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Quality of work life in a cohort of Italian health workers

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ABSTRACT. BACKGROUND: *Quality of work life (QWL) includes some objective and subjective factors which may condition operations and other inner aspects concerning the quality of relationships and methods of management.*

Aim: *To analyse the quality of work life indicators in a cohort of Italian health workers.*

METHODS: *Semi-structured interviews were conducted, to assess the quality of work life through the identification of the most important indicators and to evaluate the degree of satisfaction and the importance of each indicator. 112 health operators were interviewed. All workers belonged to the same local health service in North West Italy.*

RESULTS: *We have pointed out some macro areas which are relevant to define work life quality of the analysed sample: relationships with colleagues, work organization, taking care of patients, professional ability and professional growth. The weekly number of patients seems to be important to determine the differences among the workers in the quality perceived in their work life.*

CONCLUSIONS: *The collected data contribute to define which indicators must be taken into consideration in order to complete an evaluation of the quality of health organizations; this includes also the subjective variables connected to the quality of the work life.*

Key words: *Quality of work life, health organizations, health workers, work satisfaction.*

RIASSUNTO. QUALITÀ DELLA VITA LAVORATIVA IN UNA COORTE DI OPERATORI SANITARI ITALIANI.

BACKGROUND: *La Qualità della Vita Lavorativa (QVL) risente di numerosi aspetti oggettivi e soggettivi che possono influenzare le attività svolte, la qualità delle relazioni professionali e le modalità operative presenti nell'organizzazione.*

SCOPO: *Analizzare gli indicatori di qualità della vita lavorativa in una coorte di operatori sanitari italiani.*

METODO: *Sono state condotte delle interviste semi-strutturate per valutare la qualità della vita lavorativa attraverso l'identificazione dei principali indicatori e la loro misurazione riferita al grado di importanza e soddisfazione. Hanno partecipato allo studio 112 operatori sanitari appartenenti a una struttura sanitaria dell'Italia nord occidentale.*

RISULTATI: *Sono state individuate alcune macro aree principali connesse alla qualità della vita lavorativa nel campione analizzato: relazioni con i colleghi, organizzazione del lavoro, assistenza ai pazienti, competenze professionali e crescita personale. Le differenze tra i soggetti nella loro percezione della qualità della vita lavorativa risultano determinate in misura significativa dal numero settimanale di pazienti.*

CONCLUSIONI: *I dati raccolti contribuiscono a definire gli indicatori oggettivi e soprattutto soggettivi da tenere in considerazione per compiere una valutazione della qualità della vita lavorativa nelle organizzazioni sanitarie.*

Parole chiave: *Qualità della vita lavorativa, organizzazioni sanitarie, operatori sanitari, soddisfazione lavorativa.*

The concept of quality of life and quality of worklife (QWL) are frequently adopted in research within health organizations while dealing with the subjects of wellness and professional satisfaction (1, 2). Many studies have brought to light how the QWL is influenced both by the inner methods of management of the organization (in particular as far as management HR), and by the external context where the organization operates; this may also influences the operating modalities. At the same time it has been demonstrated that the quality of health service is influenced particularly by the state of wellbeing and satisfaction of the health operators. Today experts in this field agree on the importance of at least two essential aspects of the quality of work life: multidimensionality and subjectivity (3). The definition of multidimensionality must cover different work life dimensions such as physical, social, psychological, environmental (4). One's daily experience, and the specific elements responsible for the quality of one's work life assume highly personal and subjective configurations. Not only this, but it must be considered that there might be interpersonal and intra personal differences in the perception and in the evaluation of objective aspects both in health and in work. Therefore, paraphrasing one definition of Calman about the quality life (5): the quality of work life is the result of an evaluation that each individual carries out comparing his own hopes, expectations and desires with what he considers as reality. In this perspective, similar behaviours may not have the same importance for all the individuals. More over, the relevance and the importance of certain behaviours do not remain static, but may be modified during life and according to the change of work conditions.

Nowadays, recent modifications in health care in Italy require precise assessment of the quality of work life for health workers, in order to identify the consequences of new organisational structures, so that it will be possible to evaluate their effects on the patients wellness (6). Besides, also in the Italian health system, evaluations of the quality like ISO 9000 that demand the monitoring and the appraisal of the condition of health and satisfaction of the health operators are being diffused. Such appraisal is based both on the use of specific instruments (for example self reports, which measure aspects of working dynamics), and on the use of structural variables, process variables or results produced or perceived by the user. This evaluation

system does not consider the subjective and relational dimensions of the work life.

Several specific measures are available for different aspects of work life such as commitment (7), job satisfaction (8), stress (9), and burnout (10). The objective is to define the possible indicators which might reveal the quality of work life, so that it can be evaluated (11). In the past, the quality of work life has been sometimes identified with a specific objective measurement, while the examination of other important and subjectively relevant variables, has been left out. According to this approach, a more complete and general evaluation would necessarily require the use of many questionnaires and consequently imply wastefulness (12).

The present study offers a new perspective and suggests an individual approach to assessing the quality of work life based on the measurement, for each health worker, of a specific range of wishes, hopes, and expectations on which he bases the evaluation of his own work life. The objective is to investigate the quality of work life indicators in health care workers.

Methods

The quality of Work life measurement of the health worker has been carried out through a structured interview, which was conceived in order to measure the quality of worklife based on a range of areas considered important by the individual subjects. The interview includes three types of questions:

1. Which are the person's most important areas of work life?
2. At the moment what is his evaluation of each one of these areas?
3. What is their relative importance?

These questions are set in an interview divided in three phases. The first consists in collecting of personal data: sex, age, education, profession, place of work, weekly working hours, years of work in health service, number of patients visited per week. The second is related to the identification of the five most important aspects (labels), in one's present work life. The third phase implies the evaluation, of a visual analogue, on a vertical scale, and therefore the satisfaction rate referred to each label. Each evaluation can vary from 0 to 100. The last phase is dedicated to check the relative contribution of each area towards the total quality of work life. For this, the interviewed must divide, inside a given rectangle, each area corresponding to the weight given to each label. In order to perform this, he must draw horizontal lines joining the two sides of the rectangle, naming the areas he has defined. The height of each drawn area is measured in order to evaluate the ascribed weights. The total sum of the five weights vary from 0.00 to 1.00.

The interview gives an overall score of quality of work life which is the result of multiplying the satisfaction rate of each area by the weight ascribed and summing the scores. This total ranges from 0 to 100.

Participants

112 health workers were interviewed for this research: 41 men and 71 women (mean age=39.51, SD=7.9). 45 were hospital doctors, 48 nurses, 10 midwives and 9 were family doctors. All of them belonged to the same local structure of the National Health Service in Northern Italy. The health workers were employed in seven different operating units: 18 Pediatric staff, 17 General ward staff, 24 Gynecology staff, 14 Surgery staff, 14 Emergency ward staff, 16 Orthopedic staff, and 9 General Practitioners .

The health workers had worked for an average of 14 years (SD=7.62) and had an average stay in their present department of 8.8 years (SD=8.08). The amount of work was measured by the number of visits which was 85.48 (SD=119.83) patients per week, while the number of weekly working hours was of 43.10 (SD=9.44).

Procedure

This interview was conducted individually during working hours. The time spent was approximately 20 minutes, and there were no problems reported with the comprehension of the questions. Data collection was carried out in February 2005 by a single researcher with experience in social data collection. Answers were audio taped and then analysed by two independent researchers trained to identify common indicators of work life quality. Descriptive statistics and variance analysis were used for data investigation.

Results

Table I shows the work life aspects that the participants reported as important. It is evident that the relationship aspects in health care have a remarkable prominence of the perceived quality of work life: 79.5% of the workers included relationship with colleagues as one of the five most important areas, and 73.2% included the relationships developed with patients.

A content analysis of the work life aspects has revealed five quality of work life indicators: Professional Relationship, Work Organization, Taking Care of Patients, Professional Ability and Professional Growth. Different categories were created starting from the descriptions of the aspects given by each staff member. The Professional Relationship indicator gathers all aspects involving common work dynamics, both formal and informal: relationship with colleagues or with managers, teamwork, and information flow between different workers. The Taking Care of Patients indicator refers to the emotional and relationship dynamics which may originate between workers, patients and patients' relatives. The Work Organization indicator refers to those technical and managerial aspects which form part of health work (for example, techniques, work shifts, bureaucracy and definition of targets) or those practical aspects which make work more comfortable (for example distance from home, work environment). The Professional Ability indicator refers to the im-

portance of roles inside the organization structure, the level of autonomy and one's personal professional esteem. Finally, the Professional Growth indicator refers to understanding how to build one's job know how, salary and career improvement. These indicators offer the opportunity of focussing how much the workers were satisfied in the areas of professional growth and the organization of their work (Table II). These indicators, however, are not the most important in defining the quality of work life. Instead, the relevant indicators seem to be those describing the work aspects of addressing to patients, as opposed to their professional ability and relating to patients, which are the areas considered most satisfactory by the workers (Table III).

In addition to the analysis of the aspects which were considered important by the workers in defining their quality of worklife, the interview permits a global score for quality of work life. As it can be seen in Table IV, the quality of work life global score does not appear to be influenced by sex, role, age, or number of working years in a specific department; on the contrary, what seems affecting for the quality of work life is the amount of weekly work. The health workers with a greater amount of weekly work, in terms of number of patients, reported a significantly lower quality of work life. In particular, they have revealed to be unsatisfied with the professional relationship ($F=3.0705$, $p=.0510$) and organization category ($F=2.9762$, $p=.0562$).

Table I. Participants' Most Important Work Aspects (5 Answers for Each Participant)

Work Life Aspects	Frequency	Frequency %
Relationship with colleagues	89	79.5
Relationship with patients	82	73.2
Organization	48	42.8
Professional learning	42	37.5
Emotive reactions to patients	39	34.8
Technical ability	34	30.4
Professionalism	26	23.2
Career	23	20.5
Work shift	23	20.5
Work team	17	15.2
Relationship with management	12	10.7
Bureaucracy	11	9.8
Work environment	11	9.8
Independence	10	8.9
Communication	9	8.0
Salary	7	6.2
Objectives	7	6.2
Role	5	4.5
Distance from home	4	3.6

Discussion

In the health service which, in the last ten years, has been forced to undergo change while keeping low cost levels and good quality of interventions, the quality of worklife may gain a strong role among the indicators of professional life, together with the development of guide lines and evidence based medicine. Previous studies, carried out not in the health service, underline how the quality of worklife may have a positive influence on performance levels (13) and on the accident risk (14) while work stress, often used as theoretical definition similar to quality of worklife, is related to a lot of negative physical, psychological and behavioural effects (15).

Table II. Satisfaction Ratings For Each Aspect and Category of Work Life

Work labels	Satisfaction		
	n	M	SD
Relationship with colleagues	89	72.10	22.92
Communication	9	50.44	20.14
Work team	17	51.71	25.64
Relationship with management	11	42.09	28.76
Relationship total	100	68.35	23.03
Relationship with patients	82	77.61	19.69
Emotive reactions to patients	39	66.49	27.84
Treatment total	98	73.95	21.09
Distance from home	3	37.67	42.19
Bureaucracy	11	23.18	15.89
Objectives	8	45.75	33.14
Work shift	23	47.91	29.93
Organization	46	40.71	27.65
Technical ability	36	63.90	24.81
Work environment	11	54.82	31.76
Organization total	92	48.16	27.11
Salary	7	27.86	20.28
Career	23	60.20	28.26
Professional learning	42	57.06	26.12
Professional growth total	60	55.37	27.48
Independence	10	71.10	31.00
Professionalism	26	70.75	16.06
Role	5	43.40	37.21
Professional grade total	38	67.11	23.56

Table III. Relative Importance of Each Aspect and Category of Work Life

Work labels	Importance		
	n	M	DS
Relationship with colleagues	89	19.92	7.87
Communication	9	17.89	9.18
Work team	17	16.44	6.39
Relationship with management	11	14.36	7.71
Relationship indicators	100	18.65	7.20
Relationship with patients	82	23.31	10.31
Emotive reactions to patients	39	19.52	11.52
Treatment indicators	98	22.06	8.91
Distance from home	3	29.00	4.58
Bureaucracy	11	22.27	5.28
Objectives	8	22.13	12.57
Work shift	23	19.83	11.49
Organization	46	19.45	8.81
Technical ability	36	18.75	9.50
Work environment	11	16.82	10.88
Organization indicators	92	19.71	9.66
Salary	7	24.00	9.83
Career	23	19.43	9.40
Professional learning	42	16.19	5.90
Professional growth indicators	60	17.85	6.27
Independence	10	24.40	12.92
Professionalism	26	22.88	8.22
Role	5	19.40	8.91
Professional grade indicators	38	22.54	8.10

The richness of the qualitative data collected has helped to focus some aspects which appear to be critical in defining the quality of life in health work. They also represent some of today's most problematic topics which form the base of development of the health systems in Italy, and not only. Nowadays, there are key-themes of sanitary management: the issues such as professional education and its development, relationship management among workers, the creation of work groups or teams, aspects linked with the humanization of treatments and the organizing of services. The adopted interview has done nothing but point out how these themes have already entered the culture of the health workers. Nevertheless, it also offers an opportunity of evaluating the influence of these themes in modifying the global level of perceived quality of worklife. We have also been able to evaluate the influence on these categories of social-

Table IV. Quality of worklife

	n	M	DS
Sex			
Males	41	62.20	22.01
Females	71	64.02	16.97
F		.24	
p		Ns	
Role			
Doctors	54	62.56	19.94
Nurses	48	62.47	18.55
Midwives	10	71.88	13.32
F		1.12	
p		Ns	
Age			
Until 30	13	55.73	15.40
31-40	55	64.82	18.57
41-50	31	62.59	18.79
More than 50	13	66.60	23.35
F		.96	
p		ns	
Average years of work			
Less than 2	33	62.92	19.05
2-8	33	61.93	16.69
More than 8	46	64.70	20.52
F		.22	
p		ns	
Patients per week			
Less than 50	52	65.16	19.67
50-100	40	66.89	14.21
More than 100	18	50.66	21.63
F		5.37	
p		<.01	

demographic variables or of work load, pointing out how these are important in order to understand the differences in the quality of work life.

In particular, the collected data have contributed to point out how the subjective perception of the quality of work life is influenced mostly by the amount of the demanded performances. Currently the Italian health system, based on the economic-managerial autonomy of the health organizations and on their financing in relation to the carried out health performances, aims at rewarding the health organizations in order to produce a greater number of per-

formances; but this aspect, as it is revealed by the research, can negatively influence the subjective wellbeing of the workers and, consequently, can also involve a probable worsening of the quality of service provided.

These data allow us to consider the structured interview as a useful instrument in order to locate the key areas important for the development of quality improvement cycle.

Moreover they emphasize the importance to insert processes of appraisal of the quality of work life subjectively perceived inside the systems of the quality evaluation; this is an unavoidable source of data in order to keep the possibility of high quality in the health service.

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