

# Consolidated Report - Case Studies of Healthy Organisation

D4.2 – March 2008

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**Quality** is an innovative, quantitative and qualitative research project that aims to examine how, in an era of major change, European citizens living in different national welfare state regimes evaluate the quality of their lives. The project will analyse international comparative data on the social well-being of citizens and collect new data on social quality in European workplaces in eight strategically selected partner countries: UK, Finland, Sweden, Germany, the Netherlands, Portugal, Hungary and a candidate country for EU enlargement, Bulgaria.

Quality is a Specific Targeted Research or Innovations Project funded within the European Commission's Sixth Framework Programme (contract no 028945), Priority 7, Citizens and Governance in a Knowledge-based Society (March 2006 to February 2009).

Lewis, S. (2008). Consolidated Report: Case studies of Healthy Organisation. Deliverable of EU-project Quality, Utrecht: Utrecht University



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# 1. Introduction

The notion that organisations can be described as healthy or unhealthy has been discussed since the early 1990s (Cox and Haworth, 1990; McHugh and Brotherton, 2000; Cooper and Cartwright, 1994; Wilson, Dejoy, Vandenberg, Richardson and McGrath, 2004; Cernigoj Sadar et al, 2005), although definitions, areas of focus and criteria differ. At a general level, however, there is some agreement that healthy organisations are those that are effective in what they do and meet the needs of the workforce, recognising that individual and organisational health are interdependent (McHugh and Brotherton, 2000; Cernigoj Sadar, 2005). In conceptualising healthy organisations in this report, we focus on both employee and workplace needs addressing a dual agenda of employee quality of life and workplace effectiveness (Rapoport, Bailyn, Fletcher and Pruitt, 2002; Lewis and Cooper, 2006). We also incorporate the notion of social sustainability (Webster, 2004; Lewis, Gambles and Rapoport, 2007) in our definition. This involves thinking about the future as well as current context.

Work package 4 of the Quality project builds on and extends the previous work packages by focusing on change and its impact on current quality of life as well as anticipating issues that may affect quality of work and life (positively or negatively) in the future. It employed a qualitative approach to explore in depth the notion of a healthy and socially sustainable workplace and the factors that are perceived to contribute to or challenge quality of life and workplace effectiveness in one specific organisation in each country. The research was carried out in two stages; 1) interviews and 2) innovation groups.

The objectives were:

- To examine the perspectives on healthy and socially sustainable organisations of employees at various organisational levels, in one organisation in each country;
- To explore the trends and practices that contribute to and those that pose barriers to healthy organisations and employee quality of life, in the contemporary context;
- To consider implications for policy and practice.

A further goal was to engage managers and other employees in creative thinking about current and future working practices to enhance both quality of life for employees and workplace effectiveness. This will be addressed separately in the report on the innovation groups (deliverable 4.3).

## 2. Design and methods

A case study approach was used, employing qualitative research methods. Each partner approached one of the four organisations that had completed the survey in work package 2, to invite them to participate in the qualitative phase of the research. In order to ensure some comparability, the cross national research team decided to focus on hospitals, insofar as this was possible, as this seemed particularly appropriate when studying the “healthiness” of workplaces. However this was not feasible in all the countries, in which case negotiations were carried out with the other organisations. Ultimately the research was carried out in 5 hospitals (in Sweden, Finland, UK, Bulgaria and Germany) and in three private sector organisations; one finance sector company in Portugal, a telecom company in the Netherlands and a household retail chain in Hungary (see table 1). Negotiation of access to carry out the qualitative research was easier in some countries than others. It was most difficult in Germany where the approval of the hospital workers’ council was required. Eventually this was reluctantly granted, but with strict conditions. It was only possible to carry out eight interviews and the researchers were not permitted to tape the

interviews. In Hungary there was some uneasiness among individual interviewees about their interviews being recorded, related to distrust and concern about anonymity, which may be a heritage of the socialist regime. Participants may have been less willing than those elsewhere to talk openly and especially critically, about their organisation.

	Sector	Number of interviews
The Netherlands	Telecom	13
The UK	Hospital	20
Bulgaria	Hospital	14
Finland	Hospital	12
Portugal	Finance	14
Sweden	Hospital	10
Hungary	Retail	20
Germany	Hospital	8

Table 1 the case study organisations

The case studies were carried out in summer 2007. In each organisation interviews were carried out with between 8 and 20 participants. These included medical and nursing personnel at various levels of seniority and administrative staff and managers in hospitals and a range of staff and managers in the private sector organisations. Key informants, usually from Human Resource Management helped to recruit convenience samples which were gender balanced, and included those differing in occupation, status and where appropriate, ethnicity. Union representatives were also interviewed. The original intention was that participants should come from a single department to enable an in depth focus on specific issues in the second phase (innovation groups) but again this was not always feasible.

A semi structured interview schedule was developed collaboratively by the cross national team, to ensure common approaches as well as attention to national and organisational context (see appendix 1). The schedule first introduced the notion of the dual agenda. In order to get an understanding of the ways in which the organisations are changing and the impacts on effectiveness and employee quality of life, a time based approach was used , taking a past, present and future time perspective. Participants were first asked about what it is like to work at their organisation at the present time; what were the main challenges and how this affects work effectiveness and quality of life (and how this might differ by gender). The interviewer then moved on to ask the interviewee to reflect on the past and how things had changed since they had worked there, or in the past 5-10 years before proceeding to consider what are perceived to be the main challenges and opportunities to the effectiveness the organisation and quality of working life in the next 5 to 10 years. The idea was that future thinking would be embedded in reflections on the past and present trends. The interview schedule was piloted in each country.

Interviews were taped, except in the German hospital where this was not permitted and as many as possible were transcribed. There are no verbatim data in from the German case because interviews could not be recorded although detailed notes were taken. Some initial content analysis of the transcripts (and notes in the German case) was undertaken to identify major themes relating to aspects of 'healthy organisations' and barriers reported across countries. This contributed to a framework for thematic analysis of the transcripts for each organisation. Resources did not permit translation of transcripts but reports, including interview quotes, are in English. Emerging themes were fed back to a mixed group of managers and other employees in innovation groups in the second phase of this work package.

## 3. Findings

### 3.1 The hospitals

#### Hospital contexts

The case study organisations in Bulgaria, Finland, Germany, Sweden and the UK were large publically funded hospitals, although some focused on smaller units within these hospitals while others involved participants from across the organisation. The context in all the hospitals, to varying extents, was one of rapid change and often turbulence in the national health care sectors, with substantial financial pressures, much of it related to socio-political contexts.

The extent of change was particularly great in the Bulgarian context, reflecting the radical social transformation of the wider society. Wide-scale reform of the health sector was ongoing, including major changes in the financing of health care and the growth in private hospitals. Restructuring of the case study hospital resulted in accumulation of debts as was the case in most hospitals in the country. There had been a fall in the salaries of the personnel but at the time of the field work the hospital had started to pay its debts and salaries had been linked to the rise of the minimum salary in the country. Despite all the changes the staffing at the case study hospital was stable, with a low level of turnover at the time of the case study.

The UK hospital was also undoing deep changes in the context of considerable wider National Health Service ongoing change and turbulence. Much of the change experienced by the hospital was associated with a host of national initiatives- although local implementation is important. At the time of the fieldwork there was a great deal of uncertainty about the future status of the hospital, linked to wider national initiatives. The hospital recently faced a large funding deficit in the context of constant organisational changes as local hospital trusts attempted to meet centrally determined targets, cut costs and rationalise services. Dealing with this deficit involved a number of organisational changes, under the umbrella change strategy known as 'turnaround'. In this process the Government sends external management consultants (from the private sector) into those hospitals experiencing financial deficits, who propose a raft of changes mainly in the form of cut backs. The main changes in the Turnaround process at this hospital included vacancy control and freeze in certain areas, the loss over 200 staff , a series of ward closures/reopening and tight control over the use of agency staff for short term cover. The wider UK context has been one of significant investment in the health sector to bring it up to comparative international standards, but this year on year increase is now tailing off.

Sweden has a decentralized healthcare system with decision-making largely in the hands of regional and local politicians. Swedish counties enjoy a high degree of political and economic autonomy with the primary mandate to develop health services that are in line with the needs of their constituencies. However, the Swedish team argue that in the Swedish context, the constellation of an elite, knowledge driven organization, with continuous demands for investments in human capital and technology; led by politicians charged with a political mandate but with a lack of time, insight and/or economic wherewithal to carry out their assignment, often result in a decision-making processes and practices that block efforts to create healthy organizations. There have been some recent mergers and reorganization at the case study hospital and the merging of different autonomous units into one large integrated institution has not been without friction. Some of the aftermaths of the merger are still visible. Some services traditionally carried

out in hospitals have been or are in the process of being outsourced in the Swedish hospital, as elsewhere, often leading to conflict or a loss of competence in some strategic area of medical expertise.

Hospitals in Finland have had to find ways to increase their internal efficiency following a Government act in 2006 which sets targets for the maximum waiting times in public hospitals (similar targets exist in the UK). The case study hospital has been preparing to introduce a new procedure into emergency services (the focus of this case study) in order to increase its functional efficiency and cut costs. The hospital is ambitiously aiming to raise the proportion of patients that flow through the polyclinic, using a work procedure that is new and innovative in the Finnish context, and it is not yet fully implemented in the organisation.

The German case study is of an emergency outpatient unit in a hospital specializing in occupational-related accidents. It is funded by health insurance operated by the employers' liability insurance association ("Berufsgenossenschaft"), and is subject to public law. There are rumours that the emergency unit will be restructured, but as in the UK hospital information is scarce. Nurses are generally open to changes but fear that it will result in additional work that comes on top of their current work demands. One of the changes to which the hospital was adapting at the time of the field work was a new law regulating doctors' working hours. This was creating some problems in a context of staff shortages.

A further aspect of context, discussed across the hospitals was changing patient needs and demands. Generally patients are more well informed (or miss informed) about their illnesses. They search the Internet and other sources and come to the hospital with ideas about the way they should be cared for. Patients also know their rights, in many cases are more demanding and often do not understand the additional pressures that staff are under.

## Aspects of healthy organisations

Overall the employees in this sector in all the countries were highly committed to their work and particularly to patients, and derived considerable intrinsic satisfaction from meaningful work, although this was challenged by many of the organisational issues and trends discussed later.

There was general agreement across the case studies that in principle healthy organisations would meet the dual agenda of workplace effectiveness and employee quality of life, which would be essential for the sustainability of hospitals. In practice however, the two aspects of the dual agenda were not always accorded equal importance by management or in many cases by non managerial employees. This was largely because effectiveness was interpreted in terms of patient care and the link between quality care and employee quality of life was not always recognised.

In Bulgaria for example, interviewees defined the healthy organisation as one which was, first, economically efficient, second, caring for the patients, and third, caring for employees. In the UK hospital there was prevailing view that changes taking place at the hospital prioritised workplace effectiveness, particularly in economic terms often at the expense of employee well being and with potential disadvantages to patients. A comment by a Swedish participant suggested similar concerns '*[finances] threatens both personnel and patients and by extension jeopardizes the possibility to achieve the overarching goal for the work in the entire hospital*' and this goes to the heart of the complexities of putting a dual agenda into practice .

Nevertheless a number of positive factors were identified in the hospitals. Aspects of a healthy organisation identified by interviewees included job security and predictable working time, opportunities for self development, and positive collegial relationships as well as satisfaction in a worthwhile job, if they were supported in doing this well.

Evaluations of hospital workplaces as healthy are inevitably affected by frameworks of expectations. The Bulgarian hospital tended to be regarded as a healthy organisation by participants who stressed the financial stability of the organization, and what they believed to be the satisfaction of patients with the services as well as the satisfaction of the medical personnel with the working conditions. It offers relatively secure jobs, with fixed working time, regarded as not badly paid by national standards and providing all family leaves allowed by the state. With the private sector developing in the country, most of the doctors and many nurses work additionally in private clinics or have their own practices. These positive views contrast with the UK hospital where widespread uncertainty about the future of the hospital and security of jobs undermines both employee quality of life and sometimes also workplace effectiveness.

Opportunities for self development are also highly valued. Bulgaria participants valued additional prestige of working in a university hospital with the most advanced technology, good career prospects and intellectual climate. In all the cases sustaining competence, meeting a constant need for training and life long learning were viewed as an integral part of their professional lives, which, if met, contributed towards definitions of a healthy organisation. This was particularly stressed in the Swedish, Bulgarian Finnish and UK hospitals where participants talked about increasing training demands and competences needed. Many of the Finnish interviewees considered that there should have been more training, to deal with changes in job descriptions and new medical equipment. Many new challenges were discussed. For example in Finland at the Emergency Policlinic all special fields are represented and nurses had to be capable of treating all kinds of patients. Patients have also more multi-illnesses and are therefore much more demanding to nurse than before.

Good social and interpersonal relationships, team spirit and a sense of collegiality were also mentioned in all the cases as positive aspects of a healthy organization, in some cases compensating for the more frustrating and challenging aspects of their work. Often help and support were forthcoming from colleagues and immediate relationships were good, even though wider relations across the hospital might be less positive with some staff feeling unheard and under valued in the wider context. In Finland, for example, the good collegiate atmosphere partly compensated for an experienced lack of training. In the German hospital despite the increasing number of patients and tiring night shifts both doctors and nurses reported that cooperation among nurses and with doctors and cleaning staff works very well.

Accounts of experiences of social relations and communication were mixed in the UK hospital. Some of the key changes observed by many staff relate to the fact that the general atmosphere at work is not as friendly as it was prior to the various changes. The Turnaround process for reducing the financial deficit by a series of cutbacks was experienced as being ineptly managed and appears to have generated an atmosphere of distrust. At the same time however there was still a strong sense of social solidarity and, for example, a Save the Hospital campaign brought people together and brought about closer links with the local community. Some interviewees talked about very good social relationships and strong team ties and cohesiveness as one of the main positive aspects of working at the hospital.

## Challenges to healthy organisations: some common themes

A number of common challenges to healthy organisations and employee quality of life emerged in the hospitals, as well as some themes that were unique to particular hospital and national contexts. Common themes emerging in all the cases were largely related to the need to deal with constant organisational change. They include

- Financial pressures and resources issues
- Work intensification, work tempo, haste, stress
- Relationships/ communication issues
- Gender and work-personal life issues were also raised

### Financial pressures and resources issues

Financial pressures were evident in most of the hospitals. The ways in which these are dealt with can undermine employee well being and the fear that it can also undermine patient well being was voiced particularly in the UK and Swedish hospitals. Most interviewees in the UK expressed anxiety about the financial crisis of the hospital and the subsequent uncertainty. In this context, the actual costs of employing management consultants to make cuts and reduce the hospitals debts were widely resented. The loss of so many staff has had an impact upon staff morale which tends to be low although there remains high commitment to the job and patients, often under difficult conditions. In Sweden too, the hospital's economy is a recurring theme. There have been numerous targeted and general budgetary cutbacks which are again a source of continuous unrest among all personnel categories. Almost all the interviewees, regardless of level and position, were affected by these and there was a fear that ultimately financial considerations would affect the quality of work and the level and developmental potential of the hospital's unique expertise.

There was some ambivalence about financial issues, especially salaries in the Bulgarian hospital. Most interviewees cited inadequate payment of services by the National Health Insurance Institute, lack of state support for public health and inadequate level of salaries of doctors and particularly nurses, but this was perceived as more of a problem of the health care sector in the country than of the specific hospital as an employer. Indeed many interviewees stated that their payment was higher than in other medical organisations and the recent introduction of additions to the salaries depending on the number of patients treated was seen as a positive change. The Bulgarian staff tend to compare themselves favourably with those working in other Bulgarian organisations and this process of social comparison process increases their level of satisfaction with the hospital if not the wider context.

Financial issues were related to concerns about ageing medical equipment and buildings and inadequacies of other resources in Bulgaria and in some parts of the UK hospital at the time of the field work. Again there was a fear that this affects both the quality of care and working conditions. This contrasts with the situation in the Finnish hospital where interviewees reported that there was now much more space and modern medical equipment. Some updating of buildings was taking pace in the German and Bulgarian hospitals but the failure to involve and consult staff who use them can create problems.

### Work intensification, work tempo, haste, stress

Work intensification, heavy workloads and a general speeding up of work emerged as a feature of modern work in all the hospitals and among different occupation and levels. This was mostly attributed to increased demand to treat more patients in a shorter period of time without corresponding number of extra staff, often to meet increased targets. However, it was also attributed to changes in job descriptions,

skill demands and work environments, to pressures to keep abreast of new techniques, rules and regulations, and in some cases increased demand for reporting and other aspects of bureaucracy. For management in particular, technology such as e-mail and mobile telephones encourage and foster availability and work intensification.

A recurring cross national theme is that paradoxically working time regulations to meet the EU Working Time Directive often have the unintended consequence of increasing work overload and intensification of work. In the German emergency unit new regulations on doctors' working time, without extra staff, mean that they continue to work long hours but accumulate overtime. Overtime can only be compensated by free time and it is not clear if and how they will be able to use this at the end of the year. Similarly in the UK hospital junior doctors, who are no longer allowed to work more than a 48 hour working week, are also not supported by any additional staff or fall in workload, intensifying workload. Moreover, the reduction in working time has resulted in the loss of overtime payments - so doctors are working more intensively, seeing the same or greater volume of patients and losing pay. In the Swedish hospital too, the EU working Time Directive is viewed as paradoxical in its effects: often increasing the tempo of work as more has to be accomplished in less time. This leads to some doctors seeking work outside of the EU on completion of their training. In the UK this issue was compounded with problems in processing junior doctor jobs last year, which led to a loss of up to 1/3 of junior doctors to jobs abroad often in Australasia and America.

The interviewees presented the rising intensity of work as one of the main issues undermining healthy organizations; impacting on effectiveness and wellbeing at work, confirming previous European research (Lewis, Smithson et al, 2006). There were concerns that work would suffer as both doctors and nurses experienced greater stress and often exhaustion, and that nurses in particular felt that they had much less time to offer emotional support to patients and had to limit their efforts to medical procedures . This suggests an under valuing of emotion work which contributes significantly to organizational outcomes and probably staff well being (Ashkanasy, Hartel, & Zerbe 2000; Mark 2006) . The fact that more has to be done in less time with the same numbers of staff causes feelings of inadequacy and fear of making mistakes The most pressure was experienced by those groups that had least control over their how their work was distributed, such as doctors and nurses. Administrative personnel in every hospital also reported having an increasing workload. Managers had more control over their work but tended to alleviate high stress levels by staying after regular work hours or by taking their work home. In the UK hospital working long intense hours was not new, but resentment caused by the Turnaround process had affected morale and good will in this respect. In the Finnish hospital trends such as rising intensity of work, haste and organisational changes in work procedures, appear to be accepted as inevitable properties of modern working life. There was both an individual focus on being able to cope with these pressures, but also recognition that team spirit and social support help. Overall however, there was a concern in all the hospitals that it will not be possible to sustain healthy organizations under such intensified working conditions

## Relationships/ communication issues

Although group cohesion and collegiality are among the positive aspects of working in a hospital, this is often restricted to immediate work teams while information channels between different levels of the organization function poorly, with wider relationships and communication issues often undermining healthy organizations. This was reported in the Swedish, UK and German hospitals. In the German accident unit nurses reported that organizational change always occurs top-down with the

“Berufsgenossenschaft” or the hospital administration as the main drivers. Nursing staff are not consulted but then has to live with those changes. In both the German and UK contexts communication is felt to be poor, leading to rumours and uncertainty. Work on nursing in the UK setting suggests that gossip is used as a coping strategy for the uncertainty inherent in current UK healthcare organisations (Waddington & Fletcher 2005).

## Gender issues and the reconciliation of employment and family life

Gender and other forms of equity, and opportunities to reconcile employment with family life are crucial for both aspects of healthy organisations- workplace effectiveness and employee quality of life (Rapoport et al, 2002). All the hospitals have formal equal opportunities policies though often there are implementation gaps in practice. Furthermore deep seated assumptions about gender often go unchallenged. For example, in the Bulgarian hospital there are prevailing gender stereotypes about competences, such as the belief that women doctors are more likely to panic than men in emergencies. Even in the Swedish context, with the very explicit and proactive commitment to gender equality, different value systems exist in the same workplace and intersect in complicated and gendered ways, reiterating assumptions about both gender and the meaning of medical work as set out in Cassell's seminal study of women surgeons (Cassell 1998) and confirmed in a more recent study of the issue in Swedish hospitals (Davies 2003). The gender order sometimes tends to be reinforced as a consequence of traditional values and stereotypes and specific issues associated with the wider role of medicine in western society (Lupton 2003). In the British hospital despite a comprehensive diversity policy, discrimination on the grounds of both race and gender were reported by some interviewees across different occupations and occupational levels. While many of these problems exist across the NHS, those who have worked in other hospitals report more of a glass ceiling here than elsewhere.

There were however, differences in the extent to which stereotyping and/or active discrimination were experienced, acknowledged, tolerated or ignored. There appeared to be the most explicit awareness of these issues in the Swedish and British hospitals but this did not mean that it was always tackled. In the UK hospital there was a view that, especially at the most senior level, many women “kept their heads down” and got on with their work and did not explicitly draw attention to gendered practices. Other UK participants say that gender is not an issue or not one that they have thought about. In the Bulgarian hospital the dominant discourse is that there is little or no discrimination, despite strong stereotypes about mothers who were expected to take the main responsibility in terms of time and slow down their career to care for small children, reflecting wider societal norms. In Finland men make up a minority of the emergency unit workforce, but their numbers are growing and both women and men interviewees felt that a higher number of men balances the atmosphere of women-dominated health care work and see this as very positive. There was some evidence of stereotyping about competencies but these were considered harmless. Even if there were some gender-based divisions of tasks, differences were not presented as discriminatory practices. Rather, the interviewees (most of whom were women) presented them as something that can be tolerated, or even permitted for men who are the minority. However, these issues were not explicitly discussed. Clearly there are a number of silent discourses around gender in all the hospitals, played out in different ways, and at many levels.

Gender stereotypes are also implicated in the low pay of female dominated jobs like nursing, and interact with issues relating to the reconciliation of work and family or personal life. In the German hospital two male nurses both left the ward shortly before the interviews took place. They found jobs with better pay,

with more family-friendly working hours, and increased opportunities for career advancement, claiming that the salary of a nurse is no longer sufficient to support a family.

Issues relating to reconciliation of work and family or “work-life balance” emerging from the interviews centre around both flexibility of work and also the impact of intensification of work on time and energy at home, but again these are experienced somewhat differently in the different contexts. In the Bulgarian hospital this is considered purely as a woman’s issue and women largely accept their gendered roles, while at least some men (fathers) are also concerned about flexibility to manage work and family in the other hospitals.

The Bulgarian women tend to use the flexibility offered by shift work to manage their multiple responsibilities. But shift work is not necessarily flexible and can also interfere with family life. There were concerns, particularly in the UK and Swedish hospitals about lack of autonomy and control over their work or rotas which could be stressful. In the UK hospital a new rota system had been introduced which was creating difficulties for nursing staff. Staff were required to put forward their desired shift and working hours well in advance – up to 6 weeks - and the rota cycle was for a four week period. The rationale for this was for effective management of staff and to ensure that all areas are covered, given low levels of staff. Interviewees found this inflexible and considered that it impinged on their family life because caring commitments can be highly unpredictable. In the UK hospital as in other UK contexts (Bond et al; Lewis, 1997;2001) ability to work flexibly often depended on sympathetic managers and there was much inconsistency in this respect. Interviewees in the Finnish hospital varied in their experience of a three-shift work pattern that was in place, but for many this was depicted as demanding when it comes to the reconciliation of work and private life. Shift work or rotas over which staff have little control can also make childcare difficult especially in Germany and the UK where it is very expensive. A converse issue was also voiced in the UK hospital by one interviewee was that an assumption was often made that those without family responsibilities would be available for holiday cover such as Christmas which was not always fair or equitable.

Regulation can help, by limiting the timing of shifts, but again can also be double edged. In the German contexts doctors reported that the new 12 hour shifts interfere even more with private life at the weekends than for example a 24 hour shift on Saturday and a free Sunday.

A major impingement on family or leisure time, widely reported across all the hospitals, is fatigue resulting from increased work tempo and work intensification. There were also examples of work to family spillover of stress. For example in the German case staff had to deal with severe cases such as young people with multiple injuries in a critical state which is psychologically demanding. In the past, there was time to talk over those cases with colleagues. Due to work intensification and limited staff this so called “blue hour” in the morning has disappeared. Nurses more frequently take those stories home, and talk them over with a family member if one is available.

## **Some country specific challenges to healthy organisations (hospitals)**

In addition to the common themes discussed above, some country/hospital specific theme also emerged. In particular, participants the UK hospital talked about experiences of deprofessionalisation/deskilling, bullying and race issues. It should be noted that this does not mean that similar issues were not faced elsewhere, but that they were not discussed, which may be because they are not experienced, they are less

pressing than other concerns, or that they were concerns but not ones that participants felt comfortable talking about in the interviews.

## Reflections on future challenges to hospitals

A number of potential challenges to the future effectiveness and sustainability of the hospitals and quality of life of their workforces were highlighted. In particular:

- There was a somewhat pessimistic view that the intensification of demands and fast tempo of work would continue to grow, and that this will have serious implications for recruitment and turnover, employee well being and the quality of health care provision, as well the well being of families and communities.

Other specific future challenges identified include:

- Growing numbers of patients with more complex illnesses usually a function of an ageing demographic but also a function of international mobility and other factors;
- Changing expectations- of patients and health professionals;
- Population changes –ageing populations, emigration (Bulgaria), immigration increasing multiculturalism, more employees who are also informal carers;
- More security issues- perhaps requiring more police on site – less respect- unpredictable and aggressive patients undermining safety at work;
- Loss of staff not just through emigration but also the growth of private hospitals and attraction of alternative careers;
- Demands on staff to be flexible- lifelong learning, new job descriptions, working with different occupational groups and perform different task throughout their work life;
- New technologies and the corresponding organisational change, new hospital software products, E-health services, quality assessment criteria;
- Challenges to team working in intensified workplaces- making it difficult to sustain group cohesion and support;
- Impact of climate change, growing pollution creating new health issues, More superbug infections;
- Conflicts between cooperative and competitive national health strategies.

On the positive side there were some examples of good practice in certain sections of the case study hospitals - for example in the intensive care unit in the UK hospital and it may be possible to learn from the principles involved in such cases. In Bulgaria there was also considerable optimism the expected positive impact of EU membership.

## 3.2 The private sector organisations

### Private sector context

The private sector organisations include: the Dutch division of a telecom company headquartered in the USA; an electronics and household retail chain in Hungary, again part of a multinational company, and a Portuguese bank. In the context of global pressures and competition all have been undergoing considerable change: mergers, acquisitions and reorganisations in the Dutch telecom company,

modernization, internationalization and mergers in the Portuguese bank and expansion from a smaller to a large organization in the Hungarian retail chain.

## Healthy organizations

Good, fair, pay is a priority in the private sector organisations. People stay at the Dutch company because it pays well and working conditions are perceived to be good. This seems to compensate for high levels of work pressure. In the Hungarian company, in contrast, participants were less satisfied with salaries in the context of high inflation, and felt that salary levels were no longer competitive with other organisations . The Portuguese employee reported that the corporation respects them and they like to work in one of the largest corporations in Portugal. Job security is also important. In the Portuguese bank most people said they felt they were secure within the bank at present. Nevertheless in both the Portuguese and Dutch organisations there was some sense of insecurity about the future, which can challenge employee quality of life.

Healthy organisations provide various opportunities for satisfaction and growth for employees. As in the hospital sector, opportunities for training and development were also appreciated as a mark of healthy organisations. Opportunities to use skills and qualification in challenging work are also important. In the Portuguese bank professionals felt that they had a wide field of opportunities for working in new areas to be developed, like health and tourism but some of the employees in the back-offices felt that they were not able to utilise their professional skills. Work that involves dealing with people also seems to be enjoyable for many people, particularly in the Hungarian retail chain, - though it is recognised that it can involve emotional work which some find more difficult.

Working patterns can be satisfying if they meet the needs of the workforce and the business. For example, in the Hungarian firm, the pattern of 3 working days followed by 2 days off and working every third weekend suited most participants who had no young children but is less suitable for those with family responsibilities.

As in the hospitals good social relationships, communication and team spirit are highly valued. In the Hungarian organisation, for example, a strong spirit of solidarity and loyalty compensated for some dissatisfaction with pay. This contrasts with the Portuguese bank where almost all of the clerks said they would easily leave this for any other bank if they were to be better paid. The Hungarian participants also like what they see as the consensual and flexible way of deciding about the division of work and the schedule of breaks and holidays among themselves, and in supporting colleagues who are facing difficulties in their private life. Coping with the seasonal work overload is greatly influenced by the atmosphere at the department and the attitudes of the management towards workers and work.

## Common challenges in the private sector organisations

Common challenges to quality of life were articulated as

- Work intensification;
- Survival in a highly competitive market;
- Some new ways of working;
- Team and interdepartmental issues/internal communication;
- Gender issues and the reconciliation of employment and family life .

## Work intensification

Work intensification emerged as a major concern across all the organisations in the public and private sectors. In the three private sector companies this was attributed to; higher targets and performance goals (Dutch telecom company and the Portuguese bank); increasingly demanding customers, especially in the commercial sector of the bank and in the Hungarian stores, and the need to survive in a competitive market (all) .

In the Dutch company all respondents highlighted work pressure which can result in reduced work satisfaction and de-motivation. High targets can reduce sense of achievement, commitment and feelings of control over work. The Portuguese employees also reported having to deal with evermore challenging demands and objectives which are continuously scrutinised at the individual level. They also experienced growing precariousness and uncertainty and an individualization of objectives and goals, but also a good deal of empowerment (at least for the more qualified workers). They felt positive about the company achieving a prominent place in a highly competitive market. However uncertainty and high levels of change affect how the workers perceive their own future and quality of life in mixed ways that are not easy to qualify as mainly positive or negative. Several respondents in the Hungarian company felt that more breaks were needed in the working day because of the length and intensity of working time.

## Survival in a highly competitive market

Survival in a highly competitive market is a crucial challenge for all the private sector companies, although as the Hungarian company is currently expanding and is the market leader, less concern was expressed about this than in the other two companies. In the Dutch telecom company participants talked about various strategic decisions, for example to diversify or to focus more attention for the quality of services, which create constant pressure. There was a feeling of having to run just to stay still and maintain the company's market position in those areas where they have been strong but in which competition is growing. This leads to a feeling of constant change, but also dynamism- so is not just negative. But reorganization can cause unrest and job insecurity- not always about losing jobs but also about the form that jobs might take in the near future if departments are relocated.

## New ways of working

The need to remain competitive can also generate feelings of constant change associated with new ways of working. In the Dutch company, quality of work was negatively affected by new ways of organising work which are more pressured, fragmented, closely monitored with decreasing work autonomy. Many workers no longer do the whole work process by themselves but only a part of it. Task division has increased in the last few years, and workers have become more dependent on the input of co-workers and other departments to finish their work. Because of work intensification and higher targets dependency relations are under pressure. In order to meet the higher targets people tend to prioritize their own work before doing things for other departments. For example service engineers have a track system in the car, so the supervisor knows exactly where the engineers are at any moment in time. They need to solve a certain number of problems a day, and they do the standard problems while things out of the ordinary are left to a senior engineer: a 'trouble shooter' for each region. Consequently, the job can become less interesting and challenging. Similarly in Portugal changes in the way of working can create feelings of deprofessionalization. Considerable effort has been put into modernization and rationalisation of procedures. Teams were recruited for audits all departments, to evaluate their degree of efficiency and suggest the necessary changes to improve results. These forms of work organisation prioritise efficiency but do not take account of employee quality of work or life.

## Team and interdepartmental issues/internal communication

Although close social relationships tended to be good, communication beyond immediate work groups and departments was an issue for the private, as well as the health care sector workers.

The Dutch employees noted that communication between workers and management would need to be improved in order for management to see the unintended effects of current policies and the problems that people face in the daily practice of their work. Lack of communication undermines the potential for a healthy organisation. A number of tensions were reported in the Portuguese bank; involving competition and distrust between departments, between the commercial area and the back-offices, and between older and the younger workers. Each department has its own goals to achieve and the corporate culture encourages the competition between them. Participants also reported some ongoing fragmentation arising from a recent merger, which was experienced as unhealthy. Although the majority of Hungarian respondents expressed their satisfaction about the efficient and adequately in/formal, smooth communication with their colleagues, team members and immediate superiors there were complaints about the flow of information from the central management to the stores.

## Gender issues and the reconciliation of employment and family life

All three organisations are highly gendered, although the discourses tend to be that things are getting better. In the Hungarian company the fact that 2 out of 17 store directors are women was mentioned as a sign of progress. Gender segregation, horizontal and vertical is a feature of all three, as is some degree of gender stereotyping. In the Hungarian organisation it is noted that customers also display gender stereotypes, preferring to consult a man or women on the shop floor according to the nature of the equipment on sale. There are different views within as well as across organisations about whether there is any actual gender discrimination, but certainly examples were highlighted.

In all three societies persistent inequalities in the division of household and childcare labour are also reflected in the workplaces and it is accepted that women find it more difficult than men to reconcile work and family. In the Portuguese bank some women were able to achieve promotion to senior levels, but usually this was by behaving like men, not having children or delaying childbirth and having the resources to outsource domestic and childcare work. Sometimes they felt that family life had suffered because of their professional commitments. For these women the double burden remained and had a detrimental effect on their quality of life- although some did feel that it was possible to 'have it all'. In the Hungarian company women with young children were in a minority, probably reflecting the difficulty in reconciling the particular working patterns with family obligations.

Regulation can help with the reconciliation of work and family but often policy and practice diverge. In the Portuguese bank there were problems associated with family leaves. Usually the bank does not recruit anyone to replace women during maternity leave (4 months), apart from those cases when it is absolutely necessary. Colleagues have to do their work. Mothers who need to leave early from work can also be criticised by their supervisors, and be labelled as not committed to their work.

## **Some country specific challenges to healthy organisations (private sector)**

The Portuguese interviewees talked about a growing discrepancy between company growth and employee quality of life. One of the major themes which emerged during the interviews relates to general feeling of unfairness common amongst the workers caused by the ever-increasing profits of the bank. In a national

context of economic difficulties and widespread cuts in public expenditure, the workers were uneasy about what they perceive to be the lack of financial rewards and general increases in their quality of life that should be forthcoming, due to the successful performance of the company, which the interviewees think is mainly due to their collective performance. Some managers also mentioned the dilemma of having to get profits to shareholders avoiding the increase of HR wage costs.

Thus a sense of fairness of outcomes or distributive justice may be an important ingredient of a healthy organisation in the private sector.

## Reflections on future challenges - private sector

A number of potential future challenges to quality of life of employees and hence effectiveness and sustainability of the organisations were highlighted. In particular emergent issues included concerns about:

- Further work intensification and targets which could result in stress epidemic
- Takeovers and mergers

This was a major concern in the Dutch and Portuguese companies, resulting in feelings of insecurity which can undermine both effectiveness and quality of life. However while some emphasize negative consequences, like the lay-off of people, others envision new career opportunities.

- Outsourcing

Respondents worry about the impact of increased outsourcing on the quality of services and commitment of outsourced workers.

- Corporate citizenship

This might involve companies taking more account of the dual agenda- and rewarding employees in ways that are commensurate with for the success of the company

- Technological innovations

(The need to keep the pace with the competition in regards to technological needs and innovations)

- Changes in national economic conditions.

Interviewees in Hungary look to the government to turn around the deteriorating economic conditions of the country, which is felt to be important for quality of life as well as future prospects of organisational development

## 4. Conclusions

### 4.1 Conclusions

Analysis of the interview data contributes to an emerging picture of the characteristics of healthy organisations from employees' perspectives in eight different national and workplace contexts. Quality of working life in healthy organisations is enhanced by indications that the workforce is valued, by meaningful and secure work that offers opportunities for self growth, development and use of skills, good collegial interpersonal relationships and communication, and an overall sense of fairness and equity. In healthy workplaces work is engaging but also leaves time and energy for a life beyond work. All this enables workers to contribute to vibrant and effective organisations, whether this is in terms of good patient service in the health sector, or market competitiveness in the private sector. These outcomes can also be sources of satisfaction, commitment and engagement. There are some differences between the health care and private sector organisations. While adequate pay is an essential hygiene factor for all, in the private sector organisations level of pay is emphasised more and in one case at least, it is considered

important that pay is perceived as fair in relation to the profits to which staff effort has contributed. Appropriate resources and support to be able to contribute to good patient care is vital for hospital staff. Most of the people interviewed in this work package agreed in principle that healthy organisations embody practices that support both workplace effectiveness and employee quality of life. In practice however the former is sometimes prioritised, revealing an assumption that workplaces can be effective without attending to the quality of life of the workforce upon whom the success of any organisation depends. This raises questions about the longer term sustainability of such organisations.

Many of the barriers to healthy, sustainable workplaces appear to be endemic in modern working life. Usually taken for granted as inevitable there is often little consideration of how to overcome them. They include, above all, a widespread intensification and fast tempo of work or work patterns that ignore worker needs, stemming largely from reduced or stable resources in the face of greater health care demands in the hospitals, and higher targets due to pressures for survival in highly competitive markets in the private sector organisations. This intensification is associated with a number of risks for the health of the organisations including: mistakes or employee fear of making mistakes (especially significant in health care); inadequate time for important emotional work; employee feelings of inadequacy, low morale, stress and exhaustion; and reduced time and energy for family life. The latter has implications well beyond the employing organisation. Work intensification may also be one factor contributing to poor organisational communication in many cases. The management of change is more effective if workers are involved in and encouraged to participate in decision making, but such processes take time (Rapoport et al, 2002; Lewis and Cooper, 2005). Time is a scarce commodity, although an initial investment of time can save time in the long term.

A healthy organisation also appears to be a fair and equitable one. The consultation and participation of the workforce and effective communication contributes to a sense of procedure justice. There were many examples of perceived procedural injustice underpinning unrest in some of the organisations. A sense of distributive justice- that is perceived equity of rewards and outcomes is also important. This was most graphically illustrated by the Portuguese bank where employees felt that their contribution to the success of the business was not acknowledged and rewarded. A third form of justice relates to equity and diversity. A climate that appeared to tolerate inequity of treatment according to race and power (bullying) was reported in only one of the case studies- though it may possibly have existed more widely. Certainly in this case- the UK hospital- it resulted in what for many of the interviewees was an unhealthy and unpleasant atmosphere.

One form of inequity pervaded all the case study organisations to a greater or lesser extent. All the workplaces were highly gendered. In many cases the dominant organisational discourse is that men and women are treated equally and fairly. This assumes that everyday practices are gender neutral. Yet vertical and horizontal segregation is common. This is often justified on the grounds of gender stereotypes and also reflects gendered patterns beyond the workplace such that women often continue to take the major responsibility for domestic and care work. Some examples of direct discrimination and harassment are also reported. Yet assumptions about gender are rarely made explicit and discussed or challenged. There is growing evidence that working practices based on gendered assumptions undermine not only gender equity but also workplace effectiveness (Rapoport et al. 2002; Bailyn, Bookman, Harrington and Kochan, 2006) . Addressing these issues will be essential for healthy workplaces to meet the future challenges identified by the participants in this research.

## 4.2 Some implications for policy and practice

### **The Working Time Directive**

The interviewees presented the rising intensity of work as one of the main issues undermining healthy organizations, impacting on effectiveness and wellbeing at work. While the EU Working Time Directive has the potential to enhance quality of life, it can also exacerbate work intensification if not carefully implemented. The regulation and reduction of working time is often not accompanied by any reduction on workload. Thus the same or a greater amount of work has to be performed in less time, and often with a reduction in pay. The WTD needs to be strengthened with regard to workload demands so that it does not encourage work intensification.

### **Investing for sustainability**

There was particular concern in all the hospitals about sustainability of effective health under such intensified working conditions. Although the employment of more staff to deal with increased demands is regarded as a cost that cannot be met by already stretched budgets, this should be weighed against the future costs of sick health care work forces. This will have serious implications for recruitment and turnover, employee well being and the quality of health care provision, as well the well being of families and communities. The same may be true of private sector organisations albeit possibly with fewer wider societal implications. Policy makers at many levels, European, national, community and workplace also need to consider the long term impact of the depletion of time and energy for families and communities resulting from increased work tempo, work intensification and fatigue.

Employing organizations also need to invest more time into collaboration, participation and communication for effective change management

### **Gender equity- beyond policy to implementation and practice**

Despite national and workplace equal opportunities policies, persistent gender inequities remain. It is time to focus on the implementation of these policies, on systemic change in workplaces (that is, change in structures cultures and practices ) and on wider societal practices. In particular this will involve attempts to make visible deeply held assumptions and values in organizations, which incorporate and reproduce gendered stereotypes, and organization cultures that support the notion of an ideal workers as one who works as though they have no family responsibilities ( Lewis, 2001). Only by making visible and challenging taken for granted gendered assumptions will systemic change to support gender equity, begin to occur.

### **A dual agenda for change to meet the challenges of the future**

Overall, a major challenge for the future is for organisations to meet new demands by attending to both aspects of the dual agenda- recognising that employee quality of life and workplace effectiveness are equally important and interdependent- and for national policy makers to find ways of encourage this.

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