Staff working in hospital units with greater social capital experience less work-home conflict: Secondary analysis of a cross-sectional study

Anika Nitzsche[a,*], Ludwig Kuntz[b], Felix Miedaner[b]

[a] Institute of Medical Sociology, Health Services Research and Rehabilitation Science, Faculty of Human Sciences and Faculty of Medicine, University of Cologne, Eupener Strasse 129, 50933 Cologne, Germany
[b] Department of Business Administration and Healthcare Management, University of Cologne, Dürener Strasse 56–60, 50931, Cologne, Germany

ARTICLE INFO

ABSTRACT

Background: When the interplay between work and private life does not function correctly (work-home conflict), this constitutes a well-known risk factor for poorer health, increased absenteeism and lower work performance. Information about influencing factors of work-home conflict is therefore indispensable in order to avoid it. In this study, we analyse whether a good working atmosphere that fosters mutual trust, support and a 'sense of unity' (organizational social capital) can reduce an employee's conflict between work and private life.
Objective: This study investigates the link between organizational social capital and work-home conflict in health professionals.
Design: This issue was investigated using a cross-sectional study conducted in 2013.
Participants and setting: Data from questionnaires completed by physicians and nurses (n = 1733) were linked with structural data from 66 neonatal intensive care units in Germany.
Methods: Using multi-level analyses, we investigated associations between organizational social capital at the ward level and work-home conflict at the level of individual employees, taking into account additional structural and individual characteristics.
Results: Employees on wards with greater social capital reported significantly less work-home conflict. Our results support the hypothesis that organizational social capital is an important collective resource.
Conclusion: As such, more attention should be given to establishing a good working atmosphere that fosters mutual trust, support and a 'sense of unity', and this should be encouraged in a targeted fashion.

What is already known about the topic?

- Health professionals are often affected by conflicts between their working life and their private life (work-home conflict).
- Numerous studies have demonstrated an association between work-home conflict and important employee outcomes like health, satisfaction, turnover intentions and work performance.

What this paper adds

- Our results emphasise the importance of organizational contextual factors for work-home conflict of health professionals.
- Compared to larger hospitals, employees in smaller hospitals were more severely affected by work-home conflict.
- A good working atmosphere on hospital wards that fosters mutual trust, support and a 'sense of unity' (organizational social capital) is associated with less severe physicians' and nurses' work-home conflict.

1. Introduction

Paid employment and private life are not separate areas of existence, but rather influence each other mutually. The interaction between the domains of work and private life can be defined as 'a process in which a worker's functioning (behaviour) in one domain (e.g., home) is influenced by (negative or positive) load reactions that have built up in the other domain (e.g., work)' (Geurts et al., 2005, p. 322). As such, there is a complex interplay in which the various areas of life influence one another both positively and negatively. The negative influence of work on private life is often the focus of interest. From the perspective of role conflict theory, this can be described as 'work-family conflict' or 'work-home conflict'. Such conflict occurs when experiences in one role interfere with meeting the requirements of and achieving effectiveness in the other (Edwards and Rothbard, 2000; Greenhaus and Beutell, 1985).

We know that this type of conflict is associated with poorer physical

and psychological health (Frone, 2000), increased absenteeism (Lidwall et al., 2010; Sabbath et al., 2012), reduced satisfaction with work and life (Rice et al., 1992), less commitment to an organization (Netemeyer et al., 1996) and stronger turnover intentions (Boyar et al., 2003; Nohe and Sonntag, 2014) (for reviews, see Allen et al., 2000; and Amstad et al., 2011). The results of meta-analyses have also shown that conflict between work and private life correlates negatively with self-rated and general measures of work performance (Gilboa et al., 2008), as well as supervisor-rated work performance (Hoobler et al., 2010). In the hospital setting, an association between surgeons' work-home conflict and professional burnout, symptoms of depression, alcohol abuse/dependency and the intent to reduce clinical hours and leave the current practice were found (Dyrbye et al., 2012).

Several studies have reported a high prevalence of work-home conflict among nurses and physicians (Dyrbye et al., 2014; Grzywacz et al., 2006; Simon et al., 2004). Many characteristics of the work environment that are typical of the work in hospitals have been identified as risk factors for a conflict between private and working life. The results of research in various settings show, for example, that shift work (Haines et al., 2008), irregular work schedules (Yildirim and Aycan, 2008), work hours (Kossek et al., 2006), overloading (Smith Major et al., 2002) and work pressure (Grzywacz and Marks, 2000) are associated with more severe work-home conflict (for reviews, see Byron, 2005; Michel et al., 2011). By contrast, more autonomy (Thompson and Prottas, 2006) and perceived control in the workplace (Kelly et al., 2014), as well as support from management (Cortese et al., 2010; Yildirim and Aycan, 2008) and colleagues (Grzywacz and Marks, 2000), can help reduce work-home conflict.

Against the background that there is already a present shortage of well-trained health professionals that will further increase in the future (Buchan and Aiken, 2008; World Health Organisation, 2006), the improvement of employees' work-home conflict in the hospital setting is of great importance. Avoiding or reducing work-home conflict is thus in the interest not only of employees, but also of organizations and employers. Information about the factors that potentially influence work-home conflict is therefore indispensable in order to find appropriate measures to achieve this.

Data examining factors that explain differences in the work-home conflict of health professionals in hospitals, and which also focus on organizational-level factors, are important, but rare (Cortese et al., 2010; Leineweber et al., 2014). As Leineweber et al. (2014) remarked, this is notable, as many decisions in regard to the work environment are made at different organizational levels. Thus, they recommended multi-level analysis to explore how individual and contextual factors may impact work-home conflict.

Additional important contextual factors in the workplace include typical formal work-family benefits (e.g., assistance caring for dependents, flexible working arrangements and parental leave) and aspects of organizational culture, such as having a 'work-life balance culture' or 'work-family culture' where, for example, there is an acceptance of the importance of making work and private life compatible, and management actively supports this. Numerous studies have demonstrated the importance of this type of organizational culture (Allen, 2001; Dikkers et al., 2004; Gordon et al., 2007; Janasz et al., 2013; Mennino et al., 2005; Nitzsche et al., 2013b; Thompson et al., 1999). In a meta-analysis across 38 studies, Mesmer-Magnus and Viswesvaran (2006) compared the relationships between work-family benefits (i.e., flexibility and dependent care) and work-home conflict, and a perceived family-friendly organizational culture and work-home conflict. The results showed that a perceived family-friendly organizational culture plays a more important role in terms of work-home conflict than the examined concrete work-family benefits. Recent research demonstrated similar results among hospital nurses in Belgium (Lembrechts et al., 2015).

In addition to specific work-family context variables, broader and more general organizational context variables that do not involve direct individual benefits are also associated with the interplay between work and private life, such as perceived organizational support, perceived fair interpersonal treatment and trust (Behson, 2002; Lembrechts et al., 2015), as well as a sense of community (Fuss et al., 2008). These are aspects that describe the degree of collaboration and cohesion in organizations or organizational units; they are an integral part of the broader concept of organizational social capital and may be associated with work-home conflict.

1.1. Social capital

The concept of social capital has grown in importance in many different areas of research (Kwon and Adler, 2014; Portes, 2000). A basic distinction is made between network and cohesion theories of social capital (Kawachi, 2006). Network theorists define social capital as 'resources embedded in social networks accessed and used by actors for actions' (Lin, 2002, pp. 24 & 25). As such, it is primarily conceptualised as a 'private good', and individuals can both invest in their own capital directly and benefit from it (Esser, 2008). By contrast, social cohesion theorists regard social capital as a collective good that makes collective action easier and is available to all actors within a given collective (Coleman, 1990, 1988). 'Unlike other forms of capital, social capital inheres in the structure of relations between actors and among actors' (Coleman, 1988, p. 98). Putnam takes a similar view and defines social capital as 'features of social life – networks, norms, and trust – that enable participants to act together more effectively to pursue shared objectives' (Putnam, 1995, pp. 664 & 665). Esser (2008:25) refers to this form of social capital as 'system capital', since as a characteristic of a collective system as a whole (e.g., a climate of cooperation or mutual trust) it 'cannot be achieved by individual intentional efforts alone'.

Social capital is also regarded as an important resource in the workplace, since it is likely to arise wherever people spend a great deal of time together (Kawachi, 1999). Empirical research investigating social capital in different workplace settings (e.g., Finnish public-sector employees, Japanese private-sector employees) has identified associations with greater satisfaction and better health (e.g., better self-rated health, less depression and burnout) and health-related behaviour (e.g., quitting smoking) (Kouvonen et al., 2008a, 2008b; Oksanen et al., 2010, 2008; Requena, 2003; Suzuki et al., 2010). Results from a meta-analysis of prospective multi-level analytic studies have also confirmed a causal association between social capital and employee health (Murayama et al., 2015). In the hospital setting, higher social capital was found to be linked to less emotional exhaustion (Kowalski et al., 2010; van Bogaert et al., 2013), as well as more organizational commitment on the part of nurses (Hsu et al., 2011).

While the importance of social capital in the workplace is undisputed, few studies to date have investigated social capital as a contextual factor and a feature of a collective (e.g., a ward). In this study, which is based on the 'collective good' approach to social capital, organizational social capital is regarded as a resource that is available to the actors within a defined collective. Hence, a collective with high social capital is characterised by a high level of mutual trust, shared values and standards, and a willingness to cooperate based on reciprocity.

1.2. Research model

We developed a research model (see Fig. 1) considering the current state of research described above and theoretical assumptions based on the 'Work-Home Resources Model' (Ten Brummelhuis and Bakker, 2012). The model itself uses insights from conservation of resources theory (Hobfoll, 1989). One main assumption in conservation of resources theory is that people seek to acquire and maintain resources and that stress occurs when they risk or lose resources. Resources can be differentiated according to context (i.e., the social context a person is embedded in) and personal resources (Hobfoll, 2002). Two main