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CHAPTER 1

General introduction and outline
1.1 General introduction

In health care settings, the time when quality of care for a patient is achieved at the expense of the health of employees, seems to be over. High absence and turnover levels in the health care sector show that more attention to care employees is of great importance for their well-being and health. To illustrate, in the Netherlands the percentage of absenteeism in health care settings in the last decade has consistently been above the national average. Between 1998 and 2010 absenteeism rates in health care are 1 to 3% higher compared to the national mean (CBS Statline, 2011). In view of these facts it is no surprise that health care employees also experience reduced quality of work and well-being.

In the literature, often cited determinants of employee health and well-being are job demands, control and social support (JDC(S)-model; Karasek, 1979; Johnson, Hall & Theorell, 1989; Karasek & Theorell, 1990). The work conditions of the JDC(S) model are frequently studied in health care employees (Häusser, Mojzisch, Niesel & Schulz-Hardt, 2010), who are often confronted with high levels of job demands (Bakker et al., 2007). Overall, these work conditions are found to be predictive of well-being of health care employees (De Jonge, Mulder & Nijhuis, 1999). Other quality of work factors, such as organizational risk factors (Akerboom & Maes, 2006) and role ambiguity (Pomaki, Supeli & Verhoeven, 2007), have also been associated with well-being of health care employees.

The most cited well-being outcomes studied in health care settings are burnout, job (dis)satisfaction, somatic complaints and psychological distress (Bakker, Demerouti, De Boer & Schaufeli, 2003; Häusser et al., 2010; Van der Doef & Maes, 1999a). Health care employees specifically experience lower job satisfaction, and lower levels of well-being compared to other occupational groups (Pousette & Hanse, 2002).

The improvement of quality of work and well-being of care employees implies more than just an active policy on sickness absence. Since 1994 employers in health care institutions are responsible for guidance of the employees that become ill, according to the Sickness Absence (Reduction) Act. This law necessitates managers to have an active attitude in creating a healthy workplace. An active attitude can be created by means of a worksite intervention in which both managers and health care employees are involved. By implementing worksite interventions, managers need instruments and methods to enhance the quality of work and eventually employees well-being, e.g. procedures with information for care employees to improve the communication and in this way to increase support from supervisors (Akerboom & Maes, 2006; Johnson & Hall, 1988; Johnson et al., 1989; Karasek & Theorell, 1990). This implies that managers have to increase their knowledge of the organizational context by involving employees (Israel et al., 1996). This dual approach, a combination of a top down
approach (involvement by management) and a bottom up perspective (involvement of employees), might be most effective in worksite interventions (Arneson & Ekberg, 2005). Moreover, as Lavoie-Tremblay (2004, p. 470) argued with respect to participatory interventions: “Rather than imposing solutions, it recognizes that people have the capacity to develop and implement their own solutions”.

If one wants to develop a new worksite wellness/health intervention, it is important to realize what the state of the art is in this domain. The first worksite intervention programs were focusing on improving safety and physical health of employees. However, progressively more attention was given to quality of work and well-being of employees (Maes & Van der Doef, 2004). Even though consistent associations have been reported between quality of work aspects such as job demands, control and social support, and employee health/wellness outcomes (Van der Doef & Maes, 1998, 1999a; Häusser et al., 2010), there seems to be no unequivocal answer to what works nor, how and why in intervention programs (Michie & Williams, 2003). Particularly in health care centers for disabled people, job demands for both care employees and their managers are high and educational levels are often lower (Bolhuis, Mandos & Hollander, 2004). However, as stated before, for intervention programs that are targeted at improving quality of work and well-being of health care employees, a more clear implementation approach as well as a comprehensive theoretical framework for explaining changes in quality of work and well-being outcomes in employees is needed (LeBlanc et al., 2007).

A theory that can contribute to the shaping of the process of worksite intervention programs might be problem solving. Problem solving theory (e.g.: Locke & Latham, 2002; D’Zurilla & Goldfried, 1971; Austin & Vancouver, 1996; Bandura, 1989; Gollwitzer & Bargh, 1996; Gollwitzer & Moskowitz, 1996; Pervin, 1989; Wegner & Pennebaker, 1993) is focusing on the goal directed and regulative aspects of human behavior. A problem solving approach includes behavioral aspects such as monitoring, feedback and control processes (D’Zurilla & Goldfried, 1971). Moreover, problem solving theory presumes that behavior is dynamic, goal-directed and would require an active and participatory position from employees as well as managers in worksite intervention programs. Goal setting and goal facilitation at work are important aspects of a problem solving approach. Within worksite health promotion intervention programs, a distinction can be made between, 1) organizational goals, which are often directed at reducing turnover levels, and improving productivity and quality of patient care, and 2) personal goals of employees, which are directed at e.g. being healthy, feeling confident at work and maintaining social relationships. Alignment of personal and organizational goals is an important process in a problem solving intervention program to overcome or to prevent a conflict between organizational and personal goals. Therefore, it is important that intervention programs are not only implemented
through top-down processes (where only the management decides what needs to change and how to change it). Bottom up processes, where employees participate in decision making, should also be used in order to attain both organizational goals as well as personal goals of employees (Arneson & Ekberg, 2005).

A problem solving approach is occurring in four phases: 1) goal setting and shaping the plan of action, 2) feedback and process evaluation, 3) control procedures, and 4) reformulating (realistic) goals (D’Zurilla & Goldfried, 1971). In this systematic, problem solving approach, problematic components within the organization are selected and an action plan is made in a participatory manner. By means of qualitative and quantitative evaluations insight can be gained on the effectiveness of the intervention components on quality of work and well-being of employees.

Previous studies show that interventions applying a problem solving or participatory approach, affect quality of work and well-being of employees (e.g. Lavoie-Tremblay et al., 2005; Lokk & Arnetz, 2000; Mikkelsen, Saksvik & Landisberg, 2000). However, due to sparse data and mixed results no consistent conclusion can be drawn about the influence of a problem solving approach on quality of work and well-being of employees. There are several complicating factors in reaching unequivocal conclusions about how intervention programs may influence quality of work and well-being of health care employees. For example, frequently no comprehensive theoretically based approach is used, often there is a lack of an adequate research design and in a large amount of studies small research samples are used (Michie & Williams, 2003).

The foregoing introduction illustrates the persistence of problems in quality of work and well-being of employees in health care. The effectiveness of intervention programs to this respect is not yet systematically reviewed, and more insight is needed into the mechanisms responsible for improving quality of work aspects and wellness in health care settings. Problem solving might be an effective approach to steer the implementation process of worksite health promotion programs in health care settings.

For the purpose of examining the usefulness of a problem solving perspective on quality of work and well-being, an intervention study was conducted in health care centers for mentally disabled people. The study included six health care centers that had indicated, that a relatively large number of their care employees and managers were frequently absent from work for a long time, whereas the exact cause of that absence was unclear. Therefore, the policymakers of the participating health care centers wanted to gain insight into the determinants of absence, well-being and quality of work of the health care employees in their organizations. Then on the basis of this knowledge interventions to improve quality of work and well-being of the employees will be performed. Hence, the goal of the participating health care centers was: developing an active, wellness and health promoting work policy, which must
have a positive influence on the quality of work of the employees and eventually on
their well-being. In 1998 a grant was obtained from the National sickness fund to
carry out an intervention project with these health care centers. Three health care
centers served as the intervention group and three as the control group. The goal of
the researchers was to determine the effects of a problem solving implementation
approach. The intervention program was based on the outcomes of a screening project,
and was directed at improving the quality of work and well-being of employees. The
research project was carried out in cooperation between PCC Health Promotion and
the department of Health Psychology of Leiden University. The intervention project
was called ‘Work Without Worries’.

1.2 Outline of the thesis
In Chapter 2 research findings are explored through a review, a) on the effectiveness of
worksite health promotion interventions on quality of work and well-being of health
care employees, and b) on the characteristics of worksite health promotion programs
in health care settings. From the results of this review conclusions are drawn and
relevant empirical findings are discussed about the effectiveness of worksite health
promotion programs in enhancing quality of work and well-being among health care
employees. Directions for future research are presented as well.

The purpose of Chapter 3 is to describe the state of the art with respect to the
theoretical background in worksite health promotion intervention programs targeted
at quality of work and well-being of employees. Firstly, quality of work factors derived
from the JDCS model and organizational risk factors from the Tripod model and their
relation to employee wellness is explored. Secondly, the problem solving perspective
is introduced as an intervention approach to optimize the implementation process
of worksite health promotion intervention programs. Finally, practical implications
for the implementation of worksite health promotion intervention programs are
formulated.

In Chapter 4, results are presented of a cross-sectional survey that was conducted
among 1673 health care employees of three experimental and three control health
care centers. The objectives were to: 1) describe differences between the three
experimental health care centers on quality of work (psychosocial job characteristics
and organizational risk factors), higher order goal facilitation and well-being of the
health care employees, 2) identify problematic factors in the experimental health care
centers and present these aspects as targets of worksite health promotion intervention
programs in the three experimental health care centers, and 3) present the intervention
plans that were formulated in cooperation with the experimental health care centers.

The purpose of the intervention study, described in Chapter 5, is to evaluate
the effectiveness of a problem solving intervention program on quality of work and
well-being of health care employees, in three experimental health care centers in comparison to three control health care centers. In the control centers no advice was given following the baseline measurements and no intervention plans were advised or implemented.

The following two research questions were formulated: 1) do work conditions and organizational risk factors improve after the implementation of a problem solving intervention program, compared to a control group? and 2) do higher order goal facilitation, job satisfaction and well-being aspects of health care employees improve after the implementation of the intervention?

For this purpose 707 health care employees completed questionnaires at baseline (T1) and three years later (T2). Quality of work factors covering work conditions and organizational risk factors were assessed. Well-being factors relevant for health care employees, e.g. higher order goal facilitation, job satisfaction, emotional exhaustion, depersonalization and personal competence, were included. Quality of work and well-being of the experimental group and the control group were compared at T2 using multivariate and univariate covariance analyses, with kind of shift, years in sector, education and baseline scores as control variables. Results concerning the effectiveness of the intervention program for quality of work and well-being are reported.

In Chapter 6, results from a 3-year longitudinal study in health care employees are presented, that investigated whether (changes in) work conditions and higher order goal facilitation are predictive of well-being outcomes of health care employees. In this chapter, work conditions, higher order goal facilitation and the changes in work conditions and higher order goal facilitation at T2 are related to job satisfaction, psychological distress, somatic complaints, emotional exhaustion, depersonalization and personal competence at T2. 707 health care employees completed questionnaires at baseline and at a three-year follow up (T2). Well-being outcomes at T2 were regressed on baseline scores regarding well-being, higher order goal facilitation and work conditions, and changes in work conditions and higher order goal facilitation between T1 and T2. Conclusions are presented regarding the relationships between work conditions, higher order goal facilitation and well-being of health care employees, and implications for further research are proposed.

The results of the foregoing chapters are discussed in Chapter 7 in view of the different theoretical perspectives and especially from the problem solving perspective. Methodological limitations of the studies are addressed, followed by suggestions for future research on problem solving based interventions for worksite health promotion of health care employees.