
Politics of organizational restructuring in health care and work ability of nurses'

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Abstract: Nurses are the largest employee group in health care but continue to lack presence in organizational restructuring processes. This study examines whether nurses' opportunities to be involved in organizational restructuring are associated with their work ability. Respondents of a survey were asked to identify the organizational changes that had transpired at their workplaces in the previous two years, and to evaluate their opportunities to be involved in these changes. They were also asked to evaluate their work ability and to assess certain statements related to their individual resources and the characteristics of their work at the time of the survey. The study shows that exclusion of nurses from health care restructuring processes may cause feelings of injustice and lower commitment to work and thus decrease work ability. Nurses who evaluated their opportunities to be involved in the restructuring as poor were at a two-fold risk of decreased work ability in comparison to nurses who stated that their opportunities to be involved were good. We conclude that the nursing profession should collectively aim to enhance individual nurse's opportunities to take part in the planning and implementation of organizational restructuring in health care. Poor opportunities to be involved in restructuring processes may result in costs not only to individual nurses but also to society at large as successful public health outcomes of health care restructuring are dependent on nurses' work ability and performance.

Keywords: Health Care, Organizational Restructuring, Work Ability, Nurse

1. Introduction

Evidence shows that the inclusion of nurses in health care restructuring has traditionally been poor (1-4). At the macro-level the power to create political discourses and to build health care restructuring processes is usually limited to a dominant few. Influencing political agendas often goes beyond the scope of nurses because of the realm of intense everyday practice, exhaustion and lack of knowledge regarding reform (5-6). At the level of service production, the power structures within health care organizations largely determine the opportunities for involvement in decision-making and restructuring processes (7-8). Evidence suggests that inside health care organizations, change is often dominated by managerial and biomedical stakeholders, and nurses are left to preserve the status quo and to adapt to the results of the restructuring processes (3,9).

In addition to clinical measures, a legitimate method for assessing work ability is to use employee's self-evaluation. Self-evaluated work ability reports whether or not the

employee him/herself feels able to cope with work and is highly predictive of future sick leaves and disability pensions (10-14). It has been shown that work ability is largely determined by the balance between the demands of the work and the resources of an individual employee (15-18). Work ability is thus sensitive to changes in work and might deteriorate as a result of organizational restructuring.

In this study, we examined whether nurses' opportunities to be involved in the organizational restructuring taking place at their own workplaces were associated with the characteristics of their work, with their individual resources, and ultimately with their self-assessed work ability.

2. Methods

2.1. Participants

In 2010, a sample of 1969 nurses was selected from a database maintained by Statistics Finland in which every employee with a formal job contract in Finland is registered under a personal identification number. The nurses were

asked to identify organizational changes that had taken place at their own workplaces over the previous two years, and to evaluate their opportunities to be involved in these changes. In addition, we asked the respondents to evaluate their work ability and to assess whether certain statements related to their individual resources and the characteristics of their work were true or false at the time of the survey. We used stratified random sampling to represent all 19 provinces of Finland and different sectors of the health care industry in proportion to their relative sizes. Nurses who had entered the health care industry after 2007 were excluded from the sample. Survey forms were mailed to selected nurses together with a pre-paid return envelope. Altogether 540 registered nurses, 504 practical nurses and 160 nursing assistants (n=1204) answered the survey, meaning a response rate of 61.8%. Before analysis, the 431 nurses who answered that they had not experienced organizational changes at their own workplaces during the past two years, who did not answer the questions regarding organizational changes at all or no longer worked in the health care industry were removed from the data. Thus, 773 nurses who had undergone organizational restructuring at their own workplaces during the past two years and still worked in the health care industry were included in the analysis.

2.2. Measures

2.2.1. Opportunities to be Involved in Organizational Restructuring

The indicator used to measure the opportunities to be involved in organizational restructuring was based on an earlier study and was thus scientifically tested (19). The indicator comprised two statements: a) The staff has been sufficiently involved in the planning of the organizational change, and b) I have been able to influence the implementation of change at my workplace. Answers were given on a five-point Likert scale (1=fully agree, 2=agree to a point, 3=neither agree nor disagree, 4=disagree to a point, 5=fully disagree). The original two questions were combined to form a sum variable for which Cronbach's alpha coefficient was 0.79. Before analysis, the sum variable was dichotomized by combining alternative answers 1-2 and 3-5.

2.2.2. Work Ability

The indicator used to measure work ability was based on intensive work by Finnish researchers (15-16,18,20). We used a single-item question, shown to accurately predict the outcome of the wider work ability index (14,21). The exact question was: Let's assume that your work ability at its best is worth 10 points. How many points would you give your current work ability? Answers were given on an 11-point scale (0=entirely incapable of working, to 10=at the height of work ability). The work ability estimations were dichotomized by combining alternative answers 0-7 and 8-10, as in previous studies (22).

2.2.3. Individual Resources

We measured health, professional competence and commitment, as these elements are suggested to be the major

individual-level resources affecting work ability (18). Self-evaluated health was measured on a five-point Likert scale (1=good, 5=poor). Similarly to previous studies, the indicator was dichotomized by combining alternative answers 1-2 and 3-5 (23).

Professional competence was measured on a three-point scale (1=I need further training to cope well with my work, 2=My current abilities correspond well to my work, 3=I would be able handle more demanding work). The indicator was dichotomized by combining answer alternatives 1 and 3, as previous studies have shown that appropriately challenging work; neither too easy nor too demanding, is connected to good work ability (24).

The indicator used to measure commitment was based on four statements: a) My work is rewarding and I work because I enjoy it, b) My current work is an essential part of my life, c) I regard my profession highly, and d) I am personally committed to my current work. Answers were given on a five-point Likert scale (1=fully agree, 5=fully disagree). The original four questions were combined to form a sum variable for which Cronbach's alpha coefficient was 0.79. The sum variable was dichotomized by combining alternative answers 1-2 and 3-5.

2.2.4. Characteristics of Work

We measured organizational justice, functionality of work community, clarity of job description and prevalence of time pressure, as these elements represent major organizational level characteristics which affect work ability (18). The indicator used to measure organizational justice was based on seven statements defined by Moorman (25): a) At our workplace, decisions are based on valid information, b) At our workplace, unsuccessful decisions can be changed, c) All parties concerned are represented in decision-making, d) Decisions made at our workplace are consistent, e) Everyone has the right to state their opinion on matters that concern them, f) The effects of decisions are followed up and communicated to the staff, g) Information regarding decisions is available to those who want it. Answers were given on a five-point Likert scale (1=fully agree, 5=fully disagree). The original seven questions were combined to form a sum variable for which Cronbach's alpha coefficient was 0.91.

Functionality of work community was measured through four statements: a) Our work community is flexible, b) Our work community operates efficiently, c) Co-operation between different members of our work community works well, d) The division of labor in our work community is successful. Answers were given on a five-point Likert scale (1=fully agree, 5=fully disagree). The original four questions were combined to form a sum variable for which Cronbach's alpha coefficient was 0.85.

Clarity of job description was measured by asking the respondents how often within the previous 12 months they had been bothered by, worried or stressed about the obscurity of their job description. Answers were given on a five-point Likert scale (1=rarely or never, 2=seldom, 3=every now and then, 4=quite often, 5=often or continuously).

Time pressure was measured through asking how often within the previous 12 months the respondents had been bothered by, worried or stressed about: a) Constant rushing and pressure caused by work that has to be done, b) An inadequate number of staff, c) Too little time to take breaks during the working day. Answers were given on a five-point Likert scale (1=rarely or never, 5=often or continuously). The original three statements were combined to form a sum variable for which Cronbach's alpha coefficient was 0.84. Before analysis, all measures of work characteristics were dichotomized by combining alternative answers 1–2 and 3–5.

2.2.5. Background Characteristics

Information on age, sex, marital status, professional status and managerial duties of the participants was collected from the survey.

2.3. Statistical Analysis

We formed eight logistical regression models to study the association between opportunities to be involved in organizational restructuring and the following work ability, health, professional competence, commitment and four characteristics of work. We adjusted the models for age, sex, marital status, professional status and managerial duties.

Results are communicated as odds ratios (OR) and their p-values.

3. Results

Out of the 773 respondents, 714 (92 %) estimated that their opportunities to be involved in organizational restructuring were poor.

Table 1 shows that respondents who stated that their opportunities to be involved in restructuring had been poor were at a two-fold risk of decreased work ability in comparison to respondents who stated that their opportunities to be involved had been good. There was no statistically significant difference between the two groups as regards self-reported health, nor in whether the respondents' professional competence matched the demands of their work. Instead, the group who ranked their opportunities to be involved as lower was at an almost two-fold risk of presenting lack of commitment. The risk of assessing decision-making as unjust was five-fold in the group with poor opportunities for involvement. There was no statistically significant difference between the two groups as regards the functionality of work community, strain caused by obscure job descriptions or strain caused by time pressure.

Table 1. Risk of decreased work ability among nurses with poor opportunities to be involved in organizational restructuring

Response variables	Poor opportunities to be involved (OR)
Decreased work ability	2.13 *
Individual resources	
Health average or poor	1.35
Professional competence too high/low	0.77
Lack of commitment	2.04 *
Characteristics of work	
Unjust decision-making	5.14 *
Deteriorated functionality of work community	1.61
Strain caused by obscure job description	1.16
Strain caused by time pressure	1.65

Age, sex, marital status, professional status and managerial duties were adjusted for in each logistic regression model. p* < 0.05

4. Discussion

In this study representing all provinces of Finland and different sectors of the health care industry, only eight percent of the nurses estimated their opportunities to be involved in the organizational restructuring that had taken place at their own workplaces as good. The result is parallel to earlier studies indicating poor inclusion of nurses in health care restructuring in several Western societies (1-4) and is thus hardly surprising.

What is new is that we found an increased risk of self-evaluated work disability among nurses with poor opportunities to be involved in organizational restructuring. There was no statistical significance to suggest that this would be explained by a weakened state of health or an increased mismatch between professional competence and work tasks. Instead, the results suggest that the mechanisms behind an increased risk of work disability among those with poor opportunities to be involved in organizational restructuring

might be found in perceived injustice of organizational decision-making and lack of personal commitment. The results thus highlight the importance of the motivational aspect of work ability and the politics of organizational restructuring by large. On the basis of the results, the exclusion of nurses from the health care restructuring processes may cause feelings of injustice and lower commitment to work and thus decrease work ability.

When interpreting the results it should, however, be remembered that cross-sectional data was used in this study. The results should be validated with longitudinal data. Firstly, exposure (opportunities to be involved in organizational restructuring) and responses (self-evaluated work ability, individual resources, and characteristics of work) were measured simultaneously. As we therefore have no knowledge of nurses' work ability or individual resources or work characteristics prior to the organizational restructuring, one should be cautious in drawing causal associations between exposure and responses. Secondly, it should be

remembered that in this study, the respondents were asked to identify the organizational changes that had occurred at their workplaces during the previous two years, but were not asked to specify the time of the changes more accurately. It is thus possible that the temporal distance between the restructuring and the survey might play a considerable role in the responses. Thirdly, the time period (< two years) used in this study may be altogether too short for detecting the effects of poor involvement opportunities on the respondents' state of health (26-27). It might even be that the risk of employees with poor involvement opportunities suffering from decreased work ability was no higher than this study showed because the employees were, thanks to their good state of health, able to maintain their work ability for this time period regardless of the stress factors related to their work.

5. Conclusions

Nursing profession should collectively aim to enhance individual nurse's opportunities to take part in the planning and implementation of organizational restructuring in health care. Poor opportunities to be involved in restructuring processes may result in costs not only to individual nurses but also to society at large as successful public health outcomes of health care restructuring are dependent on nurses' work ability and performance.

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