**GRES 5136 RESEARCH PROJECT**

**MASTER IN MANAGEMENT (ODL)**

# A STUDY ON CAREER PROSPECT AND WORKING ENVIRONMENT TOWARDS JOB RETENTION AMONGST THE KELANTAN HEALTHCARE WORKERS (HCW) DURING COVID-19 PANDEMIC

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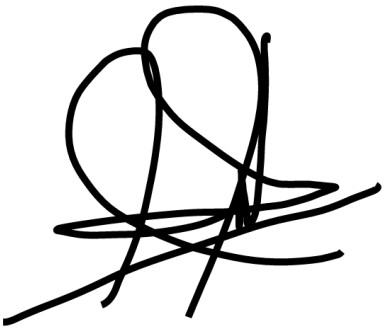
## DECLARATION

**The author hereby declares that this project paper is the original study undertaken by him unless stated otherwise. The acknowledgement has been given to references quoted in the list of references. The views and analysis in this study are that of author's, based on the references made, and this does not constitute an invitation to use this study as a technical tool for management purpose.**





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بِسْمِ ٱللَّهِ ٱلرَّحْمَٰنِ ٱلرَّحِيمِ

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## ABSTRACT

The research focus on the present issue of healthcare personnel departing in response to the pandemic cause by Covid-19 infection. Numerous research that have been conducted to determine the elements that contribute to low morale, particularly in the areas of mental health and future endeavours were examine and take into consideration. The causes of low morale among health care personnel in Kelantan will be investigated to see whether the present impact of the covid-19 outbreak in their working environment or career prospects was the primary reason prior to this.

The study collected data from health care employees in Kelantan government agencies and the private sector who handle patients at local healthcare institutions in Kelantan, either directly or indirectly. The methodology is primarily descriptive, with some correlational studies and emphasis on qualitative data. The study observed 642 respondents who responded to a questionnaire created based on earlier research and tailored to the present needs of HCWs. The questions were design using a five-point Likert scale and analysed using the SPSS program. Demographic and descriptive approaches were utilized to analyze the data, while Pearson's Correlation and regression analysis were employed to evaluate the relationship between variables in order to validate the study's premise. Findings demonstrates that career prospects have a more significant impact in job retention among HCWS in Kelantan than working conditions, which already appear to satisfy the majority of employees.

Hopefully, this study will pave the way for additional research and contribute to the practice of human capital management for HCWs in the future when confronted with similar incidences.



Key Terms: Job retention, Covid-19 Pandemic, Healthcare workers (HCWs), career prospect, working environment

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**ABBREVIATION**

CDC- Centers for Disease Control and Prevention

CMCO - Conditional Movement Control Order

FDA - Food and Drug Administration

HCW – Health care worker

IEHPs - The European Observatory on Health Systems and Policies

MCO - Movement Control Order

MERS - Middle East respiratory syndrome

MH - Mental Health

NEP - New Economic Policy

PHE - Public health emergency

PMP- Privatization Master Plan

PPE - Personal protective equipment

PTSD - Post-traumatic stress disorder

RMCO - Recovery Movement Control Order

SARS - Severe Acute Respiratory Syndrome

WHO - World Health Organization

# CHAPTER 1: INTRODUCTION

## 1.1 Background of the Study

The COVID-19 pandemic is not new and noted to be a continuation of another coronavirus recorded since early of the last century. It is now become an unprecedented challenge for the modern society. The support for maintaining the wellbeing of mental health in medical staff and affiliated healthcare workers is a critical part of the public health response recently. On 31 December 2021, Covid-19 Infection statistic indicating as below:

| Location | Cases | Death |
|---|---|---|
| Worldwide | 288,701,959 | 5.480,737 |
| Malaysia | 2,758,086 | 31,487 |
| Kelantan | 169,043 | 875 |

Table 1: The number of cases and death due to Covid-19 Infection



Doctors and other health-care professionals (HCWs) have done well and will continue to put effort in coping with the consequences of the COVID-19 pandemic. Among health-care employees, a high prevalence of pre-existing mental health (MH) difficulties is widely documented and have a severe repercussion on the best choice of care provided to patients. According on data from previous infectious epidemics, this demographic maybe at risk of mental health that keep deteriorating upon facing mass infection of a virus or bacteria. Considering the availability of fresh data on the psychological impact of comparable individuals, it appears that this population is at danger of mental health problem due to the pandemic. The prospect that HCWs will be at high risk of developing mental health problems not just during the pandemic, but also afterward, adds to the difficulties posed by these statistics.

Several aspects of the COVID-19 pandemic raise the possibility that it will have a bad impact on the mental wellbeing of HCWs that even more severely than previous pandemic. Because of the sheer magnitude of the current pandemic, both in terms of the

number of cases and the number of countries affected, everyone has come to believe that 'no one is safe' from the virus. When it comes to the pandemic, the media has repeatedly concentrated on the number of deaths among health-care professionals and the disease's spread within healthcare facilities, which may have aggravated the mental being any personnel who have a career in medical-related industry. As for the second point, conventional business practices have been significantly disrupted, with many workers being requested to in stranger places and being assigned to more dangerous roles than they had previously held.

Weakness in healthcare workers' mental health (MH) may have been exacerbated by the focus on personal protective equipment (PPE) because of the lack of clarity regarding the amount and quality of equipment, as well as the frequently changing guidance on what PPE is appropriate in specific clinical situations. There is also considerable uncertainty regarding the absolute risk of transmission. In due outcome, while it is possible that other employees were damaged because of COVID-19, the factors stated above are quite likely to cause major problem in managing the emotional wellbeing of the personnel in medical field and their family members



Even at current state of world health problem, a study conducted by the British Medical Association on May 14, 2020, found that 45 percent of UK physicians are suffering from depression, anxiety, stress, burnout, and other mental health illnesses that are related to or exacerbated by their exposure to COVID-19 during the pandemic. While there is currently little study on interventions for the mental health of HCWs, despite the availability of evidence-based psychological therapy for this population. So more recent calls to emphasize the significance of collecting high-quality data on the psychological repercussions of the COVID-19 pandemic, and several of these calls have been issued recently. These facts are necessary not just urgently, but also cautiously and scientifically rigorously, given the multiplicity of ways in which this sickness has affected society.

Factors such as high levels of stress and anxiety have been shown to lower employee morale, increase absenteeism, decrease work satisfaction, and lower the overall quality of care provided by an organisation; as a result, it is essential to understand these facts to equip health care workers to perform their responsibilities efficiently and effectively. As part of our efforts to provide health-care workers with the knowledge and skills they need

to fight back against the ravages of the COVID-19 epidemic, it is vital to recognize and address their psychological needs.

1. Personal protective equipment (PPE) problem

Despite the personal protective equipment (PPE) action that health-care workers must follow and been identified as being particularly susceptible to the negative psychological impacts of the epidemic, they do not form a cohesive group. As a result, it may be required to identify groups of HCWs who are particularly vulnerable within the larger population of HCWs and to provide them with psychological support. Specifically, the goal of this study is to determine whether any group of healthcare workers may be confidently excluded from psychological support interventions because they have a low chance of developing a mental illness. HCW support may be unsuccessful if it is approached in a one-size-fits-all manner, according to Holmes et al. So, together with a scarcity of research on the effectiveness of personalizing psychological interventions during pandemics that highlights the vital importance of identifying vulnerable groups and ensuring that they receive appropriately tailored interventions.

In the context of global shortage, policy discussions and public conversation have centered primarily on the supply of personal safety equipment (PPE). Countries should prioritize assisting healthcare workers who are on the front lines of the coronavirus pandemic early on, according to the World Health Professions Alliance, which represents many different types of health professions. Employees have been quarantined or have become ill because of difficulty to get personal protective equipment (PPE), or they have decided to stay at home rather than risk their health. Others have simply decided not to come to work at all because of the risks they face. According to a letter sent to Berlin's mayor and health minister by the Berlin Association of Statutory Health Insurance Physicians, the ambulatory care system could ground to a halt if the production for personal protective equipment (PPE) remains unstable. When COVID-19 infections were discovered in 900 out of 2500 nursing homes in the Netherlands at the beginning of April, employees who lacked sufficient personal protective equipment quit their positions.

Due to the availability of personal protective equipment, there are previously unrecognized hierarchies within the health care profession. No one addressed the threats

that personnel in administrative, transportation, and cleaning jobs faced when pleas for support for nurses and doctors first came in. Despite the fact that we are beginning to see a more nuanced perspective of the varied risk profiles, there have been times when demand from the HCWs were not taken into account when demands for personal protective equipment were made.

The inequality noted among coloured HCWs as well as the way this connects with their position in the health care system, demonstrate the COVID-19 virus's uneven impact on raced persons. A memorial dedicated to COVID-19-dead health-care workers in Canada demonstrates that coloured HCWs, particularly those employed in the rural with lack of access to health assets, have been disproportionately affected.

Even though personal protection equipment (PPE) is widely available, the gender dimension of the equipment is still visible. Personal protective equipment (PPE), for example, has been recognized as a challenge for most women in the health industry because many variations in female bodies not taken into consideration. Also, different varieties of men's facial hair have an impact on the suitability of the equipment, according to CDC research. This had to be considered by health care providers who wore turbans, hijabs, or other religious headdresses.



2. Mental Health problem

Our healthcare professionals face a unique set of challenges when it comes to communicable diseases. COVID-19, which has been recognized as a Global Public Health Emergency (PHE), presents a difficulty that interferes not only with their day-to-day work but also with their personal lives. It is expected that health care providers will face new challenges as we adjust to new ways of living and working. We found that COVID-19 had a significant psychological influence on health-care professionals, inducing high degrees of fear, despair, and sleepiness in addition to other symptoms of discomfort.

The COVID-19 outbreak brought to light a new threat to the safety of health care workers: the threat to their psychological health and well-being. According to historical precedent, the response to COVID-19 must be taken as a long-term process instead of taken it as a brief problem at hand and operating at or above maximum capabilities to keep on over the long nor medium term as expected.

Although there was some fear at the start, as the epidemic curve increased dramatically, this was quickly replaced by tiredness. Workers in emergency and critical care units are particularly vulnerable to burnout because of the long hours they work mixed with high levels of stress, pressure, and ethical demands that come with their jobs. It also entails making difficult decisions about who should have access to ventilators, as their chances of life are reduced if they do not have access to them.

Staff personnel on the front lines must also deal with difficult emotional situations when they are caring for patients who are nearing the end of their life and who are unable to be accompanied by family or friends on their journey. Due to the requirement to wear protective equipment, there is a shortage of emotional support. It also created difficulties when concerns about the country's ability to respond to the crisis overrode regulations on the appropriate time for restricted medical workers to be exposed.

Medical professionals who return home from treating patients and worry that they may have passed the illness to their loved ones are finding it difficult to sleep at night, according to a new study. When quarantined places at venues deem needed like hotel or parking spaces that available, they were used as answers whenever they were accessible. Because they need to be away from their children at the same time as they are advised to stay home with education facilities have been closed, they are faced with yet another childcare challenge. Mental (peer) support is necessary, and present crisis conditions may teach us valuable lessons that may be useful in future crises.



When doing our research, we looked for demographics that appeared to be particularly vulnerable to bad mental health outcomes during COVID-19, which could indicate a higher likelihood of quitting. When it comes to infection as a contributing factor to mental health disease, researchers from Cao et al. discovered that nurses may be at more risk than doctors of developing the condition. Several other viral epidemics have been seen in the recent past, and this is consistent with those observations. Many critics, however, claim that the researchers did not compare nurses to members of the primary care workforce or to any other categories of health-care employees since the confounding variables were not adequately addressed in the research.

| Risk factors associated with adverse mental health outcomes on health and care staff during the COVID-19 pandemic |
|---|
| Frontline staff/Close contact with COVID-19 patients |
| Nurse |
| Clinical healthcare workers |
| Heavy workload |
| Lack of personal protective equipment (PPE) |
| Point of outbreak |
| Rural location |
| Fear of infection |
| Concern about family |
| Younger age |
| Gender – Female |
| Organic illness |
| Being an only child |

Table 2: Table showing factors affecting HCWs mental health based on previous studies



Clinical HCWs were more prone than non-clinical HCWs to experience psychological distress according to study by Tan et al. that discovered that non-clinical HCWs in Singapore had a higher rate of emotional related issue than their clinical counterparts. A bigger proportion of people with poor mental health outcomes live in some nations than others. The researchers discovered that, even though the data from a comparable cross-sectional data from India and Singapore indicated a lower overall prevalence of anxiety and depression than comparable data from China. This demonstrates how conclusions can differ depending on the situation and culture. As a result of the fact that they were at different positions on the outbreak curves in their various countries, it is plausible that this had an impact, and there was evidence to suggest that it had. Researchers Tan et al hypothesized that medical healthcare staffs in Singapore had previously dealt with a SARS outbreak and were therefore mentally and logistically equipped to deal with the upcoming COVID-19 pandemic, according to the findings. This demonstrates that context and cultural characteristics, rather just the cadre or job title of the healthcare practitioner,

are more likely to be influential. The report goes on to point out how important it is to re-examine the evidence as fresh data from other nations becomes available.

In the process of doing the research, a slew of risk variables was uncovered, many of which confirmed earlier findings from previous studies on the subject. The lack of personal protective equipment, fear of infection, and a demanding workload were the ones with the strongest evidence to support them. In addition, it was revealed that intimate contact with COVID-19 cases is associated with increased levels of anxiety, depression, and sleeplessness, which is consistent with earlier outbreak findings on these symptoms. Certain investigations, such as those conducted by Li et al., appeared to produce results that conflicted with one another. Other risk factors for consideration like being younger in both age and social gender; nonetheless, this should be addressed with caution. According to the World Health Organization, another explanation for the outcomes of this study could be an increased risk of frontline exposure for women, who are disproportionately represented in lower status positions in the healthcare profession. However, it is crucial to note that most respondents in all studies (when they were broken down by gender) were female, which could have skewed the results.

Despite this, throughout the pandemic, men have continuously had a higher mortality rate and a higher probability of having serious COVID-19 disease, demonstrating that the current picture of gender and mental health is insufficient. Even though new risk variables have been discovered, it has been concluded that the degree of certainty associated with these factors is low.

In Malaysia, the implementation of Movement Control Order (MCO) estimated to cause loss of revenue up RM2.4 billion a day, with an accumulated loss of RM63 billion up to the end of April 2021. Since May 4, 2021, Malaysia has relaxed the MCO and opened its economic sector to relieve its economic burden.



## 1.2 Problem Statement

My problem statement is the increased number of healthcare workers resign or quitting due to Covid-19 Pandemic have cause loss of human capital resources for managing healthcare in Kelantan.

## 1.3 Research Objective

The research will be to study what factors giving more impact to cause low morale to Kelantan healthcare workers that choose to resign or quitting during Covid-19 Pandemic.

## 1.4 Research Questions

The research questions are the following:

1. Does low morale due to working environment or career prospect being the main cause for the low retention among Kelantan HCWs during the Covid-19 pandemic?
2. Which factors between the career prospect and working environment that indicated as the cause of low morale among Kelantan HCWs during the Covid-19 pandemic?
3. What other variables related to low morale among Kelantan HCWs during the Covid-19 pandemic?
4. Does step taken by Malaysia Ministry of Health and the Malaysian Government like vaccination, employing more contract HCWs etc help reducing the Covid-19 pandemic impact to the morale of Kelantan HCWs?



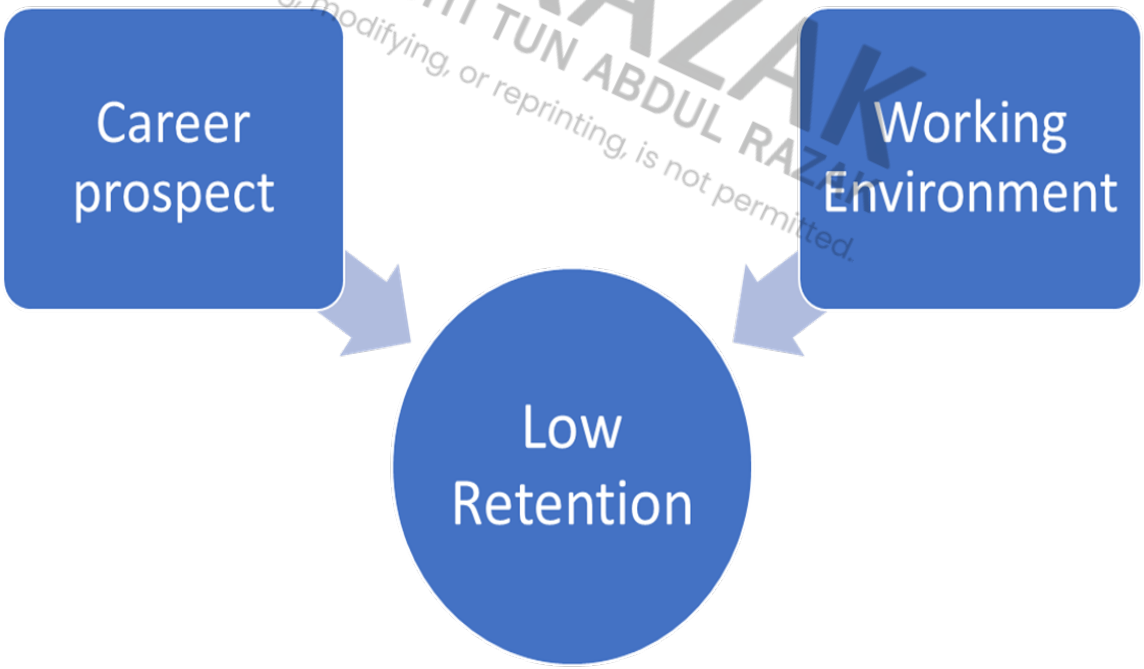



Figure 1: Factors that affecting the HCWs to quitting their jobs

## 1.5 Significance of the Study

Personnel in the medical field - the first to put their health and safety in jeopardy and the ones held accountable for COVID-19-related activities. Some 21% of healthcare employees have pondered leaving the industry, while 30% have explored lowering their hours due to COVID-19 stress (JAMA 2021). In July 2021, the situation deteriorated in Malaysia with the resignation of 15 doctors due to stress caused by the Covid-19 pandemic, which was cited as a reason for action. Healthcare personnel from states with fewer COVID-19 cases are being sent to states with a large number of red zone districts as a result of MOH mobilization (defined as having 40 active cases or more). Additionally, MOH has enlisted the help of private and retired medical professionals to help with COVID-19 management across the country, with a dedicated budget set aside to hire them on a contract basis to prevent healthcare workers from becoming burnt out and exhausted, which could have negative effects on their physical and mental health. Many members of the healthcare team are at danger of getting infected because of their work. CoVid-19 has been found in more than 500 ministry healthcare workers, and investigations have found that none of them caught the disease while working, with 70% of cases attributed to social gatherings, overseas trips, and other circumstances.



## 1.6 The Organization of the Study

There have been several things offered in Chapter 1, such as an introduction and an explanation of the topic as well as research questions and the relevance of the research to be done. On the other hand, Chapter 2 examines the literature and research that has been done on the issue under investigation, which is why HCWs in Kelantan are quitting and leaving their professions as health care providers. Chapter 3 explains the study's data collection methods and procedures. A summary of the research findings and analyses will be presented in Chapter 4. There will be a discussion in Chapter 5 as well as recommendations for future research after the study's results based on the conclusions that have been summarized.

# CHAPTER 2: LITERATURE REVIEW

## 2.1 Introduction and Theoretical Foundation

### Coronavirus

A novel coronavirus, the etiology of a bizarre pneumonia, was found in southeast China's Guangdong region in 2003. It was dubbed the SARS coronavirus, and it turned out to be the coronavirus predicted by Koch. Koch's postulates are as follows:

1. The microbe must be present in great quantities in all ill beings but not in healthy organisms.

2. For testing purposes, the bacterium must be isolated from a sick organism and cultivated in a separate pure culture.

3. Upon placed in a healthy organism, a cultured microorganism should cause sickness to the host.

4. An experimental host must be infected and affected with the causative agent before isolating the microorganism and demonstrating its identity to the original agent.

The virus was responsible for the deaths of around 10% to 15% of the population. Despite advances in medical technology, there is presently no viable medication or immunization for SARS. The emergence of a new coronavirus outbreak in the Middle East in 2012 shared several features with the 2003 outbreak. Both infections were caused by the same coronaviruses, however the intermediate host for MERS is thought to be the dromedary camel, and the fatality rate can reach up to 37% in some cases.



Except for most patients who reported fever and respiratory symptoms, the earliest clinical indicators of SARS and MERS are often nonspecific. When unprotected hospital staff meet patients' droplets or come into direct contact with them, nosocomial diseases can arise.

### Covid-19 Virus

The new highly infectious coronavirus disease, known as COVID-19, that lead to the current pandemic and had been infecting medical facilities around the world for months. On December 8, 2019, the first identification of a pneumonia outbreak with an unknown source was made in China's Hubei City, in the province of Wuhan. The Chinese Centers for Disease Control and Prevention (CDC) reported the incident to the World Health

Organization (WHO) China Country Office on December 31, 2019. The World Health Organization (WHO) formally identifies the disease COVID-19, an acronym for coronavirus disease 2019, on February 11, 2020. The Coronavirus Study Group established that the agent responsible for the infection was SARS-CoV-2, a novel coronavirus.

SARS-CoV-2 is the seventh coronavirus to infect humans, the third to cause significant sickness, and the first and only coronavirus that has the potential to produce a pandemic. It's also the world's first and only pandemic-causing human coronavirus. SARS-CoV-2 is the most recent highly pathogenic human coronavirus to emerge in the last two decades, following SARS-CoV in 2002 and MERS-CoV in 2012. In the last two decades, it has been revealed as the third highly pathogenic human coronavirus.

These coronaviruses cause respiratory illnesses in the same manner that influenza viruses do, but they are far more transmissible and possibly lethal. To disseminate the viruses, a variety of transmission pathways are used, including direct human contact, airborne droplets, and fomites, which are surfaces that may harbour the viruses for varying period, ranging from hours to days.

Viruses such as SARS-CoV-2 may survive on glass, metal and ceramic surfaces for five days; wood can survive for four days; and stainless steel and plastics for two to three days. Because of the presence of viral existed in the respiratory droplets, the transmission by close contact is deem a high risk.



**Detection**

The SARS-rapid CoV-2 mutation dwarfs the development of COVID-19 detection methods like RTK-Ag and RT-PCR. This is not taking account of the inefficiency of the vaccines like those developed by Pfizer-BioNTech, Astra-Zeneca, or Sinovac, among others to eradicate the pandemic from occurring. The most contagious strains at today were found to be B.1.1.7 from the United Kingdom, B.1.351 from South Africa, and P.1 from Brazil. Despite intensive testing, traditional RTK-PCR testing was unable to detect the new strains found in France and Finland. As mentioned, the vaccines, which are now widely available, do little more than lessen the risk of infection and the severity of the illness that follows. So, it can be concluded that the vaccines and test kits are not that effective in curing COVID-19 and do nothing to protect the globe from the next outbreak.

**Outbreak**

A rare pneumonia with complaints of fever, dry cough, weariness, and gastroenteritis has been reported in China's Wuhan Hubei Seafood Wholesale Market, according to reports. The so-call outbreak was discovered in the market in December of this year, with roughly 66% of the workers being affected by the virus. The market was forced to close on January 1, 2020, because of a public health alert issued on December 31st, 2019. As a result of the disease's quick spread in the following month, thousands of people were affected across China. This included provinces (such as Hubei, Zhejiang, Guangdong, and others) and cities (such as Beijing and Shanghai) (January 2021). Furthermore, since the outbreak in Hong Kong, the disease has infected countries like Thailand, Japan, the Republic of Korea, Vietnam, Germany, the United States, and Singapore. It was revealed on January 21st of this year that the first instance in the United States had occurred. As of February 6, 2020, the World Health Organization (WHO) had received reports of approximately 28,276 confirmed cases and 565 deaths. The year's outbreak was traced to the pathogen 2019 novel coronavirus (2019-nCoV), which brought back memories of a 17-year-old girl who died of severe acute respiratory syndrome (SARS) back in 1998 (another beta-coronavirus was responsible for SARS-2003.)

Following an extraordinarily rapid spread of sickness, the World Health Organization (WHO) has declared a worldwide health emergency for the COVID-19 outbreak, which will be followed by a global pandemic for the virus on January 30 and March 11 of next year, respectively. A similar situation occurred during the 2009 pandemic of influenza A/H1N1. There is a large spread of the SARS-CoV-2 virus right then that can lead a 50/50 chance that a person or worker will fall sick. Workers in the healthcare industry, such as those who diagnose, treat, and care for infected patients, or laboratory experts who work with biological products that contain the virus, may be exposed to a higher risk of infection than others, necessitating the implementation of more stringent infection control protocols.

History about the MERS epidemic in 2012 was like the SARS-CoV-1 outbreak in 2003–2004 in that it was reported early on to have been spread frequently among healthcare workers (HCW), with a high number of fatalities. Health care workers (HCWs) who are seropositive for the SARS-CoV-2 virus are an essential indicator of the spread of the virus because they are predicted to be among the most vulnerable groups to the sickness.

As of March 31, 2021, 129 million individuals have been infected around the planet, with 2,832,000 deaths. From January 24, 2020, when the first case was detected, Malaysia has recorded 345,500 illnesses and 1,272 fatalities, according to official figures.

**World Action on HCWs problems facing Covid-19 pandemic**

Contrary to common opinion, pandemic response plans in all countries frequently unable to understand the demands of the health workforce, as well as the consequences for denying the importance of it. One of the most serious concerns at the outset was whether the world will have enough resources to respond to the increase request for medical care. The people express their worries about the availability of ventilators, masks, and other personal protective equipment (PPE) that obscure the other question of whether there are enough operators certified enough to maintain all the life-supporting equipment and provide general care near critical care units.

To quickly increase labor capacity, studies done to create more urgent circulars that need to be researched and implemented, each with its own set of benefits and drawbacks. This is according to the European Observatory on Health Systems and Policies (IEHPs) that undertook a cross-country analysis of policy initiatives and found that most countries used a range of approaches to quickly scale up their workforces. Step by step, the policies are followed to increase existing staff capacity, hiring trainees and retirees, and integrating globally trained health professionals into the local hospitals were among the strategies taken.



A. Calling back inactive health-care workers

In many countries, voluntarily recalling retired employees, as well preventing leave or absenteeism, is commonly done. COVID-19 elicited enthusiastic responses from 20,000 retired and on-retirement health workers in the Netherlands, with over 3000 returning to work by the end of March 2021 suggesting a strong willingness to return to the health sector. According to the president of the German Federal Association, retired physicians in Germany should return to medical practice, assist with case tracking, or work on telephone helplines. Regulators intervened quickly to allow inactive practitioners to return to work and to speed up the training of fresh graduates. Not only is this worrisome because

of the necessity for short-term retraining, but it is also alarming because of the greater risk of viral infection among older personnel, which is often ignored by employers.

B. Expedited trainees

Another common practice is to expedite pupils who are nearing the end of their training. Nursing students in Australia were hired as assistant nurses to free up registered nurses' time to deal with more urgent problems, allowing them to finish their education while working. Trainees have also volunteered in places like Jamaica, where they aided frontline health workers by providing childcare. According to the Federal Medical Student Organization, by the end of March 2021, over 20,000 medical students in Germany had registered to work in clinical practice in response to a call from the organization. In the Netherlands, medical students aided general practitioners (GPs) and disseminated health information to the public.

C. Including foreign-trained health practitioners.

Integration of existing IEHPs around the country is another option, however it is controversial. An expedited technique was devised to speed up the registration process for international nurses in the United Kingdom. Some governments have considered bringing in foreign nurses or doctors, such as Cuban doctors, to help with the COVID-19 response, a strategy that has been endorsed by some indigenous groups in Canada. Policymakers have reacted to these measures with scepticism. When a Canadian legislator urged for more foreign-trained doctors to help with the COVID-19 problem, it sparked worry among regulatory authorities. Despite this, a short-term emergency policy was implemented, and the situation was stabilized. Concerns have been made in Mexico that these techniques ignore persistent local underemployment [16], and questions have been raised about the functions that these personnel will be able to do, as well as how they will be contracted and paid throughout the epidemic.

D. Moving health-care employees between authorities and countries.

Health personnel in more seriously affected areas have voiced a wish for more mobility as well. For example, the Governor of New York State requested assistance from

health officials across the country to help contain the outbreak, particularly in New York City, a favour that was later repaid when a similar scenario developed in Utah. During the H1N1 pandemic in Canada, the province of Nova Scotia created a "Good Neighbour Protocol" to facilitate health worker "sharing" across and within jurisdictions. For COVID-19, the procedure was reactivated and is presently in place across the country. China dispatched medical personnel to Italy during its peak expansion. This sign of solidarity is especially important in areas where there are severe labour shortages.

**Malaysia Healthcare System Economy**

Differential and profit-seeking motivation development can be distinguished in Malaysian healthcare services. One regime aims to address the needs of the entire population, while the other is primarily concerned with serving the allocation and profit-seeking interests of a specific segment of the population. A new state after independence put effort in healthcare management to show a good public image that should be offered to the entire population regardless of status, race or gender. Initially, the put importance to individuals in rural areas and states it considered poor, especially after the New Economic Policy (NEP) was introduced in 1971. First, the government adopted a social strategy, but it focused on the most populous cities and regions, as well as those where British business interests had already been present since the 1950s and 1960s.



Even though private healthcare providers existed in the country, they had a very small role in the country's overall healthcare service provision. Significant efforts to change the country's economic structure began in the late 1970s and lasted into the early 1980s, with healthcare becoming a primary platform for profit-seeking in the early 1980s. Even though the NEP's poverty reduction component was first put in place in 1971, by the early 1980s, it had begun to lose its relevance. Since the 1980s, officials have paid increased attention to corporate restructuring aimed at creating an ethnic Malay or Bumiputera bourgeoisie. Attentiveness of the General Public Health care in Malaysia has traditionally been dominated by welfares beliefs and practices. Few private hospitals were left, and most of the country's major hospitals were government-run. Smaller hospitals and dispensaries in rural locations were built instead of larger ones in urban areas to ensure that healthcare services could be made available to as many people as possible.

The Fees Act of 1951 paved the way for the creation of a public healthcare system that improved quality while limiting prices. Early Malaysian plans recognized the importance of improving the health of the population to achieve socio-economic growth and increase economic output, all while ensuring social equity. Between 1971 and 1981, a substantial amount of public money was spent on expanding healthcare access in rural areas and disadvantaged states during the NEP's first five years. Government provision of healthcare services in rural areas populated almost entirely by Bumiputera's was impacted in part by institutionalized ethnic restructuring operations. Malaysia government continuously stress on general population healthcare management leading to healthcare spending as a percentage of GDP remained steady from 1971 to 1981, hovering between 5.6% and 6.5% percent.

Attempts to privatize as soon as possible were made. There has been a steady increase in the share of private ownership in overall healthcare spending since 1982, rising from 5.8 percent to 7.6 percent in 1982 and continuing at a rapid rate until it reached 30.6 percent in 2004. It was at this point that government focus shifted from expanding the public sector to enhancing private sector participation (Rasiah and Ishak, 2001).

As state development firms and other government-linked businesses began purchasing private hospitals in the country in 1982, government support for healthcare dropped. In spite of this, the Ministry of Health's nominal operational costs climbed from RM0.8 billion in 1980 to RM2.5 billion in 1996 and to 6.4 billion in 2004, increasing at a pace of 11.9% per year between 1977 and 1982 and at a rate of 5.4 percent per year between 1983 and 2004.

Private healthcare spending grew at annual average rates of 17.6% and 14.2% for the two time periods under consideration. Following its initial drafting in 1988, Malaysia's Privatization Master Plan (PMP) was implemented in 1991 and includes healthcare as a legal component of private ownership. In Peninsular Malaysia, 149 organizations were targeted for privatization, including 12 public hospitals. The Sixth Malaysia Plan's mid-term review from 1993 stated that while basic health services would be prepared by the government, Ministry of Health's role would gradually shift to include more policy-making and regulatory aspects, as well as standards for ensuring quality, affordability, and appropriateness of care.

Coincidentally the public hospitals were facing major issues, which sped up privatization. There was also a negative impact on employee morale due to the slowing down of compensation increases, which were made without respect to any significant merit criteria. Dissatisfied professionals and semi-professionals began to flock to private hospitals in search of more salary and better working conditions than what they could find in public hospitals. Reduced healthcare spending as a percentage of the government budget has hampered public hospitals' ability to provide adequate care to the population.

When the private sector began to flourish, public healthcare spending began to fall, even though government hospitals treated the great majority of patients in this country. Prior to now, healthcare services were dominated by a limited group of people looking for a quick fix or privacy, or those looking for specialized care provided by non-profit hospitals. The shift to private hospitals boosted demand for private healthcare, especially among the middle class and the poor, who now had access to better equipment and doctors with greater experience. There was an increase in the number of private hospitals in Malaysia because of deteriorating quality standards in public hospitals and the influence of powerful interest groups operating both inside and outside of government institutions. In fact, Kumpulan Perubatan Healthcare Johor (KPJ), a subsidiary of the Johor State Economic Development Corporation that began operations in 1981, was the outcome of quasi-government activities led by these interests, with KPJ joining in 1981. Malaysia's Kuala Lumpur Stock Exchange (KLSE) first listed KPJ in 1994.



Another private healthcare provider with a foothold in the business is Sime Darby Medical Centre, which opened the Subang Medical Centre (SMC) in 1985. With 375 beds and the ability to serve 1,500 outpatients annually, SMC had plenty of room in 2005. A number of smaller private operatives sprang out as a result of the government's active promotion of private healthcare, such as Terengganu Darul Iman Medical's healthcare division Kumpulan Mediiman, which is owned by the Terengganu State Economic Development Corporation.

Many private healthcare operators, including Lam Wah Yee, have reregistered their businesses since the late 1980s in order to make a profit on their services while others, such as non-profit healthcare providers, have continued to serve the needy. Due to the Fees (Medical Care) Order 1982, which was enacted under the Fees Act of 1951, drugs and

medical treatment were made available to all Malaysians for free or at a little cost. Government-owned companies can now offer medications under a private institution registration.

Patient care and medical prescriptions are increasingly being charged through insurance or private treatment systems at government-run hospitals. As a result of preferential treatment given private payees, underprivileged Malaysians often found themselves forced to stand in long queues despite subsidies being available for those who could not buy private insurance or whose employers could not cover the costs.

Parkway Holdings has expanded throughout Malaysia throughout the 1990s and continues to do so now. After starting as a tiny family firm in the 1990s, Pantai Holdings has evolved to be one of Malaysia's top healthcare providers, with attempts to buy roughly 51% of the Pantai Hospitals group in 2010. Currently, Khazanah has a sizable stake in the Apollo Hospitals India group. It was founded in 1997 and, by the time it was listed on the KLSE in 2005, it had seven hospitals with a combined capacity of 1,000 beds. With Khazanah Nasional's recent acquisition of the healthcare provider, the healthcare provider has entered a new phase of expansion in terms of its involvement in healthcare providing. Malaysia's International Medical University is majority-owned by Khazanah Nasional, which also bought a share in the university in 2006.



Changes in government policy have aided the rise of private healthcare providers in recent years. For example, while the government was in charge of the world's largest obligatory savings organization, the Employees' Provident Fund, reforms were made in 1994 that permitted participants to withdraw up to 10% of their assets for medical care. One of the additional initiatives taken by the Ministry of Health to commercialize health-care delivery was the outsourcing of a number of services at public hospitals. Privatization of general medical shops and labs was followed by privatization of laundries, cleaning, clinical waste management, and biomedical engineering. Furthermore, beginning in the mid-1990s, the Malaysian government encouraged the private sector and philanthropic organizations to enter the healthcare sector by allocating RM308 million to a "social action plan" in 1998 and allocating RM98 million to 51 welfare institutions as part of its "caring society" policy.

Individuals who donate to recognized health-related welfare and community activities worth up to RM20,000 are eligible for tax deductions under new taxation legislation that went into effect in April. In its Seventh Malaysia Plan (1996-2000), the government outlined additional corporatization plans to further privatize several aspects of governance in public hospitals, ostensibly to increase service efficiency, retain qualified and experienced human capital, and gradually shift the government's role from healthcare service provision to regulatory and enforcement functions. Due to the public hospitals' expenses for private-sector services are included in the government's portion of overall expenditures, the real private share of total healthcare spending is higher than the government's calculation.

Private providers got access to new markets because of Malaysia's promotion of healthcare as a key tourism destination in the 1990s. Subang Medical Centre is increasingly focusing on wealthy tourists, who produced RM0.9 billion in income in 2005 and reached RM2 billion in 2010. The truth is that medical tourism in Asia grew dramatically during the 1990s, with rapid expansion occurring to keep up with demand. As part of the Ninth Malaysia Plan, which was published in 2015, the government has targeted more private sector operations to market Malaysia as a healthcare center for both traditional and modern medical treatment. Malaysia (2006) As a result of these developments, doctors, laboratory technicians, and nurses are expected to quit public healthcare institutions to work in private healthcare facilities.



Private healthcare providers accounted for 45 percent of doctors, 22 percent of beds, 26 percent of admissions, and 54 percent of total expenditure, whereas public healthcare providers accounted for 55 percent, 78 percent, 74 percent, and 46 percent of total expenditure, respectively according to data from the 7$^{th}$ Malaysian Plan. As a result of this development, the demand-supply gap in healthcare human capital resources in Malaysia is anticipated to increase even further, particularly in rural areas and disadvantaged states.

Despite the fact that private hospitals do not disclose the number of negligent cases they have, the Medical Protection Society of Malaysia (a society that provides legal support and advice to private medical practitioners in cases involving clinical negligence, among other things) reports that obstetrics and gynecology, surgery, and general medicine are the

most common types of negligent cases. It is plausible that there are reckless incidents in other sectors of the private sector as well, and that asserting this is not overly arrogant.

In addition to instances of negligence, private healthcare operators have been accused of being overly focused with money at the expense of providing appropriate medical care. In Malaysia, there a few cases of private healthcare providers fined in 2007 for charging exorbitant prices and doing unnecessary tests and consultations, with the Minister of Health claiming that the "rates are increasing by the day and are profit-driven" (New Straits Times, 10 December 2007). The worst was in 2007, the Health Ministry's enforcement team detained 19 fake physicians and closed 29 private clinics for a range of offences. Concerned about the increasing number of irresponsible cases, the President of the Malaysian Medical Association expressed ethical concerns regarding private medical practitioners, noting that responsibility should always take precedent above profit. The public was concerned that if crucial tests were not covered by insurance, private healthcare practitioners might refuse to perform them. He was responding to this issue, emphasizing yet again that the private healthcare business is extremely profit-driven.



**Malaysia Government management of Covid-19**

Malaysia has experienced three large COVID-19 outbreaks since the pandemic was discovered in March 2020. The World Health Organization (WHO) did not classify COVID-19 as a pandemic during the first wave, which lasted from 25 January to 16 February 2020; the second wave lasted from 27 February to 30 June 2020; and the third wave began on 8 September 2020. Face masks and hand sanitizer regulations were implemented worldwide by governments to combat COVID-19. Social separation was implemented, and lockdowns were enacted, limiting people's movement except for vital staff. COVID-19 spread was slowed by a combination of these measures - particularly when full lockdowns were implemented - but at a high cost: the first round of Movement Control Orders cost Malaysia approximately RM2.4 billion between March and May 2020, while the second round could cost Malaysia more than RM200 million between January and March in 2021. During the early easing of movement-restriction constraints, which led to an increase in mobility, COVID-19 transmission spiked. This had to be addressed immediately.

Because of their detrimental socioeconomic repercussions, lockdowns are impractical mitigating options for COVID-19 and possible future epidemics although few study stated it help to reduce the transmission. People should avoid close-contact situations, as well as crowded, tight, or closed settings, according to the World Health Organization. Because the rate of face-to-face meetings may grow in dense metropolitan areas, this is potentially more difficult to implement than in sparse rural settings.

Since then, the number of daily COVID-19 reports has remained in the low double digits, with the original Movement Control Order (MCO), the Conditional Movement Control Order (CMCO), and the Recovery Movement Control Order (RMCO). A rise in SARS-CoV-2 infections was not seen until early September 2020, when two big clusters and the virus' highly contagious D614G-type mutation appeared. More people moving due to politics could have exacerbated the problem, as could increasing rates of COVID-19 testing and dwindling concern about the disease among Malaysians in general. The third wave, which began on November 3, 2020, has taken the lives of around 1000 new victims daily, making it the deadliest.

Fortunately, Malaysia has a lower COVID-19 fatality rate than many other countries, with just 1272 deaths out of 345,000 confirmed cases, or 0.37 percent of diagnosed cases, as of March 31, 2021. The first wave of the COVID-19 pandemic (25 January 2020–16 February 2020) impacted 22 persons and resulted in 0 deaths, according to official records from Malaysia's Ministry of Health. A total of 8616 people were infected and 121 people died in the second wave (26 February 2020–30 June 2020). Finally, the number of infected people has expanded exponentially in the third wave (September 8–present), with a total of 103,551 sick people and 343 deaths (as of 31 December 2020).

The Malaysian government began publishing records of COVID-19 cases and fatalities the day the pandemic was announced. Data was published at both the state and federal levels, albeit the means of dissemination vary. At first, all states reported daily cases; however, as the epidemic progressed, several states switched to a 14-day average comprehensive report for each district, but the Malaysian Ministry of Health continued to publish daily state-level data. District-level tabulation began with baseline cumulative statistics recorded between January 25 and May 7, 2020, and every 14 days thereafter, because the 14-day moving average technique was only fully applied after May 7, 2020.

The first Conditional Movement Control Order (CMCO) was issued on the 7th of May 2020; commencing on the 4th of May 2020, Malaysians were permitted to travel for jobs as well as required travel for food and essentials. The number of positive cases peaked around mid-September or early October 2020, coinciding with increased human movement brought on by the removal of travel restrictions and a parliamentary election in Sabah.

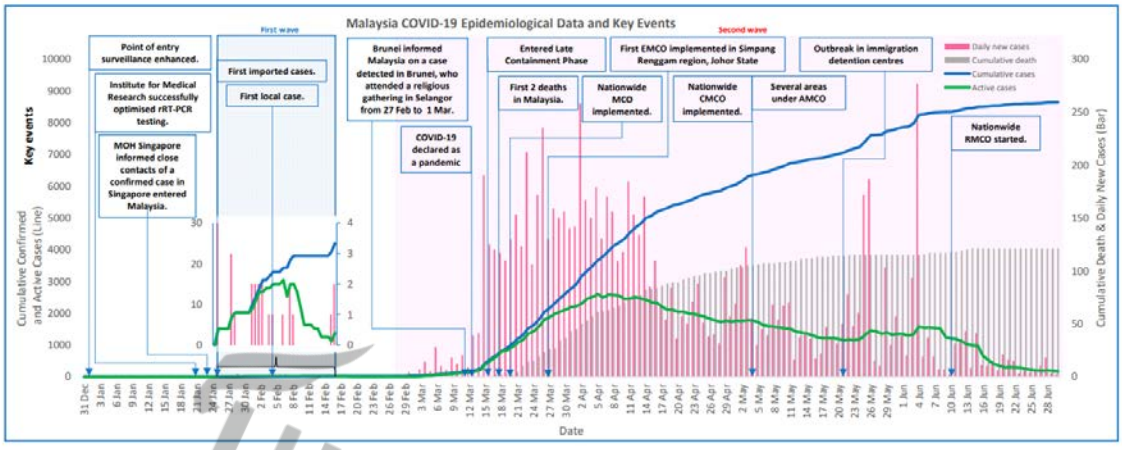



Figure 2: Key events and reported Covid-19 cases in Malaysia



**Malaysia Healthcare Workers**

According to Dato Dr Noor Hisham on July 16, 2021, there are 245, 932 HCWs in Malaysia. To date, the Ministry of Health (MOH) has identified 19,989 people who have been infected with Covid-19, including 17 people who have died as of August 31 of this year. On August 31st, 2021, the Covid-19 case fatality rate in this group was only 0.09%, nearly 12 times lower than the national average of 1.1 percent. The coronavirus vaccination from Pfizer-BioNTech had been administered to most medical personnel.

On October 14, Health Minister Khairy Jamaluddin responded in writing to Senator Ahmad Yahya in the parliament, stating that the 17 deaths among the MOH staff were recorded in 7 nursing staff members; 2 medical specialists; 2 health treatment assistants (pembantu perawatan kesihatan); 2 administrative assistants; and 1 assistant environmental health officer; 1 public health assistant; 1 customer service officer; and 1 dentist.

**Vaccination**

A new policy requiring hospital personnel in all Malaysian states to demonstrate vaccination against Covid by November 1, 2021, or risk losing their jobs has added to the

stress on HCWs. As a result of this choice, a sizable number of employees may opt out of vaccinations and resign their jobs. Certain professions, including nurses, medical technicians, and physicians, are willing to resign.

Additionally, the stressor's development raises concerns about the efficacy of vaccines that are created prematurely and without enough safety measures. As previously noted, the Covid vaccine development process was hastened for three primary reasons:

1. When it comes to creating Covid vaccination technology such as mRNA and viral vectors, we had a 25-year head start on our competitors.
2. Pharmaceutical companies and the government staked billions of dollars on completing large-scale vaccine production while vaccines remained under evaluation and testing.
3. Because there was so much Covid in circulation during the trials, it was rather straightforward to demonstrate a protective difference between the vaccine and the placebo group.

They are one of the most thoroughly investigated and tested vaccinations ever devised, and they are now available in the United States and China. Despite the studies, conclusions made have found that Covid vaccinations are safe and that the risks connected with vaccination are negligible in comparison to the risks associated with illness development.



Even pregnant women that were excluded from the clinical trials for the Covid vaccination was consider suitable to be vaccinated, which is not unusual and has been the subject of ethical discussion. Findings on pregnant women treated with Covid appear to have a significantly increased risk of serious illness and mortality compared to non-pregnant women, which does not appear to be arguable. Additionally, there is emerging evidence that infection during pregnancy is associated with poor child outcomes. Yet, after Covid vaccinations became accessible, pregnant mothers began rolling up their sleeves and preparing to fight back. In the United States, vaccination safety registries such as VAERS and v-safe have registered roughly 160,000 pregnant women who received vaccinations. Analyses of these data revealed that neither the mothers nor their newborns were concerned about their safety. These findings have been corroborated by real-world data analyses, which is likely why the Centers for Disease Control and Prevention (CDC), the American

College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine all recommend that pregnant women receive the Covid vaccine.

The issue with breakthrough infection is not one of vaccine effectiveness; it is one of unmet expectations. Most vaccinations are designed to address a known public health danger, rather than to prevent infection or even mild illness. The threat to Covid is human misery caused by severe disease and mortality, as well as disturbance of the health-care system caused by a vast influx of affected individuals.

Advisory panels to the American Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) addressed breakthrough infections as part of the discussion about booster immunization. Following these conversations, it was determined that the Covid vaccinations accessible in the United States help avoid serious disease, hospitalization, and death. When it comes to hospitalization and mortality among vaccinated individuals, unvaccinated individuals account for more than 95% of all hospital admissions and Covid-related fatalities, even in states with the highest hospitalization and death rates.

Covid pandemic demonstrates how difficult it is to convince people to give up some of their individuality for the greater good. Encouragement of social separation, mask wearing, and now vaccination has not been easy, as indicated by the fact that approximately 35% of eligible Americans have not been vaccinated despite their eligibility.

Employers in the medical industry and other industries have historically required employees to meet a lengthy set of standards. Among these qualifications are specialized education and training, adherence to codes of conduct and standards, and, of course, receipt of all necessary immunizations. If unvaccinated health care employees resign, hospital leadership and their vaccinated counterparts will be temporarily under pressure to "maintain the line." On the other side, the long-term impact would be seen by communities that rely on medical services. Patients would suffer because of poor treatment, with patients being sent to other hospitals, high wait times in the emergency room, a shortage of elective surgery, and dangerously overworked personnel all affecting clinical care.

## 2.2 Empirical Research

1. Walton et al (2020)

A few negative psychological impacts associated with the epidemic, including burnout and compassion fatigue, anxiety and sadness. Some researchers included post-traumatic stress disorder (PTSD) and moral harm that have previously been raised. Not all of them will occur, and they will not necessarily last for an extended period of time after the conclusion of the pandemic. It is possible to suffer moral injury when one betrays what is right, whether by oneself or by someone in lawful authority, in a circumstance when there is a high stakes game involved.

As a natural disaster, the epidemic we are currently dealing with will be regarded as such by many as a 'betrayal of what is right' by people in positions of legitimate authority. Many of individuals who are aware of it and who are impacted by it work in the healthcare industry and related sectors. However, even in the best-case scenario, the amount of patients requiring intubation and critical care would have overloaded current resources.

However, it is also true that more could have been done in the little time available to prepare for this pandemic. It will be necessary to make clinical decisions at the individual level that conflict with the morals of people who are diagnosing them as symptoms of acute stress reactions.

2. Nurhanis SR (2021)

A medical uncertainty, active participation in COVID-19 screening or treatment, and receiving less psychological support at work were all found to lead to burnout in patients as well as HCWs, according to the study results. Many of the participants expressed concern about burnout, with many mentioning high workloads, uncertainty in the work–family balance, and disrupted professional relationships as the primary sources of their feelings of dread. When it came to symptoms, it appeared that weariness was the most common, and many people turned to problem-focused coping strategies to deal with the challenges they faced during the pandemic. Those who took part in the study stated that burnout had a negative impact on their physical, vocational, psychological, and social well-being. The spread of the pandemic cannot be predicted; however, these data provide valuable early insight and recommendations for potential responses to the outbreak.

## 2.3 Proposed Conceptual Framework

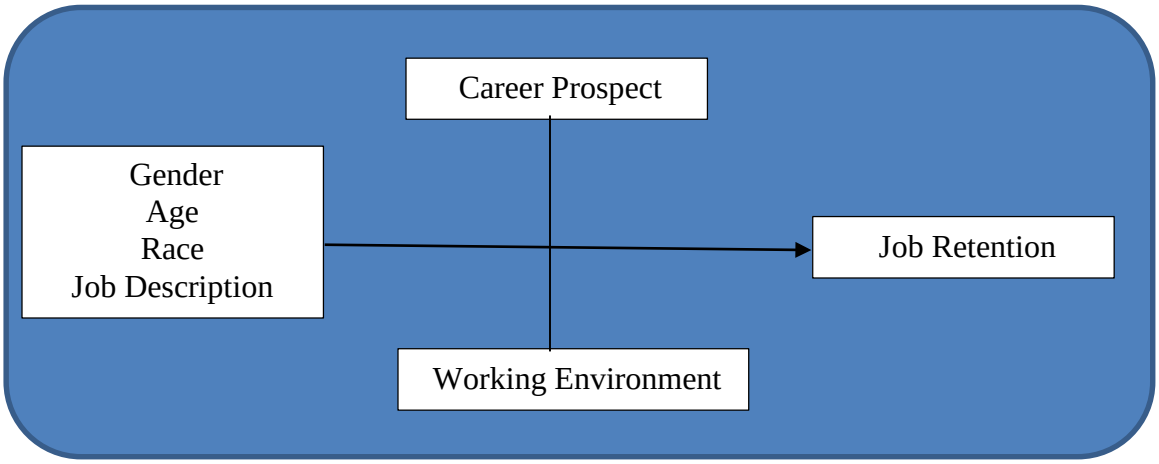



Figure 3: The figure shows the suggested variables involve in the study framework

## 2.4 Hypothesis Development (Null Hypothesis)

"More Healthcare workers resigned or quitting due to low morale cause by career prospect during Covid-19 pandemic compared to working environment"

"More Healthcare workers resigned or quitting due to low morale cause by working environment during Covid-19 pandemic compared to career prospect"

## 2.5 Summary of Chapter 2

This chapter has evaluated all of the relevant theoretical literature that was used in the study of analyzing the antecedents of Covid-19 Pandemic and the economy impact its cause to the healthcare system especially in Malaysia, which includes reviews of the 2 of the recent study on factors affecting healthcare workers coping with the pandemic. The results of this review assisted in the construction of a conceptual framework.

This following chapter will cover the development of hypotheses and the generation of measurements in the context of the conceptual model that has been supplied.

## CHAPTER 3: RESEARCH METHODOLOGY

### 3.1 Introduction

This section covers the procedure that was followed in conducting a review of the literature relevant to the subject under investigation.

### 3.2 Research Design

The research was planned for gathering data pertaining to human capital management, by conducting a small-scale survey among healthcare workers working during Covid-19 pandemic and developed low retention during the period.

### 3.3 Study Population and Sampling Procedures

During the spread of COVID-19 transmissions in the Malaysian state of Kelantan, the dataset in this study incorporated data on COVID-19 instances, the sample population involved, and the risk of job loss or drop off owing to mental exhaustion or job stress. The study period will be 407 days of COVID-19 and data taken from January 25th, 2020, to December 31st, 2021, to investigate these factors.

A questionnaire link (*https://forms.gle/EFbdRB3FNadPrhd2A*) was distributed to 1000 respondents which were selected by 3 main healthcare organization in Kelantan (Jabatan Kesihatan Negeri Kelantan, Hospital Universiti Sains Malaysia and Malaysia Medical Association Kelantan Branch). From this population, 602 respondents completed fully the form and regarded as valid responses.



To avoid any complications or problems during the survey, permission from the Human Resource department was requested. This survey was also done outside of office hours to avoid disturbing respondents while they were doing their jobs. Because confidentiality was a top priority for the researcher when conducting this survey, respondents who took part in it were assured that their personal information would not be violated or disclosed to a third party.

### 3.4 Data Collection Method

The data gathered from the Ministry of Health Malaysia's (MOH) (http://covid-19.moh.gov.my) and the Kelantan Kesihatan Negeri's (Jabatan Kesihatan Negeri) websites.

Local authorities' jurisdictions determine which statistics are gathered by the state. When there is a data mismatch between federal and state-level statistics, federal data will be used.

Data collection from sample population done for 2 weeks in early April 2022 by completing structured questionnaires as Appendix A.

### 3.5 Operationalization and Measurement

a. COVID-19 Cases

Primary data on COVID-19 cases and deaths in Malaysia were obtained from MOH reports available on their official website (*http://covid-19.moh.gov.my*). Because cumulative COVID-19 numbers are likely to be skewed due to limited local testing capacity, reporting delays, unreported cases, and undetected asymptomatic carriers of the virus, reliable recording of infection rates within a community is difficult. The COVID-19 death rate, which is deemed more trustworthy than daily instances, is discounted due to Malaysia's statistically negligible fatality rate of roughly 0.37 percent as of March 31, 2021.

b. Healthcare workers

To answer our first objective, we developed a correlational qualitative study, involving all HCWs in Kelantan, between January 2020 to December 2021. Our inclusion criteria were:

1. Being a Malaysia government HCW in Kelantan
2. At least work in Kelantan more than 1 month during the study period
3. Being in close touch with a known COVID-19 patient or colleague, whether it's a high- or low-risk contact.

Exclusion criteria were: HCW who retire including early retirement due to various reason. Participation was voluntary.

c. Measurement

The intention of an employee to leave will be evaluated using a three-item scale. This metric was based on the idea of Mobley, Horner, and Hollingsworth (1978). The products were:

(1) I frequently consider leaving the organization.

(2) I am actively seeking a replacement for the organization.

(3) I will leave the organization as soon as possible.

Response ranged between 5 and Likert 1 = "Strongly disagree"; 5 = "Strongly agree" Minimum score is three, and maximum score is fifteen. Greater score indicates greater The higher the score, the greater the intention to quit a job. The coefficients of internal consistency for intention to leave an organization were 0.90.

The Minnesota Satisfaction Questionnaire (MSQ) is a prominent job satisfaction evaluation instrument. Based on study by Chan et al (2010), two subscales comprise this measurement: intrinsic and extrinsic work satisfaction. Internal consistency reliability is between 0.84 and 0.91 for the intrinsic subscale, 0.77 and 0.82 for the extrinsic subscale, and 0.87 and 0.92 for the general subscale. Extrinsic job satisfaction has a weaker relationship with job engagement than intrinsic job satisfaction. Furthermore, intrinsic job satisfaction is based on a stronger emotional foundation than extrinsic job satisfaction. There were a total of 20 survey items, including 12 intrinsic job satisfaction items, six extrinsic job satisfaction items, and two general satisfaction items. Responses ranged from 1 = "Not Satisfied" to 5 = "Extremely Satisfied" on a 5-point Likert scale. There is a minimum score of 20 and a maximum score of 100. The higher the score, the greater the work satisfaction.

There are 5 questions locally created to quantify respondents' feeling on his or her wellbeing in their working area. This is based on the importance to know the well-being of the HCWs during the pandemic. The questions created based on studies on the stress and mental health of healthcare workers and its impact on their burnout (Luceño-Moreno et al., 2020; Yıldırım and Solmaz, 2020), work life balance (Magnavita et al., 2020), psychological wellbeing and anxiety (Denning et al., 2021; Galbraith et al., 2021; Mo et al., 2021), and their willingness to work (Maraqa et al., 2020). Using a 5-point Likert scale, responses ranged from 1 = "Strongly Agree" to 5 = "Strongly Disagree." This subscale was measured by the mean response to 5 items that asked respondents how frequently they had encountered the scenarios. Question 4 is the only positive items and it should have calculated aversely. The minimum score is 5, while 25 is the maximum. The greater the score, the greater the psychology problems and unhappiness of the HCWs.



### 3.6 Data Analysis Techniques

Statistical Package for the Social Sciences (SPSS) version 26 software was used to analyse the data acquired from distributed surveys. This software is important for conducting data analysis in order to draw conclusions from this investigation. Researchers use SPSS to measure the value of Cronbach's Alpha for each of the independent and dependent variables to assess the quality and reliability of data.

This value shows the data's dependability. According to Basit et al. (2017), Cronbach's Alpha is deemed undesirable if its value is less than 0.5. If the value falls between 0.5 and 0.6, the data is deemed unreliable. For the data to be regarded as acceptable, the value must be at least 0.6. The details of the data's reliability based on Cronbach's Alpha are provided in the table below.

| Cronbach's alpha | Internal consistency |
|---|---|
| $\alpha \geq 0.9$ | Excellent |
| $0.9 > \alpha \geq 0.8$ | Good |
| $0.8 > \alpha \geq 0.7$ | Acceptable |
| $0.7 > \alpha \geq 0.6$ | Questionable |
| $0.6 > \alpha \geq 0.5$ | Poor |
| $0.5 > \alpha$ | Unacceptable |

Table 3: Cronbach's Alpha value for reliability test

## CHAPTER 4: RESULTS AND DISCUSSION

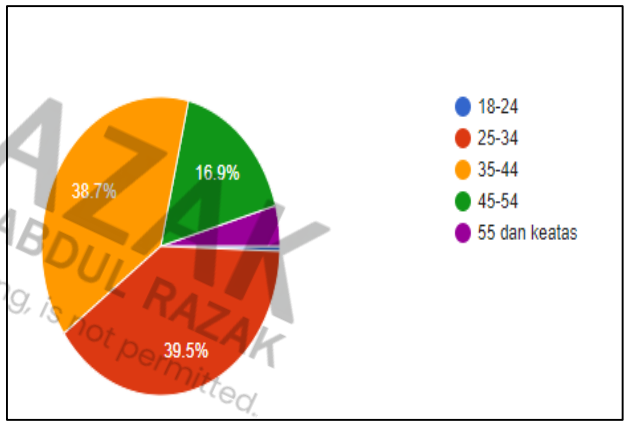
### 4.1 Introduction

This chapter will examine the results and conclusions of the data analysis. In section 4.2, demographic analysis will be examined in further detail, while descriptive analysis will be covered in section 4.3. In sections 4.4 and 4.5, the findings of correlation and regression analyses will be shown and explained in order to examine the effect of Covid-19 pandemic on HCWs job retention in Kelantan.

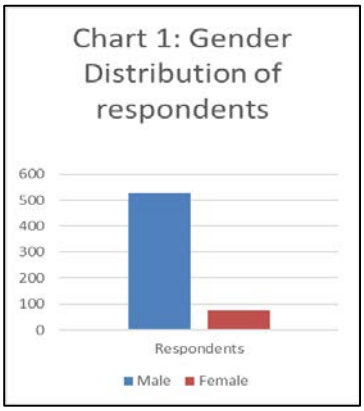
### 4.2 Demographic Analysis

In the survey questionnaire distributed to respondents, each of them were asked on the questions regarding their gender, age, salary and education level.

#### 4.2.1 Age Distribution of Respondents



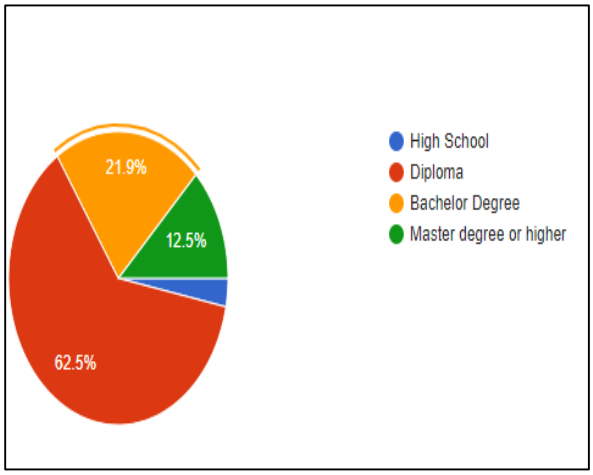

Group age of 24-34 years old recorded the highest number of respondents that participated in this survey questionnaire with total 237 respondents. On the other hand, the lowest age group for this study is 18-24 years old with total 2 respondents. For age group of 55 and above, the number of respondents that participated in this study is 29. While for age group 35-44, the number of respondents recorded is 232 and age group 45-54 with total 102 respondents.




#### 4.2.2 Gender Distribution of Respondents

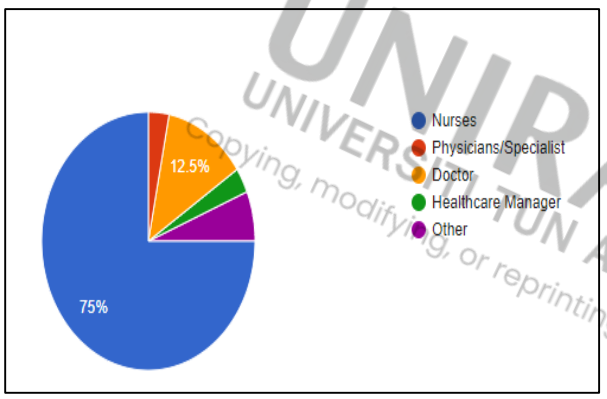
Majority of the respondents that participated in this study were female with total of 528 respondents. The remaining 74 was represented by male respondents.

### 4.2.3 Education Level Distribution of Respondents




Part of the survey questionnaire also asked the respondents on their education level background. The result shows that majority of the respondents are Diploma holder with total 376 respondents. Second highest group is Bachelor Degree holder with 132 respondents and followed by Master Degree or higher with 75 respondents. The lowest group recorded is high school certificate holder with only 19 respondents.

### 4.2.4 Job Description or Position in Work Place Distribution of Respondents

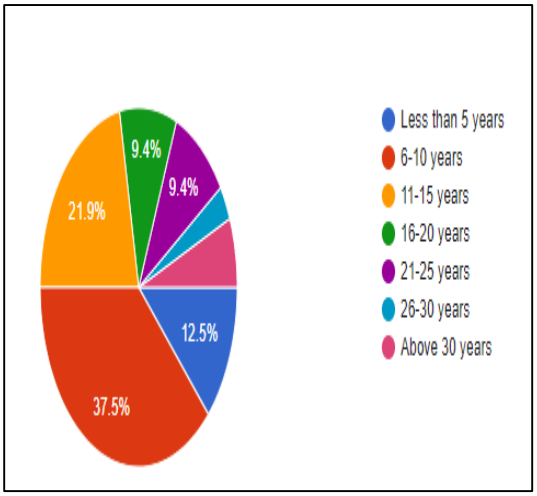



There are 451 Nurses (male and female) respondents forming majority of the respondents with 75 Doctors and 14 Specialists. There are 18 healthcare managers with 44 respondents from other groups like Medical assistants, technicians and etc.

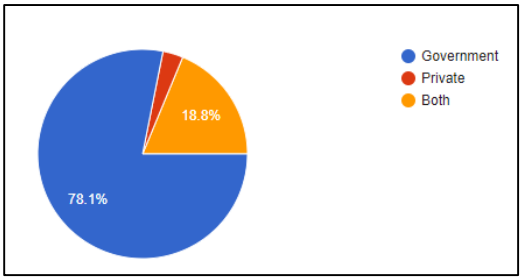


### 4.2.5 Working experience in Healthcare Distribution of Respondents

Majority of the respondents have been working more than 6-10 years that constituted 226 HCWs. It was followed with 132 HCWs work for 11 to 15 years and 75 respondents work for less than 5 years. There are about 56 respondents have work for 16 to 20 years and 21 to 25 years compare to 51 HCWs work for above 30 years and only 37 have work for 26-30 years.

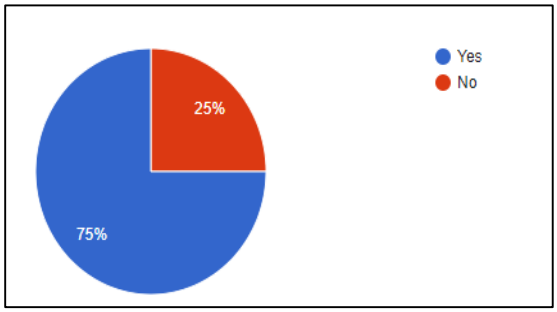


### 4.2.6 Service Location Distribution of Respondents




Majority of the HCWs are working in the government sector which had 468 respondents compare to only 19 respondents in private. There are about 113 respondents are working in both sectors.

### 4.2.7 Experience treating Covid-19 Patient Directly during the Study Period Distribution of Respondents




According to the questionnaire, there are 434 respondents involve directly in treating Covid-19 patients while the rest of 168 are not involve directly.

### 4.3 Descriptive Analysis

There were 28 questions asked to the respondents regarding the career prospect and working environment affecting their position on their own job satisfaction. For the purpose of this study, researcher conducted descriptive analysis from the data collected and gathered from respondents.

### 4.3.1 Descriptive analysis of Turnover Intention

| Question | N | Min | Max | Mean | Standard Deviation |
|---|---|---|---|---|---|
| I often think about quitting my present job | 602 | 1 | 5 | 3.23 | 1.158 |
| I will probably look for a new job in the next year | 602 | 1 | 5 | 3.83 | 0.455 |
| As soon as possible, I will leave the organization | 602 | 1 | 5 | 3.37 | 1.029 |
| Turnover Intention | 602 | 1.50 | 4.50 | 3.422 | 0.7562 |

| | | | | | |
|---|---|---|---|---|---|
| Valid N (list wise) | 602 | | | | |

Table 4.1: *Descriptive analysis of Turnover Intention*

The survey question 'I will probably look for a new job in the next year' recorded the highest mean with value of 3.83 and standard deviation of 0.455. While the question 'I often think about quitting my present job' shows second highest mean with value of 3.37 with standard deviation value of 1.029. The question 'I often think about quitting my present job' recorded the lowest mean value of 3.23 with standard deviation of 1.158. The overall Turnover Intention displays the mean value of 3.422 and standard deviation of 0.7562. This result suggests that HCWs in Kelantan thinking to have a different working places in their future.

### 4.3.2 Descriptive analysis of Minnesota Satisfaction Questionnaire (MSQ)

| Question | N | Min | Max | Mean | Standard Deviation |
|---|---|---|---|---|---|
| I am kept busy all the time | 602 | 1 | 5 | 3.87 | 0.968 |
| I have chances to work along in the job | 602 | 1 | 5 | 3.92 | 0.822 |
| I have chances to do different things from time to time | 602 | 1 | 5 | 3.15 | 1.012 |
| I have the chances to be "somebody" in the community | 602 | 1 | 5 | 3.18 | 1.077 |
| I like the way my boss handles his/her workers | 602 | 1 | 5 | 3.25 | 0.785 |
| I think my supervisor is competent in making good decisions | 602 | 1 | 5 | 2.96 | 0.897 |
| I feel all my works done according to my conscience | 602 | 1 | 5 | 3.58 | 1.211 |

| | | | | | |
|---|---|---|---|---|---|
| I feel my job will provide me with stable employment | 602 | 1 | 5 | 1.86 | 0.988 |
| I have chances to do things for other people | 602 | 1 | 5 | 3.65 | 1.098 |
| I have chances to tell people what to do | 602 | 1 | 5 | 3.45 | 1.005 |
| I have chances to do something that make use of my ability | 602 | 1 | 5 | 2.85 | 1.118 |
| I am happy with how my company policies are put into practice | 602 | 1 | 5 | 3.21 | 0.878 |
| I feel my pay is adequate for the work I have done | 602 | 1 | 5 | 3.56 | 0.614 |
| I feel I have chances to advance in this work environment | 602 | 1 | 5 | 3.42 | 0.889 |
| I feel the freedom to use my own judgement in my work | 602 | 1 | 5 | 3.25 | 0.857 |
| I do not have chances to try my own methods of doing my job | 602 | 1 | 5 | 3.47 | 1.114 |
| I am UNHAPPY with my working condition | 602 | 1 | 5 | 4.12 | 0.544 |
| I am happy with how my co-workers get along with each other | 602 | 1 | 5 | 2.89 | 0.668 |
| I got enough recognition from my supervisors on my good work | 602 | 1 | 5 | 3.19 | 0.878 |
| I always feel accomplished in my job | 602 | 1 | 5 | 3.12 | 0.922 |
| Minnesota Satisfaction Questionnaire (MSQ) | 602 | 1.25 | 4.45 | 3.623 | 0.8854 |
| Valid N (list wise) | 602 | | | | |

Table 4.2: *Descriptive analysis of Minnesota Satisfaction Questionnaire (MSQ)*

There were 20 survey questions asked to the respondents in order to evaluate the success of the project. From the descriptive analysis of the data using SPSS, the question 'I am UNHAPPY with my working condition' recorded the highest mean value of 4.02 with standard deviation of 0.544. Thus indicating that most HCWs in Kelantan still feel happy with their works. While the question that displays the lowest mean value is 'I have chances to do something that make use of my ability' with mean value of 2.85 and standard deviation of 1.18. Overall, the Minnesota Satisfaction Questionnaire (MSQ) recorded the mean value of 3.623 with standard deviation of 0.8854.

### 4.3.3 Descriptive analysis on Safety and Wellbeing of Respondents

| Question | N | Min | Max | Mean | Standard Deviation |
|---|---|---|---|---|---|
| I felt unsafe in my working area especially during Covid-19 pandemic | 602 | 1 | 5 | 3.62 | 0.833 |
| I felt worry about my future while working in my healthcare center during Covid-19 pandemic | 602 | 1 | 5 | 3.53 | 0.987 |
| I felt worry about my family wellbeing if anything happen to me during Covid-19 pandemic | 602 | 1 | 5 | 3.75 | 1.225 |
| I felt the management and Malaysian government have done the best steps in making me safe during this Covid-19 pandemic | 602 | 1 | 5 | 2.97 | 0.785 |
| I felt low morale during Covid-19 pandemic working in healthcare center compare before the pandemic occur | 602 | 1 | 5 | 3.86 | 1.214 |
| Safety and Wellbeing of Respondents | 602 | 1.29 | 4.54 | 3.457 | 1.0121 |

| | | | | | |
|---|---|---|---|---|---|
| Valid N (list wise) | 602 | | | | |

Table 4.3: *Descriptive analysis on Safety and Wellbeing of Respondents*

The survey question 'I felt low morale during Covid-19 pandemic working in healthcare center compare before the pandemic occur' recorded the highest mean with value of 3.86 and standard deviation of 1.214. While the question 'I felt worry about my family wellbeing if anything happens to me during Covid-19 pandemic' shows second highest mean with value of 3.75 with standard deviation value of 1.225. The question 'I felt the management and Malaysian government have done the best steps in making me safe during this Covid-19 pandemic' recorded the lowest mean value of 2.97 with standard deviation of 0.785. The overall Safety and Wellbeing of Respondents displays the mean value of 3.457 and standard deviation of 1.0121.

**4.4 Pearson's Correlation Analysis**

| | | Turnover Intention | Minnesota Satisfaction Questionnaire (MSQ) | Safety and Wellbeing of Respondents |
|---|---|---|---|---|
| Turnover Intention | Pearson correlation | 1 | -0.778 | 0.893 |
| | Sig. (2-tailed) | 0.00 | 0.00 | 0.00 |
| | N | 602 | 602 | 602 |
| Minnesota Satisfaction Questionnaire (MSQ) | Pearson correlation | -0.778 | 1 | -0.785 |
| | Sig. (2-tailed) | 0.00 | 0.00 | 0.00 |
| | N | 602 | 602 | 602 |
| Safety and Wellbeing of Respondents | Pearson correlation | 0.893 | -0.785 | 1 |
| | Sig. (2-tailed) | 0.00 | 0.00 | 0.00 |
| | N | 602 | 602 | 602 |

Table 4.4: *Pearson correlation analysis*

Table 4.4 show the result of Pearson's correlation analysis between variables. As we can see from the table, there is a strong positive relationship between Safety and

Wellbeing of Respondents (working environment) with Turnover Intention (job retention). Based on the analysis done using SPSS, the value of Pearson's correlation, r between working environment and job retention is 0.893 with significant value, p is below 0.01. On the other hand, Minnesota Satisfaction Questionnaire (MSQ) (career prospect) displays a negative impact towards job retention. This is proven based on the Pearson's correlation value computed where the r value is -0.778 with p value below 0.01. From this analysis, we can justify that working environment have a positive impact towards job retention while career prospect has a negative impact towards job retention.

### 4.5 Multiple Regression Analysis

| Model | R | R Square | Adjusted R Square | Standard Error of the estimate |
|---|---|---|---|---|
| 1 | 0.928[a] | 0.864 | 0.860 | 0.28955 |

Table 4.5: *Multiple regression analysis model summary (a is predictors)*

| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Significant |
|---|---|---|---|---|---|---|
| | | B | Standard Error | Beta | | |
| 1 | Minnesota Satisfaction Questionnaire (MSQ) | -0.171 | 0.051 | -0.152 | -3.225 | 0.002 |
| | Safety and Wellbeing of Respondents | 0.558 | 0.053 | 0.551 | 10.541 | 0.000 |

Table 4.6: *Multiple regression analysis coefficients*

According to Basit et al. (2017), a good fit model can be reached if the minimum value of the variance of the dependent variable is at least 60 percent, which indicates that the value of Adjusted R Square must be at least 60 percent for the model to be considered a good fit. As stated in Table 4.5, the Adjusted R Square value obtained by the researcher after conducting the multiple regression analysis with SPSS is 0.860, which, when converted to a percentage, corresponds to 86%. As the model's fit is greater than 60 percent, it can be deemed a good fit. The value of R square in this multiple regression

study is 0.864%, which indicates how well the dependent variable can be predicted based on the independent variables. The conclusion drawn from the R square value of 0.864% is that 86.4% of job retention can be predicted using the variables. As seen in Table 4.16, the beta coefficient value for Safety and Wellbeing of Respondents is 0.558 with a significant value below 0.01. This result demonstrates that the working environment positively affects project success. In contrast, the beta coefficient value derived from the Minnesota Satisfaction Questionnaire (MSQ) is -0.171, with a significance level below 0.01. This research suggests that job retention is negatively affected by career prospects.

### 4.6 Discussion of Results

| Hypothesis | Beta value | Pearson Correlation, r | Result |
|---|---|---|---|
| "More Healthcare workers resigned or quitting due to low morale cause by career prospect during Covid-19 pandemic compared to working environment" | 0.558 | 0.893 | **Accepted** |
| "More Healthcare workers resigned or quitting due to low morale cause by working environment during Covid-19 pandemic compared to career prospect" | -0.171 | -0.778 | **Rejected** |

Table 4.7: *Summary of hypothesis results*

# CHAPTER 5: CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

## 5.1 Conclusion

The primary purpose of this study was to examine the effect of career outlook and working environment on the retention of HCWs in Kelantan during and after the Covid-19 pandemic. A survey questionnaire was administered to 602 respondents from the population of healthcare professionals who had direct or indirect involvement with Covid-19 infection. The questionnaire was designed to acquire primary data from the sample.

The variables were collected using a questionnaire designed by earlier researchers and crafted locally in order to provide respondents with equitable options based on the most recent technical techniques. In order to validate the study's hypotheses, demographic and descriptive approaches were utilized for data analysis, while Pearson's correlation and regression analysis were used to analyse associations between variables.

Using SPSS to analyse the data, the findings indicate that career prospects have a beneficial effect on the retention of HCWs. This research also suggests that the working environment plays a little or non-existent role in the employment retention of HCWs in Kelantan.



## 5.2 Recommendation

The findings of this research study provide some insight into the feelings that HCWs currently have towards the direction their work will go in the future. According to the findings, encouraging healthcare workers to remain employed within the industry by luring them with the prospect of a secure job that offers a number of different ways to advance their standing is likely to be successful. As a result, the government and policymakers should place an emphasis on developing methods to ensure that a clear guide career pathway can be put forward for HCWs in order to assure the continuance of service in the healthcare industry. It would appear that the majority of workers are content with their existing surroundings, whether it be in the private sector or the public sector, with the majority of them deriving job satisfaction from their normal employment. Nevertheless, if a better step is taken to bring the working environment up to speed with the present condition of the world, it will undoubtedly urge them to perform more efficiently.

## 5.3 Limitations and Suggestions for Future Research

The small number of participants in the study was one of the most significant problems with the research project. This research study was carried out using the convenience based sampling method because there was a time limitation; this indicates that the samples were chosen based on how convenient it was for the researcher to do the research. It is possible that a different result will be drawn from this research if it is carried out on the entire population of Malaysia as opposed to only a sample of that population. In addition to that, the scope of this research study was limited because it was only conducted in few districts in the state of Kelantan; as a result, we were only able to draw limited findings and generalizations.

This research study was carried out without taking into consideration the influence of certain respondents who still feel uncomfortable to give an honest response. This is most likely due to respondents' loyalty to their current head of departments or their strong belief that confidentiality is required to ensure a smooth working condition, particularly in the healthcare system. When compared to conducting the research in a region that is more densely populated and has a more diverse demographic, such as Kuala Lumpur or Penang, it is possible that perceptions such as these, particularly among government employees on the East Coast, will have an effect on the results. Therefore, researchers ought to consider incorporating these aspects into future research in order to acquire a more nuanced understanding of the ways in which the working environment genuinely influences the career choices of HCWs. The future research study should also include other current elements that are affecting job retention among HCWs, such as instances of bullying among HCWs, the influence of family members, and so on.



In conclusion, the purpose of this research study was to investigate the two factors—career prospects and working environments—that have an impact on employee retention. Nevertheless, there are a great number of other aspects that would contribute to the success of the project. Despite the fact that it is mentioned, we have not yet thoroughly investigated it. As a result, more elements need to be investigated as part of future research in order to have a better understanding of the kinds of factors that could have a more significant influence on the rate at which HCWs are able to keep their jobs in Malaysia.

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# APPENDICES

**APPROVAL PAGE**

**TITLE OF PROJECT PAPER: A STUDY ON CAREER PROSPECT AND WORKING ENVIRONMENT TOWARDS JOB RETENTION AMONGST THE KELANTAN HEALTHCARE WORKERS (HCW) DURING COVID-19 PANDEMIC**

**NAME OF AUTHOR :**

**LONG TUAN MASTAZAMIN BIN LONG TUAN KECHIK**

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**The undersigned certify that the above candidate has fulfilled the condition of the project paper prepared in partial fulfillment for the degree of Master of Management.**



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