Although the process of transcribing is extremely time-consuming (Marlow, 1993) I did my best to transcribe all of them verbatim. According to Kvale (1996), a transcript cannot ever produce a verbatim record of discourse, given the ongoing interpretive and analytical decisions that are made. I therefore settled on what I transcribed because despite all best intentions, the textual data will never fully encompass all that took place during the interview. The researcher took the decision as to what can be included in the transcription and what should be left out. This was done with reference to my research question.

5.3 Data analysis

According to Malterud (2012), knowledge in qualitative analysis is developed from experiences by interpreting and analyzing the organized data co-constructed both by the respondents and the researcher. She proposed four steps in analyzing qualitative data namely: total impression at this stage, the researcher reads the whole transcript to get a general overview of the transcribed data in order to establish preliminary themes. The second stage involves identifying and sorting meaning units in order to make codes from the themes. Condensation entails assigning meaning to the codes and lastly, synthesizing means describing and giving conceptual meaning to the condensed data. I decided to organize the data and analyzed it according to themes derived from the primary objectives of this study. The data were organized into themes as follows; *knowledge of the upgrade before it happened, the source of funding for the project, changes in work routines as a result of the upgrade, whether or not nurses former competences were relevant to the new work roles and whether additional training was given to enhance performance*. The researcher then chose to explain the respondents' views based on these themes.

5.3.1 Thematic organization of the data

According to Malterud (2012), in qualitative analysis, knowledge is developed from experiences by interpreting and summarizing the organized empirical data. She proposes four steps in analyzing qualitative data namely: *total impression* at this stage, the researcher reads the whole transcript to get a general overview of the transcribed data in order to establish preliminary themes. The second stage involves *identifying and sorting meaning units* in order to make codes from the themes. *Condensation* entails assigning meaning to the codes and lastly, *synthesizing* means describing and giving conceptual meaning to the condensed data. Using her Systematic Text Condensation (STC) method, I read the transcribed interviews over and over again in order to establish preliminary themes. By first articulating my objectives, finding themes and establishing codes only came naturally. Secondly, I went on to find meaning units that elucidate the research question. This relates to any sentence, phrase or remark that answers any of the research objectives. After the transcription of the interviews, I went on to summarize the answers in the questionnaires and organized them into themes. I tried to use the same method to organize the answers from the questionnaires as well. This strategy gave a focus to my analysis

CHAPTER 6

6.0 PRESENTATION AND ANALYSIS OF EMPIRICAL DATA

This chapter deals with the way collected data was organized and interpreted.

6.1 Reasons for the upgrade

Majority of the respondents (19) said they were aware of the upgrade even before the news was made public through the media. Auntie Ama who is 59 years old says

“my superior told me that due to my hard work and dedication, our clinic was going to be upgraded”

Jennifer had this to say, *“I heard it at one of our staff meetings, I was happy but I knew that it will also mean more patients for us to attend to”*

As can be seen, although these nurses were informed of the upgrade, the true reason for the upgrade was lost to them. Through my interview with one senior nurse, it was revealed that government wanted to upgrade the clinic to a hospital level because of the creation of the new district and also in fulfillment of government’s plan to provide at least one public hospital in each district. Management failed to explain the exact reasons behind the upgrade. Nurses were not given the opportunity to make contributions to the impending change. The nurses felt they were at the receiving end of the table. Much like the results of Wynne 2004 where the nurses felt their views were not sought in the restructuring process.

One senior nurse had this to say, *“It was a government project, it was planned by government and we had no right to seek our workers view. This was an external matter”*

Although the nurses felt their views were not sought in the all process, I think Information dissemination mechanisms in the hospital is quiet good besides, government projects are usually designed by experts or consultancy organizations. If these companies do not do feasibility studies, then the nurses’ views will surely not be sought before the project sets off.

6.2 Source of funding for the project

The source of funding for the project is important because donor countries and agencies primarily determine what type of health intervention or strategies should be initiated. The Global Fund is a health financing organization that aims at fighting these three diseases, HIV Aids, Tuberculosis and Malaria. This explains why a unit for the care of HIV Aids patient had been established after the upgrade. Malaria treatments options had also been improved as well as treatments of tuberculosis in the hospital.

Most nurses (18) were not aware of where funding for the project came from. A few said they knew government was providing money for the project.

I know government is providing money for the upgrade, what I don't know is whether any donor country is giving us money in addition.

Another respondent: *truly, I do not have an idea where the money is coming from. Maybe it's from a donor country. I don't know.*

However, a senior nurse, who is clearly a member of the management team, said the project was funded by the ministry of health with funds from the Global fund. It is not clear why management decided to keep this information from the nurses. They probably thought it was not their job to know.

6.3 Relevance of nurses' former competencies for their new work roles

Majority of the nurses reported no change in their work roles or positions after the upgrade. As such, their competencies were still relevant to the task they performed after the completion of the upgrade.

I am still a Child Health Nurse (CHN) and I still perform the same duties as before. I give immunizations to children, I measure their weight, I give health educational talks, I do home visits of new mother and I give family planning advice to nursing mothers.

Another said: *My duties have not changed at all; I still do the same thing I used to do. The only change is that I now do it for a larger number of patients than before*

A few however got promoted to supervisory positions in charge of managing certain diseases. Those nurses were deemed to have long service and experience that made it possible for them to get these positions. This category of nurses had additional training in general management courses and management of specific diseases such as stroke and People Living with HIV/AIDS (PLW HIV/AIDS)

Quote:

I used to be a midwife officer. After the upgrade I was promoted to senior midwife officer. I am now in charge of the nurses in the delivery room and I do a lot of supervising. I organize in-service training seminars for the junior midwives from time to time.

Another nurse had this to say:

I attended various seminars to equip me in my new position as a superintendent nurse. I had training in NHIS, supervision, quality assurance and integrated management of neo-natal and childhood illnesses.

And another; *I had a lot of in-service training programs to equip me to take up the challenge.*

When probed further concerning the kind of training she had received, she said,

We have new equipment like monitors and others that we use when delivering a baby. Me and some other nurses had training in how to use these machines.

Yet another; *I attended a refresher course for 2 weeks to enable me learn new skills and the use of some equipment in my department.*

6.4 Nurses' perception of workload after the upgrade

Many of the respondents reported of an increase in the number of patients to the hospital. This is understandably relevant since the facility has been upgraded to a district hospital and is now responsible for providing health services to a wider geographical area. One nurse said:

Lots of people from surrounding communities are now coming to us for care. We were formally providing health services to a small number of patients but now our clients come from other communities as well

Most respondents said that because of the availability of new medical equipment, the number of cases they treat has increased. One nurse had this to say;

We now have monitors to check the pregnant women and we can perform an operation to remove the baby when complications arise. We are also able to treat severe malaria cases now than previously.

A few of the respondents (12) mentioned the fact that there are now fewer referral cases. She thinks that this is because of the many facilities that the hospital now has. These include a blood bank, laboratory services, an operating theatre and x ray services.

Formerly, we did not have a blood bank, an operating theatre and laboratory services. So patients who needed these services had to order them privately from other hospitals but when the upgrade was completed, we had all these in place and this equipment have helped us to provide care for more patients groups.

Another said: *we now have cases referred to us by other health centers since we are now a district hospital but formerly, we used to refer patients to other hospitals*

Some of the nurses however complained that, they feel a lot of pressure on them to deliver care to more patient than before.

I feel I have to do more work now than before. This is because the number of patients I used to attend to has increased but my working hours has not. t

Another one said:

There is shortage of nurses here, our clients have increased, and the diseases we treat have also increased. I now attend to more patients in a day than before.so i have to manage my time well. This means a little less time with each patient than before.

One nurse lamented

We are faced with more challenges such as understaffing and more workload for the few staff at post. I have to do overtime because of few staff available. I also feel stressed out.

This is because they had so many patients to attend to and in the end, they feel overworked. Similar findings were reported by Wynne's study of Australian ICU nurses in 2004.

MAIN RESULTS

I found out that nurses believed their workload had increased after the upgrade. They supported this with the large numbers of patients who now sought health services from the hospital due to the enlargement of the geographical area that is now in the hospitals' catchment area. Moreover, the hospital now had the capacity to care for several diseases that were formally referred to bigger hospitals, for example, severe malaria cases. The nurses argued that this is made possible by the availability of sophisticated machines and other medical equipment that is now used in the treatment and care of various diseases and ailment.

Furthermore, I found out that nurses remained in their former positions after the upgrade. For those who got promoted, demands for new skills were facilitated by on-the-job training and development. These training programs enhanced their competencies in order to aid effective performance in their new roles. Their essential competencies were still very much relevant to the new position refinement however, was necessary to aid performance.

Additionally, some nurses complained of burnout and stress in doing their work. They reasoned that, apart from having to attend to large numbers of patients, they had to contend with a reduction in their working pace in order to accommodate the new and less experienced nurses who had been employed after the upgrade. It means working and teaching at the same time as one nurse asserts.

CHAPTER 7

7.0 RESEARCH ISSUES AND LIMITATION

7.1 Formal approval of the project

Yin (2011) asserts that the success of any research depends on people's willingness to participate in the project. Therefore, I sent a letter to the hospital administrator outlining the purpose of my study and asking for help in selecting the nurse who formed my research group. Involving people as research participants carries ethical obligations to respect their autonomy, minimize their risks of harm and to treat them fairly. For these reasons, informants who accepted to be part of the study gave their voluntary informed consent to participate in the study by signing a written statement. In return, I assured them their confidentiality and anonymity, and that no written or audiotaped personal information or position was to be disclosed. In addition, I repeated the purpose of the study at the beginning of each interview, namely; that this research study was for educational purposes, and that I did not represent any office or authority.

7.2 The rigor in research method

In social science, "the concepts of generalizability, reliability and validity have reached the status of scientific methodological holy trinity that appears to be worshipped with respect by all true believers in science"(Kvale, 1996:229). He suggests that no scientific investigation will be completed without giving some attention to these concepts. I will therefore discuss them here briefly.

7.2.1 Generalizability

Yin (2011:98) insists "generalizability is concerned with how the study can derive greater value if its findings and conclusions have implications going beyond the data collected. Generalizability is concerned with the transferability of the findings and conclusions generated in one setting, to other settings". "Generalizability refers to the extent to which one

can extend the account of a particular situation or population to other persons, times or setting than those directly studied (Maxwell, 2002:52-53). Mason (2002) asserts that understanding the issues in focus will form the basis for wider resonance in similar settings. However, humans are complex and so are their experiences and interpretations of events and changes that happen to them. Besides, Kvale, (2009) asserts that achieving generalizability in qualitative enquiry is difficult owing to the manner in which samples are obtained and respondents are selected. He also argues that, consistent demands for the social sciences to produce generalizable knowledge may involve an assumption of scientific knowledge as necessarily universal and valid for all places and times, and for all mankind. It is however necessary to conceive social knowledge as socially and historically contextualized modes of understanding the world. Similar to these observations, I tried in my analysis to put emphasis on critically assessing informants' statements and producing convincing arguments and explanations.

7.2.2 Validity

Mason (2002:39) asserts that “validity means that one is observing, identifying or measuring what one says one is”. Similarly, validity is associated with operationalization of concepts, where concepts can be identified, observed or measured in the way one says they can. First, this research responded to the validity of data generation by applying more than one method to gather data, namely interviews, literature reviews and questionnaires. Second, validity depends on the interpretation of the data generated through a reliable research process (Mason 2002). In this case, attention was directed to the quality and rigor with which I interpreted and analyzed data from the nurses. This helped to determine whether data from these three sources observed and identified the intended concepts.

7.2.3 Reliability

According to Kvale (1996:235) reliability “pertains to the consistency and trustworthiness of research findings»; it concerns whether the interview subjects will change their answers during an interview and whether they will give different replies to different interviewers. Moreover, reliability encompasses the accuracy of the research methods and techniques, from collecting, processing, analysis and interpretations of the data by the researcher. In this study,

the research samples were based on how accurate, reliable or authentic a set of data could be generated from these samples. For the purpose of reliability, I chose informants who had experienced working during the clinic era and are still working in the hospital at present. I am therefore confident in my analysis that a replication of the same methods and strategies, under the same conditions will produce similar conclusions.

7.3 Limitations of study

Although the purpose of this research endeavor was achieved, I am aware that there are some limitations. Firstly, my initial plan to use interviews exclusively proved futile when I got to the field. To my surprise, I was told that conducting the interview with 20 nurses was not possible due to high numbers of patients who needed to be taken care off. Secondly, some of my respondents did not want their views to be recorded for various reasons. I then suggested we take the interviews after work was over for the day. This strategy worked for only the 3 interviews that I managed to conduct.

Indeed I had to find other ways of gathering the data. So in consultation with my supervisor and the hospital administrator, I set up a questionnaire and made it available to 22 nurses who answered them.

Methodologically, I made use of interview, questionnaires and hospital documentation. When it got to the point of analysis, I realized analyzing the data from these 3 sources became cumbersome but in the end, I managed to extract and make meaningful arguments from the raw data. Owing to the small nature of the sample, (25) it will be difficult to generalize the results of this thesis to larger groups. Contextualization may however be achieved since the project was primarily situated in a context of an upgrade.

Furthermore, in analyzing the data from the questionnaires, I noticed that some of the answers were not really clear to me and I would have wished the subject was present for me to probe further in order to gain clarity of what she meant. However, this was not possible to achieve. Although these situations were few, I acknowledge that they may have impacted the results of the study. Future research efforts should try to use triangulation of several methods which I believe will help mitigate this shortcoming.

Finally, there was also the issue of power asymmetry in the selection of informants. The hospital administrator gave me a note to present to the first informant who was purposively selected. This one then directed me to the next informant; essentially through snowballing. I am aware that this note from the administrator may have influenced or coerced some of my informants into participating. I however assured them that, anyone who wanted to redraw from the study was at liberty to do so at any time if they so wished which none did.

CHAPTER 8

8.0 DISCUSSIONS

In this study, the researcher set out to find out how upgrading a clinic to a hospital has affected the nurses perception of the adequacy of their competencies to handle the enlarged responsibilities, and workload of nurses who stayed at the post after the upgrade had been completed. In so doing, I set up an interview schedule and conducted interviews with the help of semi- structured questionnaires. I was expecting to see a change in the role or position and workload of nurses and to find out how this serves as a challenge to their competencies or ability to carry out their duties. The results I obtained were revealing.

8.1 Knowledge of upgrade

Firstly, my results showed that most nurses were aware that the government was upgrading the clinic to a hospital. Most nurses however, did not know that this was in fulfillment of government's policy to provide a public hospital in each district of the country. This was however, known to management. Some of the nurses felt that it was not in their interest to know the details, but others thought full information disclosure on the part of management on this issue was necessary.

8.2 Increases in workload

Workload refers to any duty that a nurse performs in relation to her patient from start of work to close of work. Majority of the nurses reported an increase in their workload (Michalski, 2000). This was initiated by 3 major factors. Firstly, the hospital is now serving a wider geographical area, a district. In essence, those patients who would have otherwise sought health care at other hospitals are now included in this catchment area, Dangme west district. Also, the number of diseases that the hospital is now able to treat has increased. Pregnant women with complications, likewise people with HIV Aids who were formally referred are now given care in this hospital.

Apart from the expansion in the physical structures and reorganization of units and departments, there are also increases in number of facilities, services and medical equipment and devices at the disposal of the hospital enabling it to provide advanced and complex care to patients. In contrast to Wynne's (2004) study where they nurses were more focused on using hospital materials more carefully, the nurses in my study felt the focus was on providing the best care for the patient.

8.3 Competence relevance

Additionally, relevance of competency to new work role or position is of significant interest to me as this formed the heart of my research. I was expecting a change in nurses' position or work role resulting from the upgrade, however, what I found was that the majority of the nurses maintained their positions. This could be explained in the light of the fact that, they have special training and indoctrination. The powerful coordination function that this training gives them within the group of health professional where nurses perform their duties. Also because these people usually perform their jobs in teams of professionals, changing their position will mean a removal from the group within which one is able to perform or function. In essence, it makes the person non-functional since his duties have to be performed in a chain manner in collaboration with other health professionals. This is not to say that public health nurses cannot progress to higher levels of responsibilities.

8.4 Promotion as a result of upgrade

My results show that some had been promoted and gained additional responsibilities. For example, one nurse was promoted from a midwife nurse to senior midwife nurse after the upgrade. She performed the same duties as a midwife but had added responsibilities in the form of supervising and conducting training programs for her subordinates. I can conclude based on my findings that, nurses' competencies were also upgraded to meet the added responsibilities that some of them had taken on as a result of upgrading the clinic. In terms of their perception of these changing roles, most of them found it important to be given such recognition. It enhanced their sense of satisfaction

8.5 Burn-out resulting from upgrade

Moreover, my results revealed some of the nurses experienced burn-out (Moore, 2001). They felt they were always working under pressure to provide health services to their patients (Wynne, 2004). This resulted in less time spent with the patient compared to how much time they spent with each patient before the upgrade. Some nurse thought this phenomenon was negatively affecting their sense of 'caring' and 'nursing'(Doherty, 2009).

Additionally, my findings revealed new nurses were employed after the upgrade to boost the staff strength (Burke, 2005). However, some of the public health nurses who stayed at the post after the upgrade felt the new nurses were less experienced in the practice. Working with less experienced nurses meant that, the experienced ones had to slow down their working pace in order to accommodate the less experienced ones. It also means attending to patient's needs and literally teaching the new nurses at the same time. This is time-consuming and difficult as well.

8.6 Donors interest served

Finally, given that, malaria and HIV/Aids are common diseases in Ghana claiming the lives of thousands in the country, Global fund's interest in the fighting HIV Aids, Malaria and tuberculosis is clearly seen in the upgrading process. A new department is dedicated to the care and treatment of People Living with HIV Aids (PLW HIV Aids). The center's main aim is to give information to patients on management of the disease and the administration of anti-retroviral drugs. Treatment of severe cases of malaria is also given a boost with new equipment and diverse treatment strategies.

8.7 Theoretical explanation

Theoretically, my results confirm the basic idea that job dissatisfaction, burn-out and depression are associated with jobs with high workload demand and low decision latitude (Landsbergis, 1988; Karasek, 1979). Nurses complained of increased workload due to the large numbers of patients who now sought health services from the hospital. This could be as a result of the nature Nurses predetermined work roles and routines that leave them with little

decision altitude. Job demands for new work roles were facilitated by on-the-job training and development programs organized by the management of the hospital.

8.8 CONCLUSIONS

This thesis has tried to investigate how upgrading a clinic to a hospital has affected public health nurses' competencies and how this can be explained in light of the theory of Job Demands-Control Model. Using qualitative interviews of nurses, examination of Government documents and administering questionnaires, this thesis has helped broaden our understanding of hospital restructuring and upgrades in particular.

The upgrade introduced a lot of changes to both the physical infrastructure and the way work was formally organized. Becoming a hospital invariably increased the number of patients who sought health services from the hospital. Public health nurses who stayed after the upgrade had been completed complained of large numbers of patients seeking care from the hospital. The nurses felt they had limited time to provide health services for the patients and therefore had to work under constant pressure and working overtime resulting in burnout.

Consequently, nurses thought they were losing out on the *nursing* and *caring* (Doherty, 2009) component of their job. On-the-job training programs helped those who had been promoted to higher levels of responsibilities where job demands for new skills were essential. These training and development programs contributed to effective performance in their new work roles.

This thesis has contributed to our understanding of hospital restructuring including upgrades by revealing and exposing the complexities in nurses' day-to-day working lives with patients.

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Appendices

Appendix I

LETTER OF INFORMATION TO INFORMANTS

I am a master student studying Health Economics, Policy and Management at the University of Oslo. I am currently writing my master thesis about the subject “how does change or restructuring affect nurses’ workload and competencies”. With this study I want to investigate how you as employees of this hospital feel about the change, upgrade or restructuring that has turned the former clinic into a hospital and how you think it has affected your workload and competencies. Do you have more responsibilities now than you did when you worked in the clinic? Did you have to undergo additional training to help you cope with the demands of your new work roles? Etc. The intention is either to confirm or criticise Mitzberg (1983) theory of the Professional bureaucracy.

I want to conduct as many interviews as possible and to deeply dwell on each informant’s experience. The questions would, for example, centre on your views about the change and how your workload has evolved as a result of this upgrade.

The data gathered will form the bases for writing my master thesis and as it is an academic exercise, your identity will be kept anonymous according to the strict rules pertaining to research ethics at the University of Oslo.

I will be taking notes during the interview. The interview will last approximately 20 minutes and it will be recorded.

Appendix II: Interview Guide

Personal information:

Age:

Education level:

Position:

How long have you been working in this hospital?

How long have you worked in this institution during the clinic era?

Do you know why the clinic was converted \ change into a hospital? (Reason for change)

Who in your opinion was responsible for this transformation\change? (Source of change)

Do you know where management got the money to undertake this transformation? (Source of funding)

What was your position during the clinic era?

What duties did you perform during that era?

What is your position now since the clinic changed into a hospital?

What duties do you perform now in your current position?

Do you think your previous abilities help you in performing your work in this current position?

Did you undergo training that you think has helped you in doing your current duties?

How has the change affected your work with other nurses?

Is there anything you wish to add or throw more light on?

Figure 1: Institutional Structure of Ghanaian Public health Services

