Impact of Absenteeism Practices on the Performance of the Gabriel Toure, Point-G and Kati University Hospital Centers in 2023.

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ABSTRACT

Introduction: The availability and quality of care provided in a healthcare facility depend on the quality of its technical and human resources, as well as the actual presence of staff during working hours. The functioning of healthcare facilities in developing countries in general, and in Mali in particular, is characterized by numerous dysfunctions. In addition to these shortcomings, there is the issue of absenteeism, which affects the quality of care provided in healthcare facilities and the performance of hospitals**. Objective:** The objective of this study was to evaluate the impact of absenteeism on the performance of the Gabriel TOURE, Point-G and Kati University Hospitals in 2023. **Methodology:** This was a cross-sectional analytical study using a mixed-methods approach (quantitative and qualitative), a hypothetico-deductive method, and a positivist epistemological framework. The study included 309 staff members and 12 administrators. A structured questionnaire was administered to technical and support staff, and interviews were conducted with administrative staff. The target population was also subjected to direct observation. The qualitative data underwent content analysis using NVivo 11, and a statistical analysis with a significance level of 5% was performed on the quantitative data using SPSS 21. **Results:** Absenteeism, encompassing its components (lateness, justified absences, and unjustified absences), is a widespread problem in our hospitals. The study revealed an absenteeism rate of 30.72%. These poor practices stem primarily from family/social reasons, working conditions, demotivation, and a lack of commitment. The performance evaluation of university hospitals revealed a poor performance level of 38.37%. The study also demonstrated the influence of absenteeism on the performance of the University Hospital Centers of Point-G, Gabriel Touré, and Professor Bocar Sidy Sall in Kati (as measured by Fisher's exact test, which showed a score of 0.028 for absenteeism). Therefore, we affirm that absenteeism has an impact on the performance of the University Hospital Centers of Point-G, Gabriel Touré, and Professor Bocar Sidy Sall in Kati. **Conclusion:** Combating absenteeism in hospitals requires a new perspective and new practices. For this fight to be effective, it is necessary to shift from a curative approach (punishment) to a preventive approach targeting the root causes, known as determinants.

Keywords: Impact, Absenteeism, Performance, University Hospital Center, Mali

INTRODUCTION

Worker productivity is essential to the success of organizations such as healthcare facilities. However, absenteeism undermines this productivity (DHAINI et al., 2015). Absenteeism is a persistent problem for hospitals. It reveals various dysfunctions affecting employees' ability to be present at work when required. Excessive absenteeism disrupts hospital operations, and its performance suffers (ROUSSEAU Thierry, 2012). According to Statistics Canada data, in 2020, the average number of days of absence in Canada was 11.6 days per full-time employee (Government of Canada, 2021).

In the United States, employees are absent on average seven (7) days per year, while in the United Kingdom, it is five (5) days. Absenteeism has a very high cost for the Canadian economy. In 2012, employee absenteeism resulted in a $16.6 billion loss for the Canadian economy, according to a 2013 study by the Conference Board of Canada. In France, national statistics show that not only are absenteeism rates two to three times higher in the public hospital sector than in other sectors of the economy, but the gap continues to widen (an 8% increase for hospitals in 2010, for example, compared to an average decrease of 1% elsewhere). Absenteeism rates vary between 9% and 14% depending on the institution. This means that each day, in an institution with 5,000 employees, for example, 500 to 700 are absent, in addition to annual leave, reduced working hours, etc. (BRAMI et al., 2014).

According to a study "on the origin and cost of absenteeism in France" published in 2018 by the Sapiens Institute, a liberal think tank, the cost of absenteeism amounts to… 107.9 billion euros per year (LEPETIT Bérangère & LOMAZZI Marc, 2018)! In Africa, avoidable absences that do not comply with legislation are common in formal companies due to the predominance of the number of people working in the informal sector (POGNON, 2009). This practice is widespread in the civil service in West Africa, as evidenced by the following statistics showing the percentage of users who reported a civil servant absent from work in certain cities: Ouagadougou (53.6%), Dakar (47.6%), Lomé (46.1%), Bamako (43.4%), Cotonou (41.6%), Niamey (38.0%), and Abidjan (35.3%) (KANTE, 2020).

The literature in management science demonstrates that performance is a polysemous, ambiguous, subjective, multidimensional, and dynamic concept. In this context, Wittgenstein (2010) and Issor (2017) argue that performance is a catch-all term, a vague and multidimensional concept that only acquires meaning within the context in which it is used. For the World Health Organization (WHO), hospital performance is multidimensional. It is defined as an institution's ability to mobilize its resources efficiently to improve overall health, meet the population's expectations, and ensure financial equity, while providing quality care (Caroline, 2018). Several methods or models have been developed to measure hospital performance. Countries such as the United Kingdom, the United States, Canada, and Australia have been using one or more frameworks for several years to model the overall performance of healthcare facilities. Similarly, the WHO and the OECD each have their own benchmarks for comparing international hospital systems (Hamdaoui, 2023).

Arah et al. (2003) conclude that a certain convergence exists between the different models or methods used to measure this performance. This convergence highlights indicators such as efficiency, clinical effectiveness (quality and appropriateness of care, safety, outcomes), and equity of access (financial, geographic). According to Markaoui & Hassine (2018), effectiveness is defined as the capacity of a healthcare facility or service to achieve its set objectives, whether qualitative or organizational. Efficiency is the optimal use of inputs by the hospital to obtain maximum outputs, given the available resources (Veillard et al., 2005). Health equity refers to "the absence of systemic and potentially remediable differences in one or more aspects of health among the population that are defined socially, economically, demographically, or geographically" (The World Bank, 2006). This is the model we are adopting for this study.

Objective

The overall objective of this study was to evaluate the impact of absenteeism on the performance of the Point-G, Gabriel Touré, and Professor Bocar Sidy Sall University Hospitals in Kati in 2023.

METHODOLOGY

This was a multicenter, cross-sectional, analytical study employing a hypothetico-deductive approach and a mixed-methods methodology. The study population consisted of all staff members of the Point-G University Hospital (526), the Gabriel Touré University Hospital (762), and the Professor Bocar Sidy Sall University Hospital of Kati (279), for a total of 1,567. After calculating the sample size, the study included 309 staff members (distributed proportionally among the three University Hospitals) and 12 administrators (4 per institution). For this study, we used a non-probability sampling method with purposive sampling to interview the managers of the three University Hospitals; and a probabilistic sampling method with systematic sampling

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(sampling interval 5) for surveys of staff members at the three University Hospitals. Data collection was carried out using a structured questionnaire to gather information from staff, an interview guide for semi-structured interviews with administrators, a document processing sheet for the analysis of secondary data, and an observation grid to verify staff presence. Testing to improve the wording and correct any shortcomings in the data collection tools was deemed a necessary prerequisite. Therefore, the tools were tested on staff members identical to those likely to be included in the sample within each organization. Following this, the revised, corrected, and improved tools were used for data collection.

For the quantitative component, data was collected using a paper questionnaire, entered into a template, and analyzed using Excel and IBM SPSS Statistics 20. For the qualitative component, the data was first transcribed into Word after collection and then subjected to content analysis.

This study received approval from the Scientific and Professional Development Committee of the National Institute for Health Sciences Training. Furthermore, the administrations of the three (3) hospitals responded favorably to our request for authorization to collect data within their institutions. Following this, we began data collection in the hospitals concerned. Obtaining free and informed consent was a prerequisite for the commencement of each survey or interview.

RESULTS

The average age in our study was 39.68 years with a standard deviation of ± 9.34. The sex ratio was 1.26 in favor of men. Married individuals were the majority at 82.8%, and the sample was primarily composed of nurses (33%), followed by medical assistants (18.8%), with 58% being civil servants. Employees with 0-10 years of service were the most represented in the study (52.4%). Over two weeks of observation based on daily attendance records, we noted a lateness rate of 40.8% and an unjustified absence rate of 27.8%. Among those who were absent during the observation period, 2.59% had authorization for their absence from the administration. Thus, the absenteeism rate was 30.72%, taking into account both justified and unjustified absences. The performance evaluation of the three (3) facilities yielded scores of 48.41% for technical performance, 0.97% for economic performance, 59.03% for political performance, and an overall poor score of 38.37%. Among our respondents, 95.5% stated that absenteeism had an impact on the performance of university hospitals. Among the reasons for absenteeism, family/social reasons were the most frequently cited (43.7%), followed by working conditions (20.7%). The study also demonstrated a significant link between absenteeism and the performance level of university hospitals, with a p-value of 0.028 at the 5% significance level. A total of 10 themes were extracted from the interviewees' comments. These 10 themes were grouped into three categories, and these categories were then grouped into a single section. Following the analysis of the verbatim transcripts, we determined the frequency of each theme and its cumulative frequency. The total frequency of occurrence of all themes was 86, corresponding to 3 categories. After counting the variables, it emerged that the theme of poor performance was cited 19 times in the interviewees' discourse, representing an occurrence rate of 23.17%. This demonstrates the significant importance that the interviewees place on the performance level of their organization. The theme of contemplative presenteeism was cited 16 times, representing an occurrence rate of 19.51%, and ranked second. The theme of "unjustified absence" was cited 16 times, representing an occurrence rate of 19.51%, and ranked second. The theme of "delay" was cited 13 times, representing an occurrence rate of 15.85%, and ranked third. The fact that these independent variables were cited in second and third position demonstrates that the interviewees are aware that these two practices are counterproductive and detrimental to the performance of university hospitals.

DISCUSSION

In our study, we found the following: an average age of 40 years, a sex ratio of 1.27, and an average seniority of 9.81 years. These results are comparable to those of seniority; the average in our study was 9.81 years, which is similar to that of Muckenhuber et al. (2014), who obtained an average age of 41.69 years, a sex ratio of 1.08, and an average seniority of 9.5 years in their study on income inequality as a moderator of the relationship between psychological job demands and sick leave: an international comparison of 23 countries.

The main reason for absenteeism in our study was family/social reasons. This is supported by the responses of some interviewees regarding the reasons for absenteeism: for R4, "social reasons, illness, working conditions," and for R9, "social events, extreme fatigue, recruitment methods." This is similar to the findings of Mukasa et al. (2019) in their study on the Organizational Factors Affecting Health Worker Attendance: Results from Southwest Uganda, in which family/personal reasons were the primary cause of absenteeism.

Our study revealed an absenteeism rate of 30.72%. Our results are higher than those of Goïta (2017) in his study on the determinants of human resource management in hospitals, which revealed an absenteeism rate of 23.33% in Luxembourg, and those of Tchuinguem (2009), who obtained a rate of 7.2% in his study on the extent, costs, and personal and occupational factors of absenteeism in the public hospital sector in Cameroon. Our results are, however, lower than the 53% found among hospital staff in Nigeria by Isah et al., 2008. Our results are also lower than the 74.29% obtained by Becker & Oliveira, 2008 among nursing staff in Brazil. The overall performance level of university hospitals was poor. Interviewees R7, "Not sufficient, given that the hospital consistently ranks last. One reason for this is that records are poorly maintained and most activities are not documented," and R11, "It's bad. There are constant strikes due to staff demotivation and discrimination among employees. Financial irregularities, inadequate equipment, and poor sanitation are also contributing factors. Our findings are comparable to those of Ahanhanzo et al. (2014), who found a very low performance level in their study evaluating the performance of Comè Hospital in Benin, as well as to those of Nabukeera et al. (2015) in their evaluation of health centers and hospitals in Kampala City, Uganda, where the performance level was also mediocre. Our results are also comparable to those of Bara et al., 2020 in their study on the performance analysis of the Tengandogo University Hospital Center (CHU-T) in Burkina Faso where the level of performance was unsatisfactory.

Our study found that absenteeism had a negative impact on the performance of university hospitals (CHU), with a p-value of 0.028 (< 0.05). According to our respondents, managing absenteeism is very complex because absentees always hide behind social reasons to justify their absence to their colleagues or superiors. However, everyone knows that social norms are deeply ingrained in our traditions. Thus, 95.5% of our respondents stated that absenteeism had a negative impact on the performance of university hospitals. Furthermore, interviewee R1 believes that "absenteeism can prevent certain tasks from being carried out, which will be a loss for the institution. This can affect performance because if one person is absent, other staff members are forced to exert more effort than necessary, which in the long run will lead to burnout among these employees." R8 states that "the influence of absenteeism on hospital performance is evident because it's a chain of operations; when an employee is absent, it disrupts the smooth functioning of the chain's activities. This is especially true in our hospitals where human resources are insufficient. Furthermore, repeated absences by some without consequences can lead others to do the same." Our results are similar to those of Brahim Abakar (2022) in his study on social dysfunctions and staff performance in public health facilities in the city of Sikasso, which found that the components of absenteeism negatively influence staff performance by 63.2%. Similarly, Adams & Bond (2003) showed that inadequate staffing levels were implicated in the increase in errors in patient care. Rousseau & Pénicaud (2012) also affirmed that absenteeism is closely linked to what is traditionally understood as performance and efficiency. The main limitation of this study was the lack or insufficiency of data at the university hospital level, which prevented us from calculating the financial and organizational costs of absenteeism in these facilities. Furthermore, given the time and resources available, we were unable to conduct a longitudinal study on absenteeism in urban, peri-urban, and rural healthcare settings. The lack of comparison between absenteeism management policies across different healthcare facilities in Mali also remains a limitation.

CONCLUSION

Absenteeism among healthcare staff, particularly in hospitals, is a complex problem with multiple causes and significant consequences. This study has revealed that absenteeism is a reality that hinders our University Hospital Centers. The factors contributing to this dysfunction, such as staff demotivation, unfavorable working conditions, and a negative work environment, are levers that hospital managers must address to quickly contain this phenomenon, which is growing daily. Reducing absenteeism among healthcare staff therefore requires a comprehensive and proactive approach with targeted prevention measures for the well-being of patients in

general and staff in particular. To fully understand the scope of this phenomenon, it would be advisable to extend this study to all healthcare facilities in Mali.

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ANNEXES

Hospital Performance Evaluation Criteria:

To measure the performance level of our three university hospitals, we defined criteria for each of the three (3) dimensions mentioned above, taking into account the Malian context.

- **For the technical dimension**, the criteria are: consultation rate; hospitalization rate; medical assessment rate; medical imaging rate; surgical procedure rate; in-hospital mortality rate; maternal mortality rate; and average length of stay.

For these criteria, we determined the different rates using the following calculation:

Rate = (Actual)/(Forecast) × 100

Indicators such as: consultation rate; hospitalization rate; medical assessment rate; medical imaging rate; and surgical procedure rate were assessed using the table below:

Table I: Performance Evaluation Criteria: Jean Claude Bernatchez (2003)

Criteria	Appreciations
80 to 100 %	Very good
60 to 79 %	Good
40 to 59 %	AVERAGE
20 to 39 %	Bad
0 to 19 %	Very Bad

- **Average Length of Stay (ALS):**

This indicator was measured by defining a scale based on the average ALS of OECD countries in 2015, which was 8 days.

Table II: Criteria for assessing the average length of stay.

Criteria	Appreciations
0 to 2 days	Very good
2 to 4 days	Good
4 to 6 days	AVERAGE
6 to 8 days	Bad
8 to 10 days	Very Bad

Source: author

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- **In-hospital mortality rate**
- **Maternal mortality rate**

These indicators were measured using a scale based on the 2014 World Health Statistics (WHO, 2014): Minimum = 1.1 per 1000 ≈ 0.11%; Average = 7.6 per 1000 ≈ 0.76%; and Maximum = 17.1 per 1000 ≈ 1.71%.

Table III: Criteria for assessing mortality rates

Criteria	Appreciations
0 to 0,5	Very good
0,5 to 1	Good
1 to 1,5	AVERAGE
1,5 to 2	Bad
2 to 2,5	Very Bad

Source: Author

- **For the economic dimension**, the criteria are: the fundraising rate and the activity implementation rate.
- **For the political dimension**, the criteria are: the number of impoverished, indigent, and eligible individuals receiving assistance; and the total number of impoverished, indigent, and eligible individuals who requested assistance.

Table IV: Results of performance indicators by structure.

Type of performance	Indicators	Gabriel Touré	Point-G	BSS de Kati	Performance level
		RESULTS			
Technical performance = Efficiency	Consultation rate	69,53	64	95,32	**48,41**
	Hospitalization rate	88	49,76	96,13	
	Medical imaging rate	56,14	53	91,71	
	Medical assessment rate	59	28,61	79,41	
	Surgical procedure rate	81	71	104,53	
	Maternal mortality rate	3	3,32	2,81	
	In-hospital mortality rate	21,9	14	8,43	
	Average length of stay	9	5	7	
	Fund mobilization rate	88	98	100,46	**0,97**

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Economic performance = Efficiency	Activity implementation rate	81	89,75	97,11	
Political performance = Equity	Total number of social assistance requests	3341	885	1322	**59,03**
	Number of requests fulfilled	711	495	1322	

Source: authors

The results in the table show us that the performance level of the three (3) structures was 48.41% for technical performance, 0.97% for economic performance and 59.03% for political performance.

Table V: Overall performance level of the three (3) structures.

University Hospitals	**Types of performance**			Overall performance level	Performance level matching.
	Technical	Economic	Political		
Gabriel Touré	48,45	0,92	21,28	23,54	Bad
Point-G	36,10	0,92	56	31,00	Bad
BSS de Kati	60,67	0,97	100	53,88	Average
Total	**145,22**	**2,81**	**197,28**	**108,42**	
Average	**48,41**	**0,94**	**65,76**	**38,37**	**Bad**

Source: authors

The results in the table show us that the overall performance level of the three structures was poor, at 38.37%.

Table VI: Intersection between absenteeism and performance.

University Hospitals	Absenteeism	Overall performance					Total
		Very Good	Good	Moyen	Average	Very Bad	
Point-G	Yes	0	0	0	2	0	2
		0,00%	0,0%	0,0%	100,0%	0,00%	100,0%
	No	0	2	1	2	0	5
		0,00%	40,0%	20,0%	40,0%	0,00%	100,0%
Gabriel Touré	Oui	0	0	1	3	1	5
		0,00%	0,0%	20,0%	60,0%	20,0%	100,0%

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	Non	0	1	1	0	0	2
		0,00%	50,0%	50,0%	0,0%	0,0%	100,0%
BSS de Kati	Yes	0	0	1	2	1	4
		0,0%	0,00%	25,0%	50,0%	25,0%	100,0%
	No	2	0	1	0	0	3
		66,7%	0,00%	33,3%	0,0%	0,0%	100,0%
Total	Yes	**0**	**0**	**2**	**7**	**2**	**11**
		0,0%	**0,0%**	**18,2%**	**63,6%**	**18,2%**	**100,0%**
	No	**2**	**3**	**3**	**2**	**0**	**10**
		20,0%	**30,0%**	**30,0%**	**20,0%**	**0,0%**	**100,0%**
Fisher's exact test = 8.730					**P-value = 0,028**		

Source: Authors

The performance assessment showed that 63.6% of respondents found the performance level to be poor and also indicated that absenteeism influences the performance of university hospitals. At the 5% significance level, the p-value was 0.028, which is less than 0.05. We therefore reject the null hypothesis and accept the alternative hypothesis that absenteeism influences the performance of university hospitals.