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Article info:

Received 08.04.2016
Accepted 07.10.2016

UDC – 005.33:614.2
DOI – 10.18421/IJQR11.01-11

QUALITY OF WORK LIFE: THE DETERMINANTS OF JOB SATISFACTION AND JOB RETENTION AMONG RNS AND OHPs

Abstract: *The health care industry (public and private) in several countries, including Saudi Arabia, is facing high turnover rate among registered nurses (RNs) and other health care professionals (OHPs). However, despite numerous studies that have been conducted in the past to tackle this phenomenon, we still believe that the functions and the connections between quality of work life (QWL), satisfaction and retention are still not thoroughly explored in the Middle East, particularly in Saudi Arabia. The aims of this current study are to examine the effects of demographic characteristics on the QWL dimensions and satisfaction, and the relationships between the QWL dimensions and satisfaction, and between satisfaction and retention among RNs and OHPs. A model was developed to link QWL, satisfaction and retention. A sample of 360 RNs and OHPs was collected in Jeddah, one of the major cities in Saudi Arabia. Multivariate analysis of variance and structural equation modeling were used to test the hypotheses. The results show that there is a significant difference between demographic and QWL dimensions and satisfaction. Satisfactions with personal growth and salary package were found to have significant positive impacts on overall retention. The paper provides a greater understanding of QWL, satisfaction and retention and their relationships with each other among the RNs and OHPs in public and private health care organizations in Saudi Arabia.*

Keywords: *Quality of work life, satisfaction, retention, other health care professionals, registered nurses, Structural equation modeling, Multivariate analysis*

1. Introduction

Health care systems and health care organizations (public and private) in several countries including Saudi Arabia are facing a variety of challenges, notably, in terms of

health care specialists (including RNs and OHPs), low output, and high rates of job dissatisfaction. The strain to deliver superior services by using the available or limited resources has been recognized by several health care organizations throughout the world and such a limitation is expected to prolong in the near future (Brooks and Anderson, 2005). Following this study on

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QWL, studies on satisfaction and retention in the health care organizations have escalated recently (Brooks et al., 2007). However, these studies were conducted in western countries and were focusing mainly on hospitals settings. Very few studies were carried out on QWL and its relationships to satisfaction and retention (Lu et al., 2004). As we all know, majority of the working professionals (including RNs and OHPs) in Saudi Arabia are foreigners. Thus, it would be very interesting for us to examine the impact of QWL on satisfaction and retention among them in Saudi Arabia. A study done by Almalki et al., (2012) found that majority of nurses in public health care organizations were dissatisfied with their quality of work life. However, the study was delimited to only QWL.

This research represents the first attempt at studying the above topic, which could

enhance our knowledge on various QWL factors and their associations with job satisfaction and retention.

2. Theoretical Background and Hypotheses Development

This study reviewed the literature on QWL, job satisfaction and retention within the field of health care by focusing on nursing and other health professionals. However, in spite of numerous past studies, we tend to still notably believe that the functions and also the relationships between QWL, satisfaction and retention are still not clearly defined. Thus, from the supported literature review, we extended it further by developing a structural framework linking QWL and satisfaction to retention (see Figure 1).

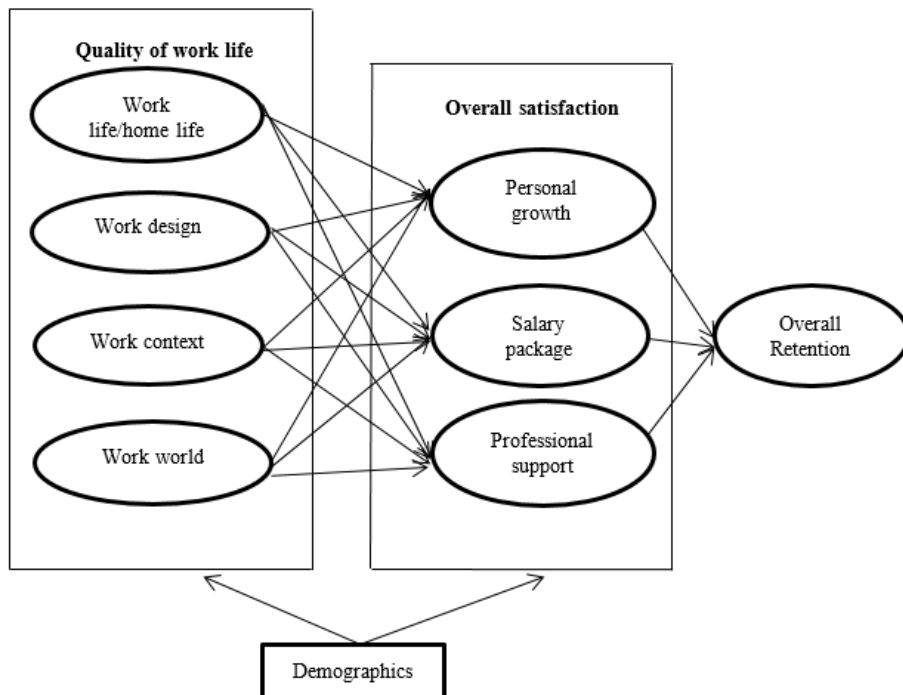


Figure 1. A model of relationship between quality of work life, satisfaction and retention

Our structural framework has three key features. Firstly, it examines the special

effects of demographics on QWL dimensions and their sub-scales and overall

satisfaction dimensions. By doing this it permits us to scrutinize the alternative components and demographic stimulus on QWL. Secondly, it investigates the effect of QWL dimensions and their sub-scales on the overall satisfaction dimensions. Third, it examines the relationship between overall satisfaction dimensions on overall retention. Figure 1 is used to develop our hypotheses.

3. The importance of QWL and its related factors

The term “Quality of work life” is a distinctive conception. Today, quality of work life (QWL) is becoming an imperative issue for achieving the goals of an organization in every industry sector. Many research results have been published on this topic. According to Adhikari and Gautam (2010), QWL is a multi-dimensional conception which shields an employee’s feelings towards numerous measurements of work that comprised the job gratified, working conditions, fair and adequate compensation, career development opportunities, task discretion, contribution in decision making, industrial safety and health, occupational anxiety, career safety, managerial, social relations and work-life balance. Similarly, Daubermann and Pamplona (2012) and Heidari et al., (2010) have defined QWL as a process by which the organization’s employees and stakeholders learn how to work better together to improve both their staff’s quality of life and their organizational effectiveness, simultaneously. In fact, improving the QWL is an important process to develop the quality of life of employees and is very essential in organization to attract and retains its employees (Nayeri et al., 2011). QWL is vital for extending organizational productivity (Dolan et al., 2008) because it is an intricate unit that is prejudiced through interacting with several aspects of work and personal lives.

The quality of work life has been studied in various areas, including psychology,

management, and sociology, health care and nursing. Today, QWL has received increasing attention in health care settings. QWLs of nurses and other health care professionals need to be recognized as important facets of health care organization’s performance (Janaabadi and Nastiezaie, 2012). Huang et al., (2007) have conjointly claimed that QWL impacts the performance and commitment of workforces in varied production environments, including the health care industry. Consequently, the problems of recruitment and retention in health organizations can be handled by focusing and attaining a high level of QWL.

According to the recent publication report by Giang and Trung (2016), the first research on QWL was published in 1994. Until 2002, another study had been conducted. From 2002 to 2009, one or two papers that focused on QWL were published every year. However, 2011 and 2012 could be considered as two remarkable years, where an average of four papers were published per year. In terms of continent, Asia had the most articles (n=7, 43.8%), followed by Americas (n=6, 37.5%) and Europe (n=3, 18.8%). In Saudi Arabia, there was only one paper on QWL published (see Almalki et al., 2012). Over the years, various authors and researchers have proposed models of QWL, which included a wide range of factors. From our review of the literature on QWL, we have identified a number of different factors that could affect the QWL of RNs and OHPs. The results of some selected studies that were conducted in 2011 and 2012 are highlighted below.

Nayeri et al., (2011) investigated the QWL of nurses in Iran, where they assessed various factors that affect their QWL, including management and personal relations, work aspects, job promotion, salary and rewards, and autonomy. The results indicated that only 3.6% of the nurses reported high QWL. About one third of them reported that their productivity was moderate. All of participants who had a high

or a very high level of productivity reported their QWL as desirable.

An et al., (2011) examined the QWL of nurses in Korea, where they measured various other factors that affect QWL, such as organizational culture and organizational effectiveness. The results of the study showed that a significant difference between the respondents' rationality culture and education. Furthermore, QWL by age showed a significant difference in terms of job ($F= 4.65$, $p=.011$) and compensation ($F=3.57$, $p=0.030$)

Hornung et al., (2011) investigated a number of German hospital physicians and evaluated various factors that affect their QWL, including leader consideration, development idiosyncratic deals, flexibility idiosyncratic deals, work engagement, and work-family conflict. The study revealed that consideration had consistent positive effects on idiosyncratic deals on both professional development and working time flexibility. Two of these types of factors affected the indicators of the QWL differently. The results showed that development idiosyncratic deals related positively to work engagement, whereas flexibility idiosyncratic deals related negatively to work-family conflict.

In France, Pronost et al. (2012) examined QWL on caregiver (nurses and nurses' aides). They assessed the relationships between the various variables on QWL including support, perceived stress, and coping strategies. The findings showed that the QWL was inversely related primarily to the lack of recognition, the lack of time, the poor consideration for patients and their families, the lack of training and the lack of collaboration.

Hosseinabadi et al. (2012) found that, after intervention, there were significant differences between the quality circles and control groups in the scores linked to the domains of work and total space of life use and development of capacities and the total score of quality of work-life. The study was

conducted on nurses, and emergency medical technician in Iran.

Lastly, Almalki et al. (2012) investigated some primary health care nurses of Saudi Arabia. Their research was restricted to four major dimensions of QWL: work life/home life, work design, work context, and work world. The results revealed that work context produced the strongest unique contribution to explaining turnover intention. The link between turnover intention and each of the work life/home life and work world dimensions are mediated by the relationships between work design, work context and turnover intention. The researchers found that the majority of the nurses in public health care organizations were dissatisfied with their quality of work life.

Most of the studies and research described above concentrated only on developing QWL measurements and related factors. Also, a number of the studies centered solely on QWL and its relationships with employment and retaining of RNs as well as on the performance of health care organizations. The studies of nurses' QWL were based on Brooks' assessment of QWL. The results of Brooks' survey on the QWL of nurses (Brooks, 2001) were published in the US and Iran with increasing global interests. Additionally, queries to apply Brooks' questionnaire came from scientists and graduate students in Greece, Estonia, Canada (Ontario, Quebec), India, Iran, Australia, Malaysia, Turkey, and Taiwan (Almalki et al., 2012). As such, we believe that it is appropriate for us to conduct this study, particularly since the dimensions have been used by many scholars, worldwide.

After having examined the QWL measurements of nurses, the following sections will discuss some previous studies on job satisfaction and retention and their related influencing factors. Revising the existing accessible writings will assist us in expounding the perspectives of nurses' satisfaction and retention. This evaluation highlights our explanations related to the

review of the literature and provides a concrete approach for learning and addressing any knowledge gaps.

4. Job satisfaction among nurses

Job satisfaction is a composite and subjective phenomenon, whose definition varies according to the adopted theoretical framework. Different authors conceptualize it as a pleasant emotional state, resulting from multiple aspects of work. It can be influenced by individuals' worldviews, aspirations, sadness and joy, thus affecting their attitude towards themselves, family and organization (Martinez and Paraguay 2003). Research on job satisfaction of nursing staff can contribute towards identifying problems in health services, and planning possible solutions and consequent improvements in the work environment and in the quality of care delivery (Stetler et al., 1998).

Melo et al. (2011) have examined multiple factors influencing the triggering of job satisfaction. In line with the present research results, it was found that greater job satisfaction of a nursing team involves their ability to help people and when delivering care, they feel useful and stimulated by what they have accomplished (Gallo, 2005). Other factors can also arouse job satisfaction include personal accomplishments, recognition, the work itself, and responsibility (Martins, 2006). Among the various dissatisfaction factors that have been identified by researchers include lack of work systemization, lack of social acknowledgement, little valuation of the profession, wages and working conditions (Gallo, 2005; Martins, 2006; Stacciarini and Tróccoli 2001; Suehiro and Suehiro 2008). This shows that nursing professionals need to be valued and acknowledged for their work.

The prevalent scarcity of nurses and their high mobility (Kingma, 2001) have become progressively more problematic in technologically advanced countries (Aiken et

al., 2001). Furthermore, the priority given to employment and retaining of registered nursing staff is snowballing in numerous countries. While plentiful factors have been associated with registered nurses' movement, job satisfaction is the most frequently quoted factor (Cavanagh and Coffin, 1992; Irvine and Evans, 1995) and therefore it merits attention. According to Lu et al. (2005), a job, whether it is contented or disgruntling, is determined by the kind of job encompassing the prospects that individuals ought to have and what their job should provide. Numerous researchers today have tried to recognize the assorted factors of job satisfaction and they have evaluated the comparative prominence of each factor of job satisfaction and have also examined what effect these factors have on employees' output (Burnard et al., 1999). An array of conclusions resulting from quantitative as well as qualitative studies has been stated in the review of the literature on sources of job satisfaction/dissatisfaction amongst registered nurses. Job dissatisfaction amongst registered nurses (age under 30 years old) has been found in the United States and some European countries (Aiken et al., 2001). It was reported that nurses in Germany (61%) were more contented with the prospects for development and progression, whereas 57% of the nurses in the United States and 69% in Canada felt more contented with their compensation and remunerations. Similarly, Adamson et al., (1995) found that British nurses were more discontented and dissatisfied than Australian nurses in terms of professional position, relations with health care managers/superintendents, inadequate working settings, clashes between impeccable perception of work gained during training and real work practice, lack of communication and being less appreciated by other associated health specialists (health settings commissioners, surgeons and senior specialists).

Significance variations were found amongst some of the demographic variables (Almalki,

et al., 2012). Moreover, in Saudi Arabia, majority of the nurses or other health professionals were non-Saudi of different nationalities and cultural backgrounds. Therefore, based on the above background, we hypothesize that:

H1_{a-g}: Demographics affect each dimension of QWL.

H2: Demographics affect each dimension of overall satisfaction [(i) personal growth, (ii) salary package, and (iii) professional support].

H3-9: QWL dimensions relate positively to each dimension of overall satisfaction.

5. Job retention among nurses

Nursing is a benevolent profession whose principal task is compassionate and nurturing of human needs with their experiences of health and illness. Several health care groups have comprehended that the key to their efficacy lies in their capability to employ and retain competent registered nurses. Retention of nurses is an acknowledged issue for health organizations, as proved by numerous studies done by Nasseret al. (2011) in order to find some explanations why nurses leave their jobs. There have been a number of different models used to map nurse turnover and different studies have concluded different causes for nurses leaving, suggesting that the reason behind turnover may be dependent on a variety of risk factors, such as the work environment, demographic variables and individual's personal response to situations. Thus, it is vital for health care establishments to concentrate on nurse retention so that the shortage of nurses does not adversely affect patients' health, workforce health, and ultimately the financial condition of health care organizations. The key to operational excellence is the ability to have high employee retention. Nurses are pillars of the medical community, and therefore, it is important to understand the factors contributing to their retention.

Mrayyan (2005), found that there has been very little research on job satisfaction and retention, especially in the field of nursing and other health professionals. Interest in nurse retention is renewed with each cycle of nursing shortage. The findings of this research indicates that nurses were 'moderately satisfied' in their jobs with 'neutral' opinion about their retention. In addition, nurses who worked in private hospitals were more satisfied and intended to retain their jobs more than nurses in public hospitals. Nurse job satisfaction and retention are related concepts; nurses who are satisfied in their jobs are likely to retain their jobs.

According to Terera and Ngirande (2014), compensation is a single crucial issue that retains talents in different associations. The prerequisite of a well-paid compensation package is one and only of the generally debated element of retention. Rewards alone do not satisfy monetary and physical wants; however, they conjointly provide a societal position and power within an association. Therefore, an organization's strategic compensation policy should be prepared to attract the right quality of workforce, hold applicable employees, and also maintain impartiality between the workforces.

Countless studies have shown that RNs view salary as the key base of discontentment, which repeatedly caused high employee turnover. RNs from South Africa who voyaged overseas to seek employment also quoted that compensation is the main reason that influenced their choice to leave South Africa (Oosthuizen, 2005).

According to Teseema and Soeters (2006), there is an optimistic connection between financial practices and retaining of workforces. They found that intentional mobility is high amongst workforces who value high financial recompenses as a portion of their payment package. This particular study also supported the previous literature and reveals that salary package and personal growth have a significant positive

impact on overall retention. The result shows that salary package has a stronger effect on overall retention than personal growth. Nevertheless, we still believe that customer retention measurements can be used to measure employee retention or vice versa. Customer retention is a measure that combines both behavioral (Ang and Buttle, 2006) and attitudinal measurements. Accordingly, the former measurement induces customer to spread positive word-of-mouth to their social circle regarding the firms and their offerings, while the latter reflecting the customers' emotional and psychological attachment like loyalty, engagement and adherence. Thus, this study considers preference, recommending, increase in productivity, and continuing working are the key measures of employee retention practice. Hence, we hypothesize the following:

H10: Overall satisfaction dimensions of i) personal growth, ii) salary package, and iii) professional support, affect overall retention

6. Methodology

All the items in the survey questionnaire were adapted from the previous studies on QWL (40 items) from Brooks and Anderson (2005), satisfaction (12 items) from Traynor and Wade (1993), and finally, retention (nine items) from Zeithaml et al., (1996). These items were measured using 1–6 Likert scale, on which 1 indicates *strongly disagree* and 6 indicates *strongly agree* with the items.

A sample comprising of 400 questionnaires were distributed among health care professionals, which includes RNs and OHPs in both public and private hospitals in Jeddah, out of which only 360 completed sets were used for analysis.

Table 1 shows the demographic profile of the total sample. Before we proceeded to test the hypotheses developed in this study, we first performed exploratory factor analysis (EFA) on the items that measured QWL dimensions, satisfaction, and retention. Secondly Confirmatory factor analysis (CFA) and structural equation modeling were conducted. Table 2 shows the results of the EFA.

Table 1. Demographic profile

	N = 360	Percentage
Gender		
Male	137	38.1
Female	223	61.9
Age		
18 – 24 years old	60	16.7
25 – 34 years old	164	45.6
35 – 44 years old	99	27.5
45 years and above	37	10.3
Marital status		
Never married	123	34.2
Married	223	61.9
Divorced/Widowed	14	3.9
With spouse or family members living in Saudi Arabia		
Yes	255	70.8
No	105	29.2

Table 1. Demographic profile (continued)

	N = 360	Percentage
With children		
Yes	193	53.6
No	167	46.4
With older or disabled dependent		
Yes	113	46.1
No	208	52.2
Missing	39	1.7
Nationality		
Saudi	166	46.1
Non-Saudi	188	52.2
Missing	6	1.7
Ethnic group		
Arab	186	51.7
Asian	103	28.6
Indian	50	13.9
African/Caucasian	9	2.5
Missing	12	3.3
Language barrier		
Yes	117	32.5
No	235	65.3
Missing	8	2.2
Culture barrier		
Yes	113	31.4
No	238	66.1
Missing	9	2.5
Level of education		
Health institute	19	5.3
Diploma/associate degree/intermediate	62	17.2
Bachelor degree	192	53.3
Master's degree and above	81	22.5
Missing	6	1.7
Types of health profession		
Other health professional (OHP)	182	50.6
Registered nurses/midwives (RN)	172	47.8
Missing	6	1.6
Types of health care setting		
Public	235	65.3
Private	117	32.5
Missing	8	2.2

Table 2. EFA results and coefficient alpha

Factor	Factor loadings			
	1	2	3	4
Work life/home life dimensions (WHL)				
<i>Factor 1</i>				
On-site child care services*	.808			
On-site day care for elderly parents*	.788			
On-site ill-child care services*	.720			
<i>Factor 2</i>				
Able to balance work with family		.728		
Energy left after work		.820		
Policy for vacation is appropriate with family		.705		
Working hours negatively affect my life*		.411 ^a		
MSA (.688; p=.000), N = 360				
Initial eigenvalues (26.775% variance explained)				
Extracted components (60.442% variance explained)				
Coefficient alpha	.703	.688		
Work design dimensions (WD)				
<i>Factor 1</i>				
Received sufficient assistance from supporting personnel	.788			
Able to provide good quality client/patient care	.703			
Quality assistance from supporting personnel	.711			
<i>Factor 2</i>				
Workload too heavy*		.798		
Autonomy to make client/patient care decisions		-.459		
Many other administrative tasks*		.735		
Factor	1	2	3	4
<i>Factor 3</i>				
Many interruption during my daily work routine*			.493	
Enough time			.707	
Enough staff			.749	
MSA (.675; p=.000), N = 360				
Initial eigenvalues (28.337% variance explained)				
Extracted components (57.722% variance explained)				
Coefficient alpha	.636	.463	.458	
Work context dimension (WCD)				
<i>Factor 1</i>				
Able to communicate well with manager/supervisor	.494			
Adequate supervision from manager/supervisor	.512			
Sense of belonging	.442			
Feedback from manager/supervisor	.716			
Participate in decisions made by manager/supervisor	.577			
Recognition of accomplishments	.672			
Policies and procedures facilitate the work	.590			
<i>Factor 2</i>				
Communicate well with other co-workers		.577		
Feel respect		.484		
Designated break area*		-.801 ^a		

Table 2. EFA results and coefficient alpha (continued)

	Factor loadings			
Continuing education without leaving the job*		.747		
Communicate well with staff		.702		
<i>Factor 3</i>				
Adequate client/patient care supplies and equipment			.723	
Friendships with co-workers			.658	
Career advancement			.473	
Teamwork			.692	
<i>Factor 4</i>				
Support to attend continuing education programs				.580
Secure working environment				.685
Safe from persona; harm				.805
Upper level management has respect for nursing/other health professionals				.563
MSA (.901; p=.000), N = 360				
Initial eigenvalues (32.239% variance explained)				
Extracted components (54.861% variance explained)				
Coefficient alpha	.825	.739	.693	.690
Work world dimension				
<i>Factor 1</i>				
Salary adequate	.593			
Ability to find job in another organization	.555			
Job is secure	.628			
Work positively impacts lives of others	.761			
Work world dimension (continued)				
	1	2	3	4
MSA (.587; p=.000), N = 360				
Initial eigenvalues (40.829% variance explained)				
Extracted components (40.829% variance explained)				
Coefficient alpha	.510			
Overall Satisfaction (SAT)				
<i>Factor 1</i>				
Personal growth	.660			
Accomplishment	.798			
Independent	.855			
Challenge	.795			
<i>Factor 2</i>				
Salary		.812		
Fringe benefits		.821		
Fairly paid		.788		
Communications		.503		
<i>Factor 3</i>				
People around			.638	
Chance to know others			.857	
Chance to help others			.864	
Work life			.609	
MSA (.888; p=.000), N = 360				

Table 2. EFA results and coefficient alpha (continued)

	Factor loadings			
Initial eigenvalues (48.158% variance explained)				
Extracted components (70.601% variance explained)				
Coefficient alpha	.864	.844	.815	
Overall Retention (RET)				
<i>Factor 1</i>				
Prefer	0.812			
Recommend	0.770			
Optimal service	0.726			
Long-term	0.823			
Productivity	0.779			
Continue	0.866			
Position	0.784			
No intention of leaving	0.710			
Staying on	0.740			
MSA (0.906; p=000), N = 360				
Initial eigenvalues (61.026% variance explained)				
Extracted components (61.026% variance explained)				
Coefficient alpha	0.906			

Note: * reversed items; ^a = item deleted after we performed reliability test

The 40 items of the QWL for RNs and OHPs were subjected to principle components analysis (PCA) using the SPSS version 16 software. The results in Table 2 shows that the MSA values were statistically significant (.69, .68, .90, .89, and .91, respectively), and all exceeded the cut off-point of .50 (Kaiser, 1970), thus, demonstrating that a factor analysis might need to be performed.

The EFA generated two factors for items that measured work life/home life with acceptable Cronbach’s alpha values of .70 (“on-site care services”) and .69 (“balance of life”), respectively. Three factors on work design dimension, but only one factor (“work design”) with an acceptable Cronbach’s alpha value of .64 were also generated. Thus, factors 2 and 3 were dropped from further analysis. For the dimension on work context dimension, four factors were generated with acceptable Cronbach’s alpha values of .82 (“management and supervision), .74 (“co-workers”), .69 (“development and opportunities”), and .69 (“work

environment”), respectively. Due to poor Cronbach’s alpha value for the working world dimension, it was dropped from further analysis.

Based on the items that were loaded on the satisfaction construct, three factors emerged, which are called “personal”, “salary package”, and “professional support”. Table 2 showed their acceptable Cronbach’s alpha at 0.86, .84 and 0.82, respectively. For the retention construct, all items were loaded on a single factor with an acceptable Cronbach’s alpha value of 0.91.

Table 3 (Appendix) shows the conservative approach for establishing discriminant validity where the average variance explained (AVE) estimates for each factor (except for WD and WCD1) are greater than the squared inter-construct correlations associated with the factor. The factor loadings shown in Table 4 are all greater than .5 (Hair et al., 2010), thus confirming their convergent validity and discriminant validity.

6.1. Multivariate analysis of variance (MANOVA)

To test the effects of the demographic variables on QWL, and on overall satisfaction we used Multivariate analysis of variance (MANOVA). Table 5 summarizes the results of the QWL and satisfaction for each demographic variable.

7. Structural Equation Model (SEM)

The next step was to test the relationships between the factors involved in QWL, satisfaction and retention in Jeddah, Saudi

Arabia using AMOS 18.0 software. The proposed model fits the data reasonably well as shown by the chi-square/degrees of freedom (CMIN/DF) = 2.987, goodness-of-fit index (GFI) = .99, comparative fit index (CFI) = .99, and root mean square error of approximate (RMSEA) = .03 (see Table 6).

7.1. On-site care services and overall satisfaction

There are significant relationships between on-site care services to personal growth ($\beta = -.14, p = .00$) and salary package ($\beta = .13, p = .00$) amongst the OHPs and RNs and thus, they provide support to H3_i and H3_{ii}.

Table 4. Psychometric properties of the measurement

Factor	M	SD	Factor loadings	R2
Work life/home life dimensions (WHL)				
<i>On-site care services(WHL1)</i>				
On-site child care services*	2.375	1.164	.68	.47
On-site day care for elderly parents*	2.231	1.099	.61	.37
On-site ill-child care services*	2.253	1.117	.71	.50
<i>Home life(WHL2)</i>				
Able to balance work with family	3.750	1.385	.66	.43
Energy left after work	3.350	1.512	.65	.42
Policy for vacation is appropriate with family	3.450	1.456	.65	.42
Work design dimensions (WD)				
Received sufficient assistance from supporting personnel	4.120	1.148	.77	.60
Able to provide good quality client/patient care	4.690	1.073	.54	.30
Quality assistance from supporting personnel	4.030	1.208	.53	.28
Work context dimension (WCD)				
<i>Management and supervision(WCD1)</i>				
Able to communicate well with manager/supervisor	4.460	1.257	.66	.43
Adequate supervision from manager/supervisor	4.110	1.166	.58	.33
Sense of belonging	4.180	1.238	.68	.46
Feedback from manager/supervisor	4.190	1.246	.60	.364
Participate in decisions made by manager/supervisor	3.810	1.393	.64	.41
Recognition of accomplishments	4.100	1.234	.63	.38
Policies and procedures facilitate the work	4.010	1.266	.68	.46
<i>Co-workers(WCD2)</i>				
Communicate well with other co-workers	4.590	1.143	.72	.52
Feel respect	4.570	1.112	.58	.34
Continuing education without leaving the job*	4.980	1.163	.60	.36

Table 4. Psychometric properties of the measurement (continued)

Factor	M	SD	Factor loadings	R2
Communicate well with staff	4.730	1.030	.70	.47
<i>Development opportunities (WCD3)</i>				
Adequate client/patient care supplies and equipment	3.980	1.218	.72	.52
Friendships with co-workers	4.520	1.139	.58	.34
Career advancement	3.740	1.242	.60	.36
Teamwork	4.360	1.143	.69	.47
<i>Work environment (WCD4)</i>				
Support to attend continuing education programs	3.710	1.540	.51	.26
Secure working environment	3.710	1.503	.64	.40
Safe from personal harm	3.500	1.449	.59	.35
Upper level management has respect for nursing/other health professionals	4.130	1.156	.67	.45
Factor	M	SD	Factor loadings	R2
Overall Satisfaction (SAT)				
<i>Personal (SAT1)</i>				
Personal growth	3.890	1.287	.72	.52
Accomplishment	4.160	1.167	.80	.64
Independent	4.130	1.189	.84	.71
Challenge	4.130	1.336	.77	.60
<i>Salary (SAT2)</i>				
Salary	3.240	1.486	.72	.52
Fringe benefits	3.400	1.340	.82	.67
Fairly paid	3.430	1.329	.85	.72
Communications	3.730	1.316	.66	.43
<i>Professional support (SAT3)</i>				
People around	4.180	1.175	.67	.45
Chance to know others	4.380	1.111	.74	.54
Chance to help others	4.750	1.012	.86	.74
Work life	4.160	1.155	.64	.40
<i>Overall Retention (RET)</i>				
Prefer	4.020	1.291	.78	.51
Recommend	3.890	1.237	.74	.43
Optimal service	4.330	1.207	.68	.57
Long-term	3.910	1.290	.80	.75
Productivity	4.380	1.195	.74	.55
Continue	3.950	1.332	.86	.65
Position	3.730	1.449	.75	.40
No intention leaving	3.800	1.447	.65	.55
Staying on	3.570	1.412	.71	.61

Note: * reversed items; M = Mean; SD = Standard deviation; R2 = Correlation coefficient

7.2. Home life and overall satisfaction

Inspection of these coefficients indicates that, home life has significant positive impact on overall satisfaction dimensions of personal growth ($\beta = .19, p = .00$), salary package ($\beta = .22, p = .00$) and professional support ($\beta = .15, p = .00$), thus, confirming H4_{i, ii, and iii}. The result shows that home life of the respondents exerts a stronger influence on their salary package than personal growth and professional support.

7.3. Work design and overall satisfaction

Work design, as expected, was found to be

statistically significant to satisfaction with professional support ($\beta = .14, p = .03$), and thus, supporting hypothesis H5_{iii}. Obviously, RNs' and OHPs' overall satisfaction is paramount to providing good quality of client/patient care. But this can only be achieved if they receive sufficient and quality assistance from supporting personnel.

8. Results

Table 5 represents results of Multivariate Analysis of Variance.

Table 5. Results of Multivariate Analysis of Variance

Dependent variable/dimension	Age*	Marital*	Nat	Ethnic*	Edu*	Types of PHC	Profession
Work life/home life							
On-site care services (WHL1)			2.280				
Home life (WHL2)					3.505	3.508	
Work design(WD)						4.286	
Work context							
Management and supervision (WCD1)		4.123			4.117		
Co-workers (WCD2)			4.722			4.121	
Development opportunities (WCD3)						4.723	
Work environment (WCD4)	3.762	3.762				4.158	
Wilks' Lambda	1.828	2.321	3.669		2.270	5.996	
<i>p</i> value	0.013	0.004	0.001		0.001	0.000	
Overall Satisfaction							
Personal (SAT1)				4.068			
Salary package (SAT2)				3.435			3.448
Professional support (SAT3)							4.367
Wilks' Lambda				4.556			6.063
<i>p</i> value				0.000			0.000

All significant value at $p < 0.01$; *further test was performed using a Bonferroni post hoc test
 Figures in italic are the mean values

Note: Nat = Nationality; Edu = Education level; Types of PHC = types of public health care

8.1. Management and supervision and overall satisfaction

The paths between management and supervision were significantly and partially supporting H6. Management and supervision tend to have a strong significant effect (H6_i: $\beta = .46, p = .00$) on personal growth than on salary package (H6_{ii}: $\beta = .30, p = .00$). This research reveals that management and supervision are the most significant factors in building personal growth satisfaction in the health care service industry.

8.2. Co-workers and overall satisfaction

The relationship between co-workers and

professional support was significant as expected (H7_{iii}: $\beta = .24, p = .00$). This finding suggests that co-workers' level of satisfaction from professional support would be based on whether the health care organization is engaging good communication with its staff, giving respect to its co-workers, and continuing educating them without leaving these responsibilities to their co-workers. Therefore, the health care organizations should promote teamwork, continuous education, building trust and respect, and maintaining flexible scheduling. These activities would help to enhance a positive working environment.

Table 6. Results of SEM

			<i>Standardized estimates (β)</i>	<i>Critical Ratio.</i>	<i>P-value</i>	<i>R²</i>
RET						.39
SAT1						.54
WHL1	→	SAT1	-.14	-2.89	.00*	
WHL2	→	SAT1	.19	4.68	.00*	
WD	→	SAT1	.06	1.13	NS	
WCD1	→	SAT1	.46	7.95	.00*	
WCD2	→	SAT1	-.03	-.56	NS	
WCD3	→	SAT1	-.11	2.25	.02**	
WCD4	→	SAT1	.18	4.17	.00*	
SAT1	→	RET	.38	2.91	.00*	
SAT2						.44
WHL1	→	SAT2	.13	2.49	.01**	
WHL2	→	SAT2	.22	5.39	.00*	
WD	→	SAT2	.04	.71	NS	
WCD1	→	SAT2	.30	5.10	.00*	
WCD2	→	SAT2	.06	1.09	NS	
WCD3	→	SAT2	-.07	-1.40	NS	
WCD4	→	SAT2	.33	7.63	.00*	
SAT2	→	RET	.70	4.47	.00*	
SAT3						.34
WHL1	→	SAT3	.00	.071	NS	
WHL2	→	SAT3	.15	3.01	.00*	
WD	→	SAT3	.14	2.11	.03**	
WCD1	→	SAT3	-.05	.637	NS	
WCD2	→	SAT3	.24	3.66	.00*	

Table 6. Results of SEM (continued)

			Standardized estimates (β)	Critical Ratio.	P-value	R ²
WCD3	→	SAT3	.09	1.56	NS	
WCD4	→	SAT3	.10	1.98	.05**	
SAT3	→	RET	-.06	-1.01	NS	

^a Goodness-of-fit indices: CMIN/df=2.099 ($p=.01^{**}$), RMR = .01; GFI= .99; AGFI= .90; CFI= 1.00; RMSEA= 0.03

Note: *Based on Hair et. Al., (2010); CMIN= Chi-square, *df*= degrees of freedom; RMR=Root mean square residual; GFI=Goodness-of-fit index; AGFI=Adjusted goodness-of-fit index; CFI=Composite fit index; RMSEA= Root man square error of approximation
 WHL1 = On-site care services; WHL2 = Home life; WD = Work design; WCD1 = Management and supervision; WCD2 = Co-workers; WCD3 = Development opportunities; WCD4 = Work environment; SAT1= Personal growth; SAT2 = Salary package; SAT3 = Professional support; RET = Overall retention;
 Significant levels at $p<0.01^*$ and $p<0.05^{**}$

8.3. Development opportunities and overall satisfaction

Development opportunities, as expected, were found to be significantly related to personal growth ($\beta= -.11, p= .02$) and hence, supporting H8_i. Hence, the development of clinical ladder for career advancement within the organization is one of the important factors in determining the RNs’ and OHPs’ overall satisfaction.

8.4. Work environment and overall satisfaction

The relationships between work environment and overall satisfaction in terms of personal growth ($\beta= .18, p= .00$), salary package ($\beta= .33, p= .00$), and professional support ($\beta= .10, p= .05$) were significant as expected. Work environment tends to have a medium significant positive effect on salary package, thus, confirming H9_{i, ii, and iii}.

8.5. Overall satisfaction and overall retention

As expected, both personal growth and salary package have significant positive impacts on overall retention, thus,

confirming H10_i and H10_{ii}. Satisfaction with the salary package ($\beta= .70, p= .00$) exerts strong relationship with overall retention than with personal growth ($\beta= .38, p= .00$). One possible suggestion from this could be that a more constructive policy framework should be implemented to revise the current pay structure, which in turn will balance the work/home life expenses.

9. Discussion

Overall, there are some significant demographic effects on some dimensions of quality of work life and satisfaction in which, the types of health care organization having the most effects, followed, in descending order, by education, nationality, marital status, and age. The findings from this study also found significant relationships between QWL and overall satisfaction, to some extent, and between overall satisfaction and overall job retention, respectively. Hence, this Saudi study supports previous studies in the literature, especially for work context from a different cultural perspective. The list of hypotheses indicates that the hypotheses were partially supported. The results also suggest that satisfaction with personal growth and salary

package are the main reasons that RNs and OHPs would remain in their current organization.

10. Implications and Future Strategies

Based on the findings, a number of strategic implications emerged. Hence, the following strategies are recommended in order to provide job satisfaction, which in turn leads to retention of RNs and OHPs:

- RNs/OHPs must be responsible for their personal and professional growth.
- Certification programs, career development programs, personal development programs and self-confidence workshops should be conducted to direct them towards continual professional growth.
- Health care organizations (public and private) at every level should include representations from RNs and OHPs in the higher level of management hierarchies (or in other key leadership positions).
- Changing specialties can also be a type of personal development for RNs and OHPs.
- Monetary and health care organizations sustenance programs should be provided to RNs and OHPs, such as allowing them to attend various workshops, seminars, and conferences to further their education.
- To RNs and OHPs to be career oriented, management strategies for expanding their pay line and for establishing a clear career lines for them should be developed. This include establishment of steeper salary grades geared to their education, experience, competence, and responsibility.
- A fair pay level policy should be implemented on the basis of

attaining higher knowledge, competencies, and skills.

- Motivating RNs and OHPs through job enrichment, job engagement, and setting up reward systems based on their workloads.
- Reviewing the salary package for RNs because, based on the findings of this study, the OHPs are more satisfied with their salary package than the RNs. Last but not least, public health organizations should be focusing more on the quality of work life dimensions, such as work life/home life, work design, work context, and development opportunities as compared to private health organizations.

Finally, taking into consideration the current situations of the RNs and OHPs, it would be vital for the country to form a National Committee or Commission for health care professionals in Saudi Arabia. The aim of this committee or commission is to develop guidelines for the RNs and OHPs in executing their practice, and to outline future plans for their progress and success in their profession.

11. Conclusions

The current study is measured as a foundation stone that gives a strong support towards our understanding of quality of work life, job satisfaction and retention of RNs and OHPs in public and private health care organizations. As projected, both personal growth and salary package have significant positive impacts on overall retention. The result shows that salary package has a stronger effect on overall retention than personal growth.

Acknowledgment: This project was funded by the Deanship of Scientific Research (DSR) at King Abdulaziz University, Jeddah, under grant no. (G- 96-245-34). The authors, therefore, acknowledge with thanks DSR for technical and financial support.

The research study procedure was approved by Institutional Review Board (IRB)- Local approval committee (e.g. hospitals) in Saudi Arabia. The association has developed strict

measures regarding the sampling of nurses and other health professionals, and access of the data to safeguard the security, privacy and confidentiality.

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Appendix:

Table 3. Results of CFA: Properties of measurement items

Factor	M	SD	α	CR	1	2	3	4	5	6	7	8	9	10	11
1. WHL1	2.286	0.893	0.70	0.71	0.45	0.05	0.27	0.32	0.43	0.22	0.06	0.20	0.04	0.13	0.09
2. WHL2	3.519	1.139	0.69	0.69	-0.22**	0.42	0.16	0.26	0.11	0.17	0.14	0.25	0.25	0.15	0.22
3. WD	4.278	0.870	0.64	0.65	-0.52**	0.40**	0.39	0.47	0.39	0.42	0.18	0.25	0.13	0.24	0.24
4. WCD1	4.123	0.879	0.83	0.83	-0.57**	0.51**	0.68**	0.40	0.36	0.36	0.28	0.47	0.27	0.22	0.39
5. WCD2	4.719	0.832	0.74	0.74	-0.66**	0.33**	0.63**	0.60**	0.42	0.25	0.10	0.18	0.08	0.23	0.17
6. WCD3	4.149	0.854	0.69	0.70	-0.47**	0.41**	0.65**	0.60**	0.50**	0.37	0.15	0.15	0.08	0.19	0.16
7. WCD4	3.762	1.017	0.69	0.68	-0.25**	0.37**	0.43**	0.53**	0.32**	0.39**	0.35	0.25	0.29	0.13	0.32
8. SAT1	4.076	1.048	0.86	0.86	-0.45**	0.50**	0.50**	0.69**	0.43**	0.39**	0.50**	0.62	0.42	0.24	0.44
9. SAT2	3.448	1.128	0.84	0.85	-0.20**	0.50**	0.36**	0.52**	0.29**	0.29**	0.54**	0.65**	0.59	0.27	0.37
10. SAT3	4.367	0.891	0.82	0.82	-0.35**	0.39**	0.49**	0.47**	0.48**	0.43**	0.36**	0.49**	0.52**	0.53	0.24
11. RET	3.953	1.028	0.92	0.92	-0.29**	0.47**	0.49**	0.63**	0.41**	0.40**	0.57**	0.66**	0.61**	0.49**	0.56

Note:
 Values below the diagonal are correlation estimates among constructs, diagonal values are AVE estimates, and values above the diagonal are squared correlations.
 M = Mean; SD = Standard deviation; α = Cronbach's alpha; CR = Composite reliability
 **, Correlation is significant at the 0.01 level (2tailed).

