Quality of Work Life in Nursing Staff of Private and Government Hospitals

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Abstract

Quality Work Life is a multidimensional concept, and is a way of reasoning about people, work and the organization. It seems that the relationship between Quality of work life and the degree of the nurse's involvement in their work is a critical factor in achieving higher levels of quality of care delivery. In spite of the plethora of research on the subject, the efforts on the part of researchers to identify the factors of quality of work life in the Indian context have not been encouraging. In this study an attempt has been made to examine the quality of work life of Registered Nurses in private and public hospitals. The findings reveal that there are significant differences between nurses in private and public hospitals on Quality of work life dimensions.

Keywords:- nurses, quality of work life, autonomy, adequate and fair compensation.

1.1 Introduction

Today, the Quality of work life is viewed an essential dimension of the quality of life. A high Quality of Work Life is essential for organizations to attract and retain workers. In its broadest sense, QWL means the sum total of values, both material and non-material, attained by a worker throughout his career life. QWL includes aspects of work-related life such as wages and hours, work environment, benefits and services, career prospects and human relations, which is possibly relevant to worker satisfaction and motivation.

The term Quality of Work Life was first introduced by Davis (1972) at an international conference on the Quality of Working life, in the context of then prevailing poor quality of life at work place, he referred to the quality of relationship between the worker and his environment as a whole emphasizing more on the human dimensions. According to Walton (1973) "Quality of Work Life is a process by which an organization responds to employees needs for developing mechanisms to allow them to share fully in making decisions that design their lives at work". According to The American Society of Training and

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Development "QWL is a process of work organization which enables its members at all levels to participate actively and effectively in shaping the organization's environment, methods and outcomes. It is a value based process which is aimed towards meeting the twin goals of enhanced effectiveness of the organization and improved quality of life at work for the employees".

In the 1980s, emphasis was increasingly placed on employee-centred productivity programs. According to Brett (1980) Quality of work life is a term that describes workplace program which include union management cooperation, work reorganization and employee involvement. Nadler and Lawler (1983) summarize six potential definitions of QWL. QWL was a variable between 1959-1972. At this time, QWL was seen as an "individual's reaction to work or the personal consequences of the work experience". The individual at work was the focus of attention. During 1969 to 1979, labour management collaborations were advocated to improve QWL. Joint labour management cooperative projects were initiated in many organizations. The third definition emerged out of many projects aimed at forming "specific ways of changing the work place and its impact on individuals ". QWL was perceived as a set of methods, approaches or technologies for enhancing the work environment" making it more productive and satisfying. Socio-technical systems were introduced. According to Nadler and Lawler, QWL was a movement during the late 1970s. However, QWL activity deceased after this and renewed interest arose in the 1980s when QWL was considered as the best option. They expect a new definition for QWL in the near future. Nadler and Lawler defined Quality of Work Life as a way of thinking about people, work and organization. Its distinctive elements are a concern about the impact of work on people as well as on organization effectiveness, and the idea of participation in organizational problem solving and decision making."

Definition of QWL (1959 -1983)	
First Definition (1969 -1972)	QWL = Variable
Second Definition (1969 -1975)	QWL = Approach
Third Definition (1972 -1975)	QWL = Methods
Fourth Definition(1975 -1980)	QWL = Movements
Fifth Definition (1969 -1982)	QWL = Best Approach
Sixth Definition	QWL = Nothing

Source : Nadler David A. and Lawler Edward E., Quality of Work life: Perspectives and Directions and Organizational Dynamics, Winter 1983, pp-26.

Proceeding to previous definitions, **Lau, Wong, Chan and Law (2001)** operationalised QWL as the favourable working environment that supports and promotes satisfaction by providing employees with rewards, job security and career growth opportunities. Indirectly the definition indicates that an individual who is not satisfied with reward may be satisfied with the job security and to some extent would enjoy the career opportunity provided by the organization for their personal as well as professional's growth.

Estelle (2003) states that Quality of Work Life (QWL) is a multi-dimensional construct usually referring to overall satisfaction with working life and with work/life balance, a sense of belonging to a working group, a sense of becoming oneself, and a sense of being worthy and respectable. Programs of QWL usually deal with the work itself – its design and its requirements, the working environment, the decision-making processes and supervisory behaviour, and the working conditions, including the work and non-work balance.

Serey (2006) defined QWL is quite conclusive and best meet the contemporary work environment. The definition is related to meaningful and satisfying work. It includes (i) an opportunity to exercise one's talents and capacities, to face challenges and situations that require independent initiative and self-direction; (ii) an activity thought to be worthwhile by the individuals involved; (iii) an activity in which one understands the role the individual plays in the achievement of some overall goals; and (iv) a sense of taking pride in what one is doing and in doing it well. This issue of meaningful and satisfying work is often merged with discussions of job satisfaction, and believed to be more favourable to QWL.

Quality of Work Life in practice

QWL is best understood if it is seen as a goal, as a process for achieving that goal and as a philosophy setting out the way people should be managed.

QWL as a goal: - As a goal, QWL aims to improve organizational effectiveness through the creation of more challenging, satisfying

and effective jobs and work environments.

QWL as a process: - As a process, QWL calls for efforts to realize this goal through the active involvement of people throughout the organization. It is about organizational change usually from a 'control' to an 'involvement' organization.

QWL as a philosophy: - As a philosophy QWL views people as 'assets' capable of contributing skills, knowledge, experience and commitment, rather than as 'costs' that are merely extensions of the production process. It argues that encouraging involvement and providing the environment in which it can flourish produces tangible rewards for both individuals and organizations.

To summarise, QWL is viewed as a wide-ranging concept, which includes adequate and fair remuneration, safe and healthy working conditions and social integration in the work organization that enables an individual to develop and use all his or her capacities. Most of the definitions aim at achieving the effective work environment that meets with the organizational and personal needs and values that promote health, well being, job security, job satisfaction, competency development and balance between work and non-work life. The definitions also emphasize the good feeling perceived from the interaction between the individuals and the work environment.

QUALITY OF WORK LIFE ACTIVITIES AND CONCERN

Walton (1975) proposes eight conceptual categories that together make up the quality of working life - Adequate and fair compensation, safe and healthy working conditions, immediate opportunity to use and develop human capacities, opportunity for continued growth and security, social integration in the work organization, constitutionalisation in the work organization, work and the total life space and the social relevance of work life. According to Takezawa (1976) ''what constitutes a 'high' quality of working life may vary in relation to both the workers aspirations and the objective reality of his work and society. It is ultimately defined by the worker himself". The basic concept underlying the QWL is what has come to be known as "humanization of work". It involves basically the development of an "environment of work that stimulates the creative abilities of the workers, generates cooperation, and interest in self-growth. Packard (1981) divides QWL into seven categories: the work itself, working condition, climate, pay, potential for growth and development, supervision and the agency in general. Organizational features such as policies and procedures, leadership style, operations, and general contextual factors have a profound effect on how employees view the quality of their work life. QWL includes many concepts. Because the perceptions held by employees play an important role in their decision to enter, stay with or leave an organization, it is important that employees' perceptions be included when assessing QWL. A research by Huang, Lawler and Lei (2007) measures QWL in four dimensions: (a) work-life balance; (b) job characteristics; (c) supervisory behaviour; and (d) compensation and benefits. Rethinam (2008) highlighted dimensions of QWL health and well-being, job security, job satisfaction, competence development and the balance between work with non-work life. Quality of work life will be varying from place to place, industry to industry and culture to culture.

In health care organizations QWL has been described as referring to the strengths and weakness in the total work environment (Knox and Irving, 1997). With quality of care

being a top priority in all healthcare institutions, it is not surprising that quality of work life initiatives are receiving greater attention in the healthcare sector (Koehoorn et al., 2002; Yassi et al., 2002). Some of these initiatives, such as workplace wellness programs, deliver impressive cost savings and positively influence productivity (Lowe, 2002). Lowe further explains that successful quality of work life initiatives are comprehensive in scope, integrated with other human resource programs, and have well-designed implementation strategies based on strong leadership, good communication, and extensive participation.

REVIEW OF LITERATURE

Knox and Irving (1997) highlighted strong relationship between job satisfaction and quality of work life for nurses. They report meta-analysis concerning nurses and quality of work life, which indicated that autonomy is significantly associated with quality of work life. In the environment in which nurses work, the climate, open communication, and good inter professional relations influence nurses work lives. They suggested that close attention to quality of work life variables by management can foster a more humanistic work environment.

Donald (1997) highlighted how changes in health care had affected quality of work life. She examined the influence of environmental and organizational variables on the quality of work life of operating room nurses. The study covered an urban teaching hospital in Toronto. She found that influences which were considered strong were those that were found both in the literature. These consisted of (1) team-work (2) locus of control (3) organizational culture (4) change (5) multi skilled workers (6) collaborative decision-making. She found that organizational structure has no influence on the quality of work life of operating room nurses. The dismantling of the nursing department under a program management structure may diminish the nurse's sense of unity as a department. She recommended that attention must be given to leadership and organizational learning in further improving the quality of work life of nurses and other health care workers.

Baba and Jamal (1991) explored routinization of job context as indicated by employee participation in routine or non-routine shifts, routinization of job content as individual by task variety, significance, autonomy, identity and feedback and there impact on the individual perceived quality of working life. They found that routine in work hours had a positive influence on quality of work life; lack of routine in job content was positively associated with improved quality of work life.

Beaudoin et al (2003) found that social /environmental hassles were the most frequently reported category by both inpatient and outpatient nurses, followed by operational hassles and nurse hassles. The majority of the hassles for both groups of nurses were found in the social / environmental and operational categories. Nurses reported few administrative hassles, and only in the outpatient setting. , nurses working in the inpatient settings reported interdepartmental relations hassles most frequently in comparison to the nurses working in the outpatient settings who reported organizational hassles most frequently. Working conditions and physical environment hassles were the second and third most frequently reported hassles for both groups of nurses. Equipment/materials and nurse/client hassles were the fourth and

fifth most frequently reported hassles by nurses working in the inpatient settings in comparison to inter professional and technological demand and support hassles for nurses working in the outpatient settings.

Brooks and Anderson (2004) assessed quality of nursing work life in acute care in a Midwestern state. They concluded that nursing workload was too heavy, and that there was not enough time to do the job well. Respondents had little energy left after work, were unable to balance their work and family lives and stated that rotating schedules negatively affected their lives

Kemohan et al (2006) studied the quality of working life of nurses in Taiwan. They stated that nurses often complain of overwork and underpay. A total of 16 focus groups in one medical centre and five regional hospitals informed a quality of working life framework. Each group had three to five participants who were Registered Nurses in medical or surgical wards with at least 2 years' nursing experience, and who held a position below assistant nurse manager. The data were collected in 2000. They found that a total of 56 nurses' quality of working life categories were identified and fitted into six dimensions: socio-economic relevance, demography, organizational aspects, work aspects, human relation aspects and self-actualization.

Khani et al (2008) found that eighty two percent nurses who were included in the study believed that their workload was heavy, salaries were inadequate (95%), nurses were dissatisfied (63%), skill mix was found to be inadequate (72%) and a majority of nurses were unable to complete their work in the time available (54%). 79% nurses indicated that they did not have the autonomy to make patient care decisions. Respondents had little energy left after work (80%), were unable to balance their work and family lives (76%) and stated that rotating schedules negatively affected their lives (69%). Few nurses felt respected by the upper management (35%) and were able to participate in decisions (29%). Many of the nurses felt that society does not have an accurate image of nurses (62%) and indicated that their work settings did not provide career advancement (62%). They concluded that nurses' job satisfaction, salary, workload, staffing issues, skill mix, communication, autonomy, recognition and empowerment remain problematic unless policy makers and nursing managers focused on these issues.

Gurses et al (2011) found that performance obstacles affect perceived quality and safety of care and quality of working life of ICU nurses. Workload mediated the impact of performance obstacles with the exception of equipment-related issues on perceived quality and safety of care as well as quality of working life. They concluded that performance obstacles in ICUs are a major determinant of nursing workload, perceived quality and safety of care, and quality of working life.

Saraji et al (2017) highlighted that a high quality of work life (QWL) is essential for organizations to continue to attract and retain employees. The results showed that the majority of employees were dissatisfied with occupational health and safety, intermediate and senior managers , their income, balance between the time they spent working and with family and also indicated that their work was not interesting and satisfying. TUMS hospitals' employees responding to this survey have a poor quality of work life.

The purpose of this study was to explore quality of work life among nurses in private and government hospitals.

MATERIALS AND METHODS.

The present study was descriptive research. The study was conducted between 1st September and 30th Nov 2019 at 4 hospitals (two government hospitals and two private hospitals). A random sample of 120 registered nurses (60 registered nurses from government hospitals and 60 from private hospitals) were enrolled into the study. Primary data for the research was collected with the help of self-administered questionnaire that was especially designed to achieve the study objectives as outlined earlier. The questionnaire was developed from several researches through literature review. 18 independent variables were studied. These were further categorized into four factors 1) Job factors :-employee concern for work, employee commitment, job security, advancement and promotion, job development, employee involvement, employee state of mind, impact on personal lives 2) Relationship factors –relation with superior/supervisor, union management relation, work group relation, trust in management 3) Financial factors :- salary, other fringe benefits. 4) Environment factors: - physical working conditions, employee welfare, absence of job stress and respect for individual. Self-Administered quality of work life questionnaire had total 110 items having 5-point Likert scale with 1 denoting strongly disagree to 5 denoting strongly agree. The minimum possible score is 32 and a maximum possible score is 160 and the higher the value the better the quality of work life. It was categorized as low, moderate, and high using a classification of the quality of the work life total score. The same was applied for the sub-dimensions of quality of work life.

Before beginning the main research a pilot study was performed with 30 registered nurses to check the reliability and validity of the questionnaire instrument. Typically reliability coefficient of 0.7 or more are considered adequate (Cronbach, 1951, Nunnally, 1978).Content validity was examined by the experts. The reliability coefficient for this measure was relatively high (Cronbach alpha 0.92). The rating scale was "1=strongly disagree" to "5= strongly agree". The final questionnaire had 110 items. SPSS version 16 software was used for the analysis.

Table 2. Reliability Statistics

Cronbach's Alpha	N of Items
.92	110

RESULTS AND DISCUSSION

The majority of the respondents were aged 21-30 years (62.5%), followed by 31-40 years (33.3%), 41-50 years (2.5%) and 51-60 years (1.7%)(Table1) and mean aged 30. The youngest was 25 years and the oldest 54 years. The typical respondents were females (n=102, 85%) and males were 18 (15%). The majority of the nurses were experienced between 0-6 years (75%) followed by 7-12 years (20%). There were less highly experienced nurses in private hospitals as compared to government hospitals.

Table 1. Characteristics of the study sample of nurses (n=120).

Characteristics	No.	Percentage
Age (years)		
21-30	75	62.5%
31-40	40	33.3%
41-50	3	2.5%
51-60	2	1.7%
Sex		
Male	18	15%
Female	102	85%
Income		
7001-14000	51	42.5%
14001-21000	2	1.7%
21001-28000	32	26.7%
28001-35000	28	23.3%
35001-42000	7	5.8%
Years of Experience		
0-6	91	75%
7-12	24	20%
13-18	3	2.5%
19-24	Nil	Nil
25-30	2	1.7%

The income of the nurses ranged between rupees 7001-14000 per month were 42%, followed by rupees 21001-28000 per month (26.7%), rupees 28001-35000 per month were 23.3% and rupees 35001- 42000 per month (5%). The majority of the nurse's income at government hospitals was high as compare to private hospitals.

Table 2: Mean and Standard Deviation of Quality of Work Life Dimensions

Quality of Work Life Dimensions	Mean	Standard Deviation
Job factors	3.61	0.80
Relationship factors	3.64	0.87
Financial factors	3.91	0.97
Environment factors	3.58	0.81

Table 2 depicts the mean and standard deviation score of quality of work life dimensions. While analysing, the dimensions of quality work life it was depicted that financial factors had highest mean score of 3.91 with standard deviation 0.97, followed by relationship dimension with mean score of 3.64 with standard deviation 0.87, job factor dimension with mean score of 3.61 with SD 0.80 and the least mean score of 3.58 with SD 0.958 in environment dimension.

Table 1. Characteristics of the study sample of nurses (n=120).

Demographic Variables	Mean	S.D	F	p
Age	1.16	0.38	2.76	**0.03***
Educational Qualification	1.66	0.41	2.22	0.05*
Area of living	1.62	0.43	2.13	0.05*
Marital status	1.64	0.42	2.14	0.05*
Coping strategy	2.51	0.70	5.78	**0.002****
Work-Related Dimesions	Mean	S.D	F	p
Years of experience	1.86	0.60	3.21	0.01**
No. of night duties	1.69	0.43	2.32	0.05*
No. of overtime duties	1.76	0.46	2.27	0.05*
Average hours of working	1.62	0.46	3.81	0.01*
No. of breaks	**1.05**	**0.22**	**1.23**	**0.03***

Table 3 depicts the association of socio-demographic variables with the quality of work life dimensions regarding work related dimensions. The table shows that variables like age (21-30yrs), educational qualification (Nursing-B.Sc), area of living (rural), marital status (married) had significant association at p value less than 0.05 and coping strategy (listening to music) is highly significant at p value less than 0.03. The result showed that the work-related dimensions such as years of experience (1 to 3years), no. of night duties (8 to 10), average hours of working (41-50 hours) and no. of breaks (one) had significant association at p value less than 0.05.

In the Indian context, physical working environment is deterrent to quality of work life, because in large number of Indian hospitals it is still far from satisfactory. Most of the nurses from government hospitals showed dissatisfaction regarding the physical working conditions, employee welfare. When comparing the government and private hospital nurses, job stress was higher among private hospital nurses (mean score 4.13), while was lower among nurses in government hospitals (3.80). Employee welfare like recreational facilities, canteen facilities, water facilities, sanitary facilities etc was highest among the private hospitals nurses (mean score=4) while government hospitals nurses had the lower score (mean score=2.27).

In any hospital, cordial relationship at different levels- superior-subordinate, union-management, and in work groups facilitate open communication, building trust and team spirit. Work group relations received mean score of 4 and 3.93 among government hospitals nurses and private hospitals nurses respectively, implying thereby that nurses in private and government hospitals enjoy peer level support. Relations with supervisor among nurses in government hospitals and private hospitals were fairly cordial as there was not much difference between the mean

scores.

Scores on the job security and employee commitment among nurses from government hospitals were higher (mean score 3.77 and 3.90 respectively) as compare to the private hospitals nurses (mean score =2.87 and 3 respectively) implying that nurses of government hospitals are more secured, loyal and committed. Nurses from the private hospitals also showed more dissatisfaction with the level of stress and with their ability to adequately balance work and family time. Finally the salary and other fringe benefit satisfaction among the nurses from government hospitals were higher (mean score 4.12 and 3.65), while lower among the nurses from the private hospitals.

CONCLUSION

Results of this study showed that in private hospitals, nurses salary were inadequate and job stress were more. Respondents had little energy left after work, were unable to balance their work and family lives. While in government hospitals, nurses were dissatisfied with the physical working conditions like cleaning conditions, ventilation lighting etc and with the welfare facilities. Competitive salaries and scheduling options are needed. In collaboration with their colleagues in human resources, nurse executives can develop and implement employee benefit programs that would improve the work life of nurses. Shared governance and self-scheduling are a few of the strategies that could be implemented in the hospitals to improve nursing work life.

REFERENCES

1. Baba, V. B. and Muhammad, J. (1991). "Rountization of Job Context and Job Content as Related to Employees Quality of Work Life:- A study of Canadian Nurses". Journal of Organizational Behaviour. Vol.12(9). pp 379-386.
2. Beaudoin, L. E. and Edgar, L. (2003). "Hassles: Their Importance to Nurses' Quality of Work Life". Nursing Economics. Vol. 21(3). pp106-113.
3. Brett Jeanne, M. (1980), "Behavioral Research on Union and Union Management Systems" Research in Organizational Behavior, Vol. 2, pp 177-213.
4. Brooks, B.A, and Anderson, M.A. (2004). "Nursing work life in Acute care". Journal of Nursing Care Quality. Vol. 19 (3). pp 269-76.
5. Cronbach, L.J. (1951). "Coefficient alpha and internal structure test, Psycometrica 16, pp297-334.
6. Donald, J.E. (1997). "The Influence of Organizational and Environmental Variables on the Quality of Work Life of Operating Room Nurses" Unpublished Thesis. Department of Theory and Policy Studies in Education The Ontario Institute for Studies in Education of the University of Toronto, Canada.
7. Estelle, M. and Wilfrid, M. "Quality of Work Life and firm performance" http://www.usherbrooke.ca/handicap/fr/cogres/MorinEstelleCARWH2003.pdf
8. Gurses, A. P., Carayon, P. and Wall, M. (2009). "Impact of Performance Obstacles on Intensive Care Nurses' Workload, Perceived Quality and Safety of Care, and Quality of Working Life". Health Services Research. Vol. 44(2). pp. 422 – 443.
9. Hsu,M. and Kernohan, G. (2006). "Dimensions of hospital nurses' quality of working life". Journal of Advanced Nursing. Vol. 54.(1). pp120 – 131.

10. Khani, A., Jaafarpour, M. and Dyrekvandmogadam, A.(2008). "Quality of Nursing Work Life". Journal of Clinical and Diagnostic Research. Dec(2).pp1169-1174.
11. Karrir, N. and Khurana, A. (1997), "Measuring Quality of Work Life: - A Simple Approach", Paradigm, Vol. 1, No.1, pp50- 60.
12. Knox, S. and Irving, J. (1997). "An Interactive Quality of Work Life Model Applied to Organizational Transition". Journal of Nursing Administration. Vol.27(1). pp 39-47
13. LooSee Beh (2006) http://www.bai2006.atisr.org/CD/Papers/2006bai6460.doc
14. Nadler,D.A. and Lawler, E.E. (1983), "Quality of Work Life : perspectives and directions" Organizational Dynamics, Winter, pp 26.
15. Nunnally, (1978), Psycometrica, Mcgraw Hill, New York.
16. Saraji, G. N. and Dargahi, H. (2006). "Study of Quality of Work Life (QWL)" Iranian Journal of Public Health. Vol. 35.(4). pp.8-14.
17. Serey, T.T., 2006. "Choosing a Robust Quality of Work Life". Business Forum, 27(2), pp. 7- 10.