

Quality of working life from the perspective of different groups of professionals working in a maternity hospital

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Abstract *The relationship between people and work has a direct impact on quality of life and health. The objective of this article is to compare perceived levels of Quality of Working Life (QWL) across three different groups of professionals. Cross-sectional study with a random sample of 172 hospital workers (37.9±10.3 years; 73.8% women). Participants filled out the Quality of Working Life Assessment Inventory (QWL-AI). The data was analyzed using Anova and Tukey's test. Statistically significant differences were found between the groups in 36.4% of the items assessing work conditions, 35.7% of the items assessing professional growth and recognition ($p<0.05$), 12.5% of the items assessing socioprofessional workplace relationships, 11.1% of the items assessing work organization, and 10% of the items assessing link between work and social life. Overall, 21.7% of the items showed significant differences between groups. We found significant differences in perceived QWL between the different groups, suggesting that QWL interventions should be tailored to the address the specific needs and demands of different sectors and departments to be effective.*

Key words *Quality of Life, Work, Health Promotion*

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Introduction

The process of globalization witnessed in recent decades has triggered economic and social transformations that have changed the relationship between people and work¹⁻⁴. The advance of capitalism has led to increasing needs and wants of individuals, who seek to satisfy them through work^{4,5}.

As a result, greater attention has been paid to workplace well-being⁶, which is influenced by different workplace features², including the cognitive, affective, motivational, psychosomatic, and behavioral dimensions of individuals^{6,7}. Poor working conditions give rise to a range of problems, such as stress, increased risk of workplace accidents and occupational diseases, absenteeism, and lower productivity⁸⁻¹¹.

According to the World Health Organization, quality of life is defined as “[...] the individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals [...]”^{8,12}.

According to the Ottawa Charter¹³, health promotion is the process of enabling people to increase control over, and to improve, their health and to reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.

The term Quality of Working Life (QWL) stems from the concept of quality of life and is expressed in global (organizational context) and specific (work situations) representations constructed by workers, emphasizing workplace well-being, employee recognition, professional growth, and respect for the individual¹⁴.

Viewed from this perspective, attention to QWL emerges as an effective way of reducing organizational malaise, having a positive effect on workers’ health^{10,15}. Attention to QWL needs to be understood as an area within the field of health promotion. Much more than an administrative or strategic tool for improving productivity, a high level of QWL has a positive impact on the well-being of professionals, resulting in a healthier life¹⁶.

Effective QWL interventions promote improvements in workers’ health and well-being^{7,9,11,15}. A systematic review of QWL interventions conducted by Hipólito *et al.*¹⁷ showed that these initiatives bring important health benefits for workers.

However, studies have shown that health workers, including nurses, nursing assistants,

physical therapists^{5,18-22}, doctors²²⁻²⁵, and administrative staff^{3,4,11,26,27}, have varying perceptions of their own QWL.

In view of the above, we conducted a diagnostic study guided by the following questions: “How do the members of different groups of professionals perceive their QWL?” and “Is there a significant difference in perceptions between groups of professionals?”

To this end, our objective was to perform a diagnosis of the level of QWL in a hospital and analyze differences in perception between three groups of professionals: administrative staff, doctors, and other care staff.

Methods

Study design, location, and period

A cross-sectional study was conducted with staff from the Federal University of Rio Grande do Norte’s teaching maternity hospital *Maternidade Escola Januário Cicco* (MEJC), in Natal, between February and December 2016.

Participants and sampling

All staff who had worked in the hospital for at least two months were considered eligible to participate in the study. Participants were selected using probability sampling and stratified according to professional area. Each professional area was categorized into one of the following groups: administrative staff, care staff, and doctors, which are the staff divisions used by the hospital.

Sample size was calculated considering a total population of 513 staff and, based on the pre-test, adopting an estimated prevalence of the predominance of workplace well-being of 73%, 5% sampling error, and 95% confidence level. Random sampling of each stratum was then performed, where each stratum sample size was directly proportional to the total original population²⁸, resulting in a final sample of 172 staff distributed as follows: 28 administrative staff, 106 care staff, and 38 doctors.

Research instrument

We used a socioeconomic questionnaire and the Quality of Working Life Assessment Inventory (QWL-AI), validated by Ferreira²⁹. Used for assessing and monitoring QWL in corporations, this instrument provides an accurate picture of

respondents' perceptions of QWL across behavioral, epidemiological and perceptual dimensions.

According to Ferreira¹⁴, representations of workplace well-being and malaise are influenced by five core factors: Working Conditions, Work Organization, Socioprofessional Workplace Relationships, Professional Recognition and Growth, and Link Between Work and Social Life. Organizational culture also plays an important role in interpreting overall QWL as measured by the QWL-AI.

The inventory consists of 60 items distributed across the different core factors underpinning the QWL-AI. Each item is scored on a scale of 0 to 10. The average scores are analyzed using the following scale (Figure 1).

Procedure

Each participant was contacted to schedule the filling in of electronic versions of the research instruments. The respondents filled in the questionnaires in the presence of an interviewer to standardize understanding, instructions, doubt clarification.

Data analysis

The socioeconomic data was analyzed using descriptive statistics (percentages). The items of each QWL factor were presented as means and standard deviation (Mean±SD). One-way anal-

ysis of variance (Anova) was used to determine whether there were any statistically significant differences in perceptions of QWL (mean scores for the QWL factors) between the three groups of professionals. Tukey's test was used to detect significant differences between groups of professionals. A significance level of 0.05 was adopted for all analyses²⁸.

Ethical aspects

All participants signed an informed consent form in accordance with the Declaration of Helsinki. To ensure confidentiality, the questionnaires were filled out anonymously and the interviewers did not participate in data analysis. The study was approved by the Research Ethics Committee at the *Hospital Universitário Onofre Lopes* (HUOL/UFRN).

Results

Broad and specific data of the employee's situation was collected to characterize the study sample, as shown in Table 1.

The sex distribution of the groups of professionals varied considerably. While the administrative staff showed an even sex ratio, care staff and doctors were predominantly women. The majority of the respondents fell within the 30 to 39 and 20 to 29 years age groups and had a post-graduate qualification.

0-0.9	1-1.9	2-2.9	3-3.9	Negative tendency 4-4.9	Positive tendency 5-5.9	6-6.9	7-7.9	8-8.9	9-10
Intense malaise		Moderate malaise		Transition zone		Moderate well-being		Intense well-being	
Malaise dominant				Well-being dominant		Well-being dominant			
Negative result showing the predominance of workplace malaise Risk of illness				Moderate result. Indicates a "at the limit situation". Malaise and well-being coexist in the workplace Warning signal		Positive result showing the predominance of workplace well-being Health promotion			

Figure 1. Psychometric chart used to interpret the scores of QWL-AI.

The majority of respondents had less than three years of service at the hospital, reflecting the recent hiring of a large number of staff by the state-owned hospital services company *Empresa Brasileira de Serviços Hospitalares* (EBSERH), which has been running the hospital since the middle of 2014.

The majority of care staff (54%) and doctors (87%) reported that they had another job, while over 90% of administrative staff worked exclu-

sively at the hospital. The proportion of professionals holding managerial positions was greatest among administrative staff (22%, compared to 11% and 9% among doctors and care staff, respectively).

With respect to weekly work load, only 11% of administrative staff worked more than 40 hours a week, compared to 50% of care staff, and 80% of doctors.

Table 1. Socioeconomic profile of the study population.

Variables	%	Variables	%
Marital Status		Professional area x Having another job	
Married	56	Administrative	
Single	26	No	93
Divorced/separated	10	Yes	7
Stable relationship	6	Care staff	
Widow	2	No	46
Level of education		Yes	54
Postgraduate qualification	59	Doctors	
Degree	18	No	13
Secondary school	22	Yes	87
Primary school	1	Professional area x Managerial position	
Postgraduate qualification		Administrative	
Specialist training course	86	No	79
Master's	11	Yes	21
Doctorate	3	Care staff	
Age Group (years)		No	91
20-29	20	Yes	9
30-39	46	Doctors	
40-49	16	No	89
50-59	14	Yes	11
60 and over	4	Professional area x Weekly work load	
Time of service at the hospital		Administrative	
Less than 3 years	56	between 20 and 40h	89
3 to 5 years	17	more than 40h	11
6 to 10 years	3	Care staff	
11 to 16 years	10	between 20 and 40h	48
17 to 30 years	7	more than 40h	52
31 years and over	6	Doctors	
Professional area x Sex		between 20 and 40h	19
Administrative		more than 40h	81
Female	50		
Male	50		
Care staff			
Female	81		
Male	19		
Doctors			
Female	71		
Male	29		

Interpretation of the Quality of Working Life Factors

The scores for the five QWL factors based on the parameters established by Ferreira¹⁴ are shown in Table 2. The factors that showed the worst overall scores were Working Conditions and Work Organization, both of which fell within the zone of transition, demonstrating that malaise and well-being coexist in the workplace.

The means presented in Table 2 represent the scores of the total sample. Tests were then performed to detect whether there were any statistically significant differences between groups of professionals.

Statistically significant differences between groups of professionals were found in 21.7% of the items, distributed proportionally as follows: four of the 11 items in Working Conditions (36.4%); five of the 14 items in Professional Recognition and Growth (35.7%); two of the 16 items in Socioprofessional Workplace Relationships (12.5%); one of the nine items in Work Organization (11.1%); and one of the 10 items in Link Between Work and Social Life (10%).

Significant differences were found for the following items of Working Conditions: Workstation is suitable for performing the tasks ($F[2;169]=6.116$; $p=0.003$); Room temperature is comfortable ($F[2;169]=5.884$; $p=0.003$); The work I do puts my physical safety at risk ($F[2;169]=14.964$; $p=0.000$); Workplace furniture is adequate ($F[2;169]=11.079$; $p=0.000$).

Work Organization showed significant differences in the item Lack of time for rest breaks at work ($F[2;169]=6.432$; $p=0.002$), while Socioprofessional Workplace Relationships showed

significant differences in the items Conflict in the workplace is common ($F[2;169]=3.309$; $p=0.039$) and My coworkers are always willing to help me ($F[2;169]=3.581$; $p=0.030$).

Significant differences were found for the following items in Professional Recognition and Growth: The practice of recognition contributes to my professional area fulfillment ($F[2;169]=3.749$; $p=0.026$); The MEJC provides opportunities for professional growth ($F[2;169]=4.994$; $p=0.008$); Recognition of group work is an effective practice at MEJC ($F[2;169]=4.908$; $p=0.008$); Everyone has equal professional growth opportunities ($F[2;169]=3.800$; $p=0.024$); and Recognition of individual work is an effective practice at MEJC ($F[2;169]=4.338$; $p=0.015$).

For Link Between Work and Social Life, significant differences were found for The work I do is useful to society ($F[2;169] = 5.965$; $p = 0.003$). The items that showed significant differences are shown in Table 3.

Table 4 shows the results of Tukey's test, detailing the difference between the means, 95% confidence intervals (CI), and p-values.

The difference in perceptions between the groups of professionals is demonstrated by the fact that care staff obtained the lowest scores across the majority of items (left side) and doctors and administrative staff obtained the highest scores across the majority of items (right side).

Discussion

This section discusses the key differences in perceptions of QWL between the groups of professionals identified above. It is important to high-

Table 2. Overall mean of QWL factor scores and highlighted items.

Factor	mean±SD	Items with the highest and lowest scores
Working conditions	5.60±2.86	Level of lighting is sufficient to perform the activities (6.93) Physical space is satisfactory (4.31)
Work organization	5.27±2.88	I can do my job without pressure (7.12) Tasks are repetitive (3.60)
Socioprofessional workplace relationships	7.89±2.18	My working relationships with colleagues are harmonious (9.07) Communication between employees is poor (6.15)
Professional recognition and growth	6.20±2.92	The practice of recognition contributes to my professional area fulfillment (7.89) Recognition of individual work is an effective practice (4.75)
Link between work and social Life	8.04±2.01	The work I do is useful to society (9.41) Society recognizes the importance of my work (6.70)

Table 3. Items that showed statistically significant differences between groups of professionals.

Factor/Item	Mean±SD		
	Administrative n=28	Care staff n=106	Doctors n=38
Working conditions			
Workstation is suitable for performing the tasks	7.07±2.64 ^a	5.38±2.88 ^{a,b}	6.66±2.13 ^b
Room temperature is comfortable	7.64±2.21 ^a	5.89±3.20 ^{a,b}	7.29±2.50 ^b
The work I do puts my physical safety at risk	7.50±2.83 ^{a,c}	4.33±2.97 ^a	3.82±3.07 ^c
Workplace furniture is adequate	7.32±2.36 ^a	5.07±2.87 ^{a,b}	6.82±2.39 ^b
Work organization			
Lack of time for rest breaks at work	6.82±3.26 ^{a,c}	4.45±3.19 ^a	4.47±3.15 ^c
Socioprofessional workplace relationships			
Conflict in the workplace is common	7.71±2.99 ^a	6.07±3.09 ^a	6.47±2.84
My coworkers are always willing to help me	9.29±1.05 ^a	8.54±1.63 ^a	8.97±1.00
Professional recognition and growth			
The practice of recognition contributes to my professional area fulfillment	6.93±2.73 ^c	7.92±2.40	8.53±1.83 ^c
The MEJC provides opportunities for professional growth	4.21±3.39 ^c	5.32±3.08	6.50±2.02 ^c
Recognition of group work is an effective practice at MEJC	5.29±3.53	5.19±2.93 ^b	6.84±1.85 ^b
Everyone has equal professional growth opportunities	3.75±3.88 ^c	5.26±3.31	6.00±2.84 ^c
Recognition of individual work is an effective practice at MEJC	4.50±3.66	4.36±3.01 ^b	6.03±2.55 ^b
Link between work and social Life			
The work I do is useful to society	8.82±1.68 ^{a,c}	9.48±0.80 ^a	9.63±0.88 ^c

SD = Standard Deviation. Significant differences based on Tukey's test: ^a Administrative staff and care staff ($p < 0.05$), ^b Care staff and doctors ($p < 0.05$), ^c Administrative staff and doctors ($p < 0.05$).

light that caution should be taken in generalizing the results of QWL interventions in the workplace.

Attention should be paid to workers' needs, focusing on the identification of situations of malaise and the implementation of QWL interventions capable of enhancing the well-being and, consequently, the general health of workers^{1,4,7}.

The differences between the groups of professionals were greatest in Working Conditions and Professional Recognition and Growth, where significant differences were found in 36.4% and 35.7% of items, respectively.

Working conditions is one of the main pillars of the investigation of work settings. Inadequate working conditions can lead to representations of workplace malaise^{9,30}. A safe and healthy work environment fosters good physical and mental health^{1,30}.

Organizational support is essential for the promotion of QWL, reducing workplace health and safety risks and, above all, facilitating the

process of adapting to work demands²⁶. The level of satisfaction of care staff with working conditions was significantly lower than that of doctors and administrative staff, suggesting that special attention should be paid to the needs of this group in this area.

Mean scores for Lack of time for rest breaks at work were significantly higher among administrative staff (6.82 ± 3.26 ; $p = 0.002$) than care staff (4.45 ± 3.19 ; $p = 0.002$) and doctors (4.47 ± 3.15 ; $p = 0.010$). This difference may be accentuated by the fact that having two or more jobs is common among care staff, which is likely to have a negative impact on quality of life^{19-21,30}.

Daubermann and Tonete²⁰ identified an association between work overload caused by having two or more jobs and adverse events reported by health professionals and suggest that the adoption of a curative QWL approach, rather than prevention and promotion, can have an adverse effect on well-being²⁰.

With regard to Socioprofessional Workplace Relationships, the work setting influences work-

Table 4. Results of Tukey's test performed with the QWL factors.

Factor/Items	Groups of professionals	Difference between the means	CI95%	P-value
Working conditions				
Workstation is suitable for performing the tasks	ADM - CS	1.694	(0.339; 3.049)	0.010 ⁽¹⁾
	DOC- CS	1.281	(0.075; 2.486)	0.034 ⁽¹⁾
Room temperature is comfortable	ADM - CS	1.756	(0.291; 3.221)	0.014 ⁽¹⁾
	DOC- CS	1.403	(0.099; 2.706)	0.032 ⁽¹⁾
The work I do puts my physical safety at risk	ADM - CS	3.170	(1.679; 4.661)	0.000 ⁽¹⁾
	ADM - MED	3.684	(1.937; 5.432)	0.000 ⁽¹⁾
The existing furniture in the workplace is suitable	ADM - CS	2.255	(0.901; 3.610)	0.000 ⁽¹⁾
	DOC- CS	1.750	(0.544; 2.955)	0.002 ⁽¹⁾
Work organization				
Lack of time for rest breaks at work	ADM - CS	2.369	(0.766; 3.971)	0.002 ⁽¹⁾
	ADM - MED	2.348	(0.469; 4.226)	0.010 ⁽¹⁾
Socioprofessional workplace relationships				
Conflict in the workplace is common	ADM - CS	1.648	(0.132; 3.165)	0.030 ⁽¹⁾
My coworkers are always willing to help me	ADM - CS	0.748	(0.028; 1.468)	0.040 ⁽¹⁾
Professional recognition and growth				
The practice of recognition contributes to my professional area fulfillment	DOC- ADM	1.598	(0.215; 2.98)	0.0019 ⁽¹⁾
The MEJC provides opportunities for professional growth	DOC- ADM	2.286	(0.558; 4.014)	0.006 ⁽¹⁾
Recognition of group work is an effective practice at MEJC	DOC- CS	1.653	(0.384; 2.923)	0.007 ⁽¹⁾
Everyone has equal professional growth opportunities	DOC- ADM	2.250	(0.297; 4.203)	0.019 ⁽¹⁾
Recognition of individual work is an effective practice at MEJC	DOC- CS	1.668	(0.311; 3.025)	0.011 ⁽¹⁾
Link between work and social Life				
The work I do is useful to society	CS - ADM	0.660	(0.154; 1.166)	0.007 ⁽¹⁾
	DOC- ADM	0.810	(0.217; 1.403)	0.004 ⁽¹⁾

¹ 15% significance level. ADM: Administrative; CS: Care staff; MED: Doctors.

ers' emotions, mood, and feelings of affection, which can either facilitate or hinder social interactions and the development of a climate conducive to well-being³.

In this factor, scores for the items Conflict in the workplace is common and My coworkers are always willing to help me were significantly higher among administrative staff than care staff.

Social relationships in the study setting involve three main actors: colleagues, managers, and service users. It is important to bear in mind that care staff tend to have greater contact with these groups, particularly services users and, due to the rota system and existence of multiprofessional area teams, there is increased manager and col-

league turnover among this group¹⁴. QWL is influenced by aspects of job satisfaction such as a safe work environment, mutual respect, and adequate conditions and training to perform the job²⁰.

Administrative staff obtained significantly lower scores than doctors in different items of Professional recognition and growth, including the The MEJC provides opportunities for professional growth (4.21±3.39; p=0.006 compared to 6.50±2.02; p=0.006, respectively).

Studies have shown that workers tend to value two types of recognition: monetary recognition and praise¹⁴. In light of the findings, it is important to identify possible gaps in this area in the organization under study.

In this respect, the findings show that the organization's QWL policy should include career growth opportunities and foster worker participation in decision-making, regardless of professional area, in order to improve recognition and job satisfaction among staff²⁰.

The highest scores were found among doctors, suggesting that special attention should be paid to the causes of these differences (working hours, work conditions and organization, occupational prestige and social status of occupations, varying degrees of recognition of professions among managers, etc).

On the other hand, the level of workplace malaise, particularly in terms of professional growth, was shown to be higher among administrative staff. In this respect, it is possible that these workers feel that they are in jobs in which they are not fulfilling their potential. Furthermore, the fact that the organization's main activity is healthcare may have negative implications for motivation, leading administrative staff to believe that their tasks have secondary status.

With respect to Link Between Work and Social Life, administrative staff also obtained significantly lower scores than care staff and doctors for the The work I do is useful to society (8.82 ± 1.68 ; $p=0.007$; 9.48 ± 0.80 ; $p=0.007$; and 9.63 ± 0.88 ; $p=0.004$, respectively). Ferreira¹⁴ claims that happiness at work is closely entwined with the feeling of usefulness attached to the job.

The findings of this study suggest that QWL interventions should focus on care staff and administrative staff. The major differences found between groups of professionals highlight the complexities of QWL management. Souza⁴ suggests that organizations should view QWL as part of the workers' right to a safe and healthy work environment, rather than a tool for enhancing productivity.

Tailored interventions that take into account gender, job, sectoral, and regional differences tend to have a greater positive impact on health outcomes³¹. A preventive program aimed at resolving problem situations would therefore provide the opportunity to appease dissatisfaction with work relations.

One of the limitations of the study was the study design. Since cross-sectional studies are limited in their ability to determine the cause-and-effect relationship between variables, we had to rely on relevant literature to infer direction of causality.

Conclusion

Our findings show important differences in perceptions of QWL between the three groups of professionals, strongly suggesting that QWL interventions need to address the specific needs and demands of different sectors and departments if they are to be effective.

The majority of studies in this area fail to consider the importance of tailoring activities to the specific needs and characteristics of the different sectors and departments of a company to ensure the success of QWL interventions. Our findings show that levels of QWL were highest in doctors, followed by administrative staff and care staff, emphasizing the need for inclusive interventions targeting the workers who are experiencing greatest difficulty.

The findings of this study can contribute to ensure that diagnostic phase of QWL programs differentiates between different groups of professionals. It is suggested that QWL interventions in the workplace should tailor activities to the specific needs of different groups of workers, thus providing a solid foundation for fostering QWL capable of promoting health.

Collaborations

SF Camargo participated in study conception and design and coordinated data collection and the drafting of the final version of this manuscript. RHSC Almino participated in study conception and design, data collection, and in the drafting of this manuscript. MP Diógenes participated in study conception and design, data collection. JP Oliveira Neto participated in data collection. IDS Silva participated in study conception and design, data collection. LC Medeiros participated in study conception and design, data collection. KGR Dantas participated in the drafting of this manuscript. JDAS Camargo supervised project implementation, study conception and design, statistical analysis, and the drafting of this manuscript.

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