Quality of Work Life plays the Mediating role in between Workplace Empowerment and Employee Commitment: A Study on Healthcare Employees of an Indian State.

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ABSTRACT

The changing priorities in healthcare can only be pursued through innovation in systems and strategies, sustained by a competent and dedicated workforce. Quality of work life (QWL) is being accepted as the foremost criterion for attracting and retaining the human resources required for quality and sustainability of the healthcare system. Extant literature has explored the role workplace empowerment in building employee commitment, but there is dearth of research exploring the action mechanism that describes this relationship. This study covers this gap by examinng the mediating role of QWL in the association between workplace empowerment (WEM) and employee commitment (EC) by using data from 279 healthcare employees of private healthcare units in Odisha. The justification of the hypothesized model in this research elucidates that QWL partially mediates between WEM and EC. The study affirms the proposition that workplace empowerment can catalyse the cognitive domain of the employees and augment their degree of perceived QWL. Additionally, when organisations foster the ether of empowerment, the employees will reciprocate by being more dedicated and committed. This indulgence in a triadic and symbiotic alliance will materialize as a win-win strategy for the organisation.

Keywords: Structural Equation Modelling, Mediation, Bootstrapping.

1. INTRODUCTION

The upsurge of globalisation has propelled the healthcare sector into an epoch of flux. The healthcare delivery in India has been affected by changes in demographics, disease patterns, and wellness paradigms, scarcity of healthcare employees, consumer's demands and expectations, technological advancement and rising healthcare costs. These changing priorities in healthcare can only be pursued through innovation in systems and strategies, supported by a competent and dedicated workforce. Thus, healthcare organisations are spending substantial effort and resources for recruitment, selection and retention of skilled diligent, proactive and committed employees (Macey, Schneider, Barbera, and Young 2009). Work life epitomises a significant domain which borders the job content and job context of the healthcare employees. Quality of work life (QWL) comprehends the edifice of workplaces that are physically and psychologically desirable so as to facilitate the employees in satisfying essential personal needs through their work experiences while achieving organisational goals (Brooks and Anderson 2005). The employees will ascribe pleasure from their work lives only when the fundamental expectations about their workplace and job are suitably fulfilled. Therefore, organisations need to focus on the work aspect of the employees and stimulate positive attitudes and behaviour through self-worth, self-esteem and positive identity at the workplace. Further, their work role should encompass the concepts of participative management, self-leadership and employee empowerment (Dewettinck and van Ameijde 2011) so as to facilitate employees to exercise their full potential in achieving the organisational goals.

2. RELEVANCE AND SCOPE OF THE STUDY

India has embarked upon a journey of healthcare system transformation with a vision to provide access to a minimum set of qualitative health services to all the citizens. The private healthcare sector is playing a pivotal role towards achieving this vision. There is a universal consensus that employees have an indispensable role to play in the delivery of qualitative care in the healthcare organisations. As front liners of the system, they are trained to promote good health, provide care, offer comfort, and help in the recovery of the patients. While they strive to provide worthy services to the patients, their health and well-being is often ignored. They regularly deal with challenging and crucial tasks that exert intensive physical and psychological pressure on them. Specifically, heavy workload, workplace hazards, occupational stress and exposure to unpleasant emotions of illness and death are critical

factors that pose a threat to their wellbeing (Mosadeghrad, Ferlie and Rosenberg 2011). This has led to declining morale, commitment and performance of healthcare employees. The employee's prerogative of better QWL is an imperative concern for employers who are interested to improve the job satisfaction and commitment. Moreover, the QWL issues have become crucial now a days, not only due to the increasing demands of the current business environment but also due to the evolving family structure. This concern has induced significant research in developed countries in pursuit of solutions for promoting healthcare employees' wellbeing and QWL (Lowe 2004). However, organisational efforts towards better QWL are less prevalent in the healthcare sector of developing countries, such as India and there is also the lack of evidences for designing relevant intervention programs for the employees. Hence, the research targets private healthcare units in Odisha, an Indian state to draw a holistic picture about the latent mechanisms of QWL among healthcare employees.

3. OBJECTIVES OF THE RESEARCH

Quality of work life (QWL) is being accepted as the foremost criterion for attracting and retaining the human resources required for quality and sustainability of the healthcare system. QWL has been the focus of research efforts for several decades and it has been associated with several antecedents and outcomes. QWL influences employee commitment and workplace empowerment has also been significantly related to employee commitment. But the role of workplace empowerment towards better QWL is still largely unexplored. Therefore, main purpose of this research is as follows:

- To extrapolate different facets of workplace empowerment that leverages the QWL and commitment of healthcare employees.
- To examine the relationship between workplace empowerment and employee commitment while QWL acts as a mediator.

4. Theoretical Framework and Hypotheses

4.1 Key Variables

4.1.1 Workplace Empowerment

Hass (2010) defined empowerment as the process of providing authority to the employees to take crucial decisions about their day-to-day events. Further, empowerment is the entrustment of decision-making power to the employees as well as the discretion to act independently (Arneson and Ekberg 2006; Samad 2007). Empowering employees will encourage decision making at lower levels of an organisation and also enrich their work experience (Liden, Wayne, and Sparrowe 2000; Dainty, Bryman and Price 2002). The contemporary literature discusses two key concepts of empowerment: psychological and structural (Mathieu, Gilson and Ruddy 2006). Studies on psychological empowerment focused on employee's feelings and experiences of being empowered Avolio, Zhu, Koh and Bhatia 2004; Chen, Kirkman, Kanfer, Allen and Rosen 2007). Spreitzer (1995), reports psychological empowerment as improved intrinsic task motivation exhibited in an individual through four cognitions of competence, impact, meaning, and self-determination. In contrast, studies on structural empowerment have highlighted on introduction of empowerment by top management, further directing the delegation of authority and responsibility down the hierarchy (Leach, Wall, and Jackson 2003; Mills and Ungson 2003). Kanter (1993) argued that the factors requisite for empowerment are access to information, support, opportunity for growth and learning, and control over resources. Many research studies have utilized the Kanter's theory of structural power as a yardstick to measure empowerment among healthcare employees (Laschinger, Almost and Tuer-Hodes 2003; Seibert, Silver and Randolph 2004)). This study will also assess workplace empowerment using the structural approach.

4.1.2 Quality of Work Life

Quality of work life (QWL) is a multi-dimensional construct that refers to overall satisfaction with work life along with a cumulative sense of belonging to a working group, becoming oneself, and being worthy and respectable (Morin and Morin 2004). QWL comprises of favourableness of the total job environment (Rantanen, Kinnunen, Mauno and Tillemann 2011), sense of employee well-being (Bateman and Snell 2003) and innovations that targets employee satisfaction, enhances organisational effectiveness and productivity. Serey (2006) opined QWL as a construct that includes the criteria of concern, consciousness, capacity and

commitment. Researchers have stressed on both work and non-work contexts to assess QWL and have suggested six dimensions like job and career satisfaction, general wellbeing, home-work interface, stress at work, control at work, and working conditions (Van Laar, Edwards and Easton 2007). Brooks and Anderson (2005) determined nursing quality of work life through work life/home life, work design, work context and work world dimensions. The current study concentrates on five factors of QWL namely work environment (Cole et al. 2005; Musich, Hook, Baaner, Spooner and Edington 2006), occupational stress (Gelesma et al. 2006; Mosadeghrad et al 2011), professional development (Chen, Chang, and Yeh 2004; Hsu and Kernohon 2006), compensation and rewards (Lewis, Brazil, Krueger, Lohfeld and Tjam 2006; Nayeri, Salehi and Noghabi 2011) and social support(Dolan, García, Cabezas and Tzafrir 2008; Purdy, Laschinger, Finegan, Kerr and Olivera 2010).

4.1.3 Employee Commitment:

Employee commitment refers to an employee`s attachment and identification with the organisation as a whole (Mowday, Porter and Steers 2013). Newstrom (2014) defines it as the degree of loyalty experienced by the employees related to the bonding with the organisation, and the willingness to continue participating or working with it. Further, commitment has been defined as a force that binds an individual to a target (social or non-social) and to a course of action of relevance to that target (Meyer, Becker and Van Dick 2006). Meyer and Allen (1991) proposed three dimensions of commitment, namely, affective (emotional attachment), normative (moral obligation) and continuance (consciousness of the costs connected with discontinuing membership). Consequently, Meyer and Allen (1997) advocated the features of a committed employee which are: stays with the organisation through thick and thin, attends work regularly, puts in a full day, protects company's assets and shares company's goals.

4.2 Workplace Empowerment and QWL

Empowered employees are better equipped to confront challenges at the workplace (Kanter 1993) and are able to reduce the perceptual gap between their actual and expected work conditions. Empowerment can enrich individual's quality of work life at workplaces,where they have control over their workload, get support from the peers, feel more rewarded for their accomplishments and are treated fairly. Empowering workplace perceptions of the employees has been linked with work productivity or effectiveness (Shader, Broome, Broome, West and Nash 2001), as well as a declined propensity to leave the organisation

(Koberg, Boss, Senjem and Goodman 1999). Research has revealed that workplace empowerment has a positive relationship with job satisfaction, (Savery and Luks 2001; Laschinger and Finegan 2005). Manojlovich and Laschinger (2007) tested the nursing worklife model by introducing structural empowerment as a precursor for work life. Literatures on structural empowerment in healthcare identifies that innovation in work structure can support healthier employees, reduce stress, improve the perceptions of respect and fair play and enhance the quality of work life (Laschinger 2008). On the basis of the above discussion, the hypothetical statement can be derived as

H_1: Workplace empowerment will have a positive relationship with the quality of work life of healthcare employees.

4.3 Workplace Empowerment and Employee Commitment

Empirical studies point out that empowerment plays a pivotal role in building employee's commitment to the organisational objectives (Yukl 1998). It facilitates individuals with concentration, initiative, and resiliency so as to derive a superior meaning from their job. Additionally, it bestows employees with opportunities, challenges and responsibilies to accomplish extra-work role, act unconventionally, and reciprocate through committed to their organisation (Liden et al. 2000; Avolio et al, 2004). As a consequence of empowerment, employees create positive sense about their work and are more proficient in meeting organisational objectives (Baird and Wang 2010). Theoretical argumentations rightly establish that workplace empowerment dimensions are positively related to employee commitment (Huang, Shi, Zhang and Cheung 2006; DeCicco, Laschinger and Kerr 2006; Bhatnagar 2007). Empowerment conjures commitment because it bridge the gap between the employee's work roles and personal values; gives employee the conviction that they are able to execute tasks with their knowledge, skill and abilities, encouraging them to wield significant energy for the organisation; employees control their work and engage in the decision making that fosters involvement in the organisation, and assists employees with prospects to participate in sculpting the organisational system in which they are embedded (Jansen, 2004). Based on above theoretical argumentation, it can be proposed as follows:

H_2: Workplace empowerment will augment employee commitment in healthcare employees.

4.4 QWL and Employee Commitment

Employees who enjoy a sense of QWL are likely to exhibit confidence at their jobs and this affirmative attitude may result in commitment towards the organisation (Sirgy, Efraty, Siegel and Lee 2001). Furthermore, employees often evaluate the organisation's efforts to make their work life satisfying. A positive evaluation can increase motivation, influence behaviour at the workplace and guarantee their permanence in the organisation without considering the circumstances (Steyrer, Schiffinger and Lang 2008). Studies exploring the relationship between QWL and employee commitment have yielded positive and significant relationship between the variables (Karsch, Booske and Sainfort 2005; Huang et al. 2007; Normala 2010). Empirical research in healthcare have revealed the action mechanisms of work related factors such as role stress, communication, job rotation with employee commitment (Chang and Chang 2009; Ho, Chang, Shih and Liang 2009). A high level of QWL will act as a centripetal force and positively influence employee's sense of identification with the organisation (Zhao, 2013). Hence, it can be posited that:

H_3: Emphasis on quality of work life of employees will have a significant impact on employee commitment.

The above review of literature clearly depicts that there is a great deal of research exploring the relationship between any two of the study variables (workplace empowerment, QWL, employee commitment). There are few studies exploring the mediating effects of QWL (Cheung and Tang 2009, Totawar and Nambudiri 2014). But no studies examined the role of QWL as a mediator in between the association of workplace empowerment and employee commitment. This research tries to covers the gap by testing the underlying action mechanism between this relationship. Therefore, we propose the following hypotheses:

H_4: Quality of work life will mediate between workplace empowerment and employee commitment.

This model which is based on previous research and depicts the crux of this research by illustrating the relationship proposed in the derived hypotheses 1 to 4 (Figure 1).

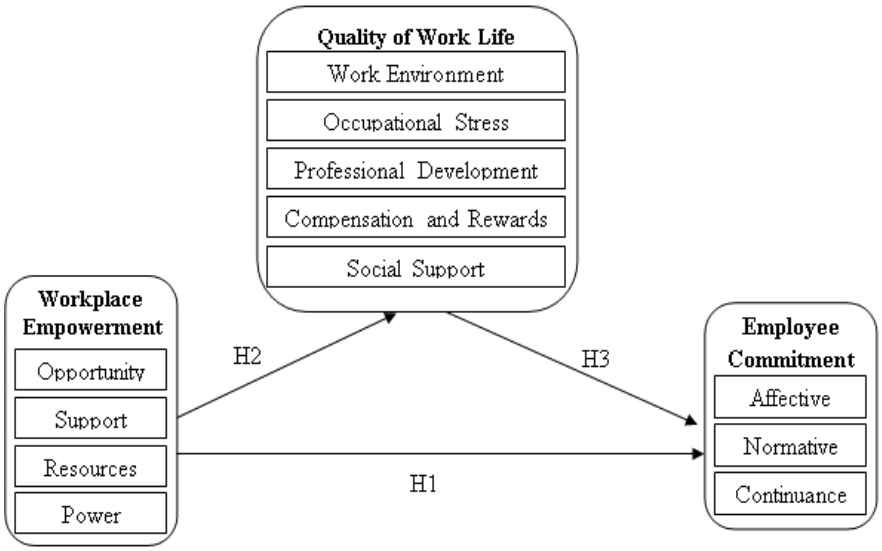

Figure 1: Hypothesized Research Model

5. METHODOLOGY

5.1 Sample and Participants

This is a descriptive survey designed to examine the interaction of three fundamental factors of workplace empowerment (WEM), quality of work life (QWL) and employee commitment (EC) among healthcare employees. A sampling frame of thirty private healthcare units providing varying levels and types of care in Bhubaneswar and Cuttack, the twin city of Odisha were selected for the study. The target population was all nurses, paramedical and supportive staffs active on the payroll of the hospitals were taken for the study. Stratified and random sampling technique was used to select participants so that the reciprocal representation of the respondents could be sought. A total of 350 self-administered questionnaires were distributed, and 279 valid questionnaires were returned yielding to an effective response rate of 79.7 per cent. The study constitutes of 41.5% of male and 58.5% of female respondents. Most of the respondents are aged between 20-30 years (48.8%) followed by 31-40 years (34.1%), 41-50 years (14.6%) and 51-60 years (2.4%). 61% of respondents were married, and 39% of respondents were single. Most of the respondents were nurses (51.2%) followed by pharmacist (26.8%), radiologist (14.6%) and pathologist (7.3%). Majority of the respondents had work experience of 5-10 years (36.6%) followed by 0-5 years (34.1%), 11-15 years (22%), 16-20 years (4.9%) and 21 and above (2.4%).

5.2 Measures

The questionnaire constituted of three scales which were adapted from the extant literature and tested in this study. The measures used included a 16 item scale for measuring workplace empowerment (Kanter 1993; Laschinger 2001). The quality of work life scale consisted of 19 items (Brooks and Anderson 2005; Saraji and Dargahi 2006). A 10 item measure of employee commitment (Meyer and Allen, 1993) was used in this study. All the items were responded to on a five-point Likert-type scale with responses ranging from strongly agree (5) to strongly disagree (1).

5.3 Procedure

As organisations and its employees were diverse, so the survey was customized to best fit each of the organisations. It was felt that a varied approach would be more feasible for the organisations and that this would help maximize response rates. Participation was granted through prior appointments and consent via phone calls from the organisation. The researchers visited the healthcare organisation to administer the questionnaires. The participants were informed about the research purpose and assured regarding confidentiality of the responses. The participants were also advised regarding the voluntary nature of participation. The hospital managers were reminded about the study by phone or visit.

5.4 Data Analysis

Data was analysed by different statistical techniques like descriptive statistics, pearson's correlation and factor analysis using SPSS version 20 for Windows. Thereafter, AMOS 20 has been utilized to derive a model which establishes the inclusive relationship among the variables of the study. We analysed our data in several steps. First, the items of each study variable (WEM, QWL and EC) are subjected to unrotated exploratory factor analysis for establishing the dimensionality of the items. Further, the items are verified through exploratory factor analysis (EFA) with varimax rotation to explore the underlying factors under each variable. This was followed by the creation of parcels according to the factors extracted to increase the ratio of the sample size to estimated parameters in the confirmatory factor analysis(CFA) (Bentler and Chou 1987). Item parcels offer certain advantages, including improved distributional properties of the indicators (West, Finch and Curran 1995) and reducing the number of possible covariances among measurement error sources (Rae 2008). However, item parcelling should only be utilised in examing the relations between the

latent constructs (Little, Cunningham, Shahar, and Widaman 2002), which is clearly the case in our study. In accordance with Coffman and MacCallum (2005), we used a homogeneous item parcelling approach.

Structural equation modelling (SEM) was used to examine the mediating effect of QWL between WEM and EC in the hypothesized model. SEM is applied because it offers simultaneous test of the whole set of variables in a hypothesized model and thus allows assessment of the degree to which the model is consistent with the data (Byrne 2010). To assess the construct validity, we examined convergent validity, composite reliability and discriminant validity. The study also uses two step procedure recommended by Anderson and Gerbing (1988) to investigate the hypotheses of the study. The first step concerned testing the appropriateness of the measurement model, whereas the second step was the testing of the structural model. All the analysis in SEM was performed using maximum likelihood (ML) estimation.

To gauge model fit, we followed Kline's (2005) recommendation and reported the chi-square test statistics with corresponding degrees of freedom and level of significance and RMSEA (Steiger 1990) for which values <.05 indicates close fit, .05 to .08 fair fit, .08 to .10 mediocre fit, and >.10 poor fit (Hair 2010). We also reported the ratio of chi-square value to degrees of freedom (Marsh and Balla 1994). Although no clear-cut guideline exists, "ratios in the range of 2 to 1 or 3 to 1 are indicative of an acceptable fit between the hypothetical model and the sample data" (Arbuckle, 2007). In addition, the baseline comparisons fit indices of TLI, NFI, IFI and CFI which compares the fit of the hypothesized model to the null or independence model must be 0.9 or more (Bentler 2007).

Baron and Kenny's (1986) technique is the most frequently used technique for testing the mediation hypothesis in both basic and applied psychological research (Preacher and Hayes 2004). According to this technique there is support for mediation if: (1) independent variables relates to dependent variable significantly; (2) independent variable significantly relates to the mediating variable and (3) mediating variable also significantly relates to the dependent variable and the relationship of the independent variable with the dependent variable is reduced significantly (partial mediation) or remain no longer significant (full mediation) when controlled for mediators. Furthermore, based on Preacher and Hayes (2004), we used bootstrap confidence intervals to test the mediation hypotheses.

5. RESULTS AND DISCUSSIONS

6.1 Preliminary Analysis

The means, standard deviations, internal reliabilities, and intercorrelations among the study variables are reported in Table 1. All measures show high internal reliabilities, with coefficient alphas ranging from 0.84 to 0.89. The pattern of correlation is consistent with the hypothesized relationships. That is, workplace empowerment has a statistically positive relationship with the potential mediator namely, quality of work life, and with the outcome variables of employee commitment. Additionally, quality of work life has statistically significant positive relationships with employee commitment.

Table **1**: Means, SDs, Reliability and Pearson Correlation Coefficients

Variables	Items	Mean	SD	α	WEM	QWL	EC
Workplace empowerment (WEM)	16	4.15	.50	.847	1		
Quality of work life (QWL)	18	3.78	.64	.890	.389**	1	
Employee commitment (EC)	11	3.87	.58	.845	.391**	.613**	1

Note: ** p <0.01

Exploratory factor analysis (EFA) with principal axis analysis (PCA) and unrotated factor solution supported the unidimensionality of the set of items that measured each study variable. The items used to measure WEM were subjected to factor analysis to recover out the relevant factors that specify the degree of workplace empowerment of health care employees. The value of 0 .821 for Kaiser-Meyer-Oklin (KMO) established the suitability of data for factor analysis. PCA and varimax rotation was employed for extracting factors from the 16 items of the study variable. The communalities of the loaded items reflected the amount of variance accounted for by each item which is between 52 to 82 percent. The results showed that the four extracted factors accounted for 65.67 percent variation in the overall sample. Resources explained greater variance (18.20) when compared to support, power and opportunity (16.27, 15.82 and 15.36 respectively). Table 2 shows factor loadings of the items under four extracted factors after varimax rotation for WEM.

Consequently, the set of items used to measure QWL was also subjected to factor analysis. The results denoted a value of 0.870 for Kaiser-Meyer-Oklin (KMO). PCA with varimax rotation extracted five factors from 18 items of QWL. The communalities of the loaded items were between 58 to 80 percent. The results indicated that the five extracted factors accounted

for 73.06 percent variation in the overall sample. Social support explained greater variance (16.94) when compared to occupational stress, compensation and rewards, work environment, and professional development (15.85, 15.21, 12.58 and 12.46 respectively). Table 3 shows factor loadings of the items under five extracted factors after varimax rotation for QWL.

Table 2: Factor Loadings after varimax rotation for workplace empowerment

Loaded Items	Factor Loadings			
	1	2	3	4
Opportunity				
WEM1				.726
WEM2				.803
WEM3				.782
WEM4				.649
Resources				
WEM5	.795			
WEM6	.813			
WEM7	.888			
WEM8	.811			
Power				
WEM9			.796	
WEM10			.803	
WEM11			.713	
WEM12			.706	
Support				
WEM13		.768		
WEM14		.769		
WEM15		.759		
WEM16		.741		

Similarly, the set of items used to measure EC was subjected to factor analysis. The items of EC displayed value for Kaiser-Meyer-Oklin (KMO) as 0.822. PCA with varimax rotation extracted three factors from 11 items that measured the employee commitment of healthcare employees. The communalities of the loaded items were between 55 to 80 percent. The results indicated that the three extracted factors accounted for 70.76 percent variation in the overall sample. Affective commitment explained greater variance (26.11) when compared to continuance and normative 24.24 and 20.41 respectively). Table 4 shows factor loadings of the items under three extracted factors after varimax rotation for EC.

Table 3: Factor Loadings after varimax rotation for quality of work life

Loaded Items	Factor Loadings				
	1	2	3	4	5
Work environment					
QWL1				.730	
QWL2				.854	
QWL3				.767	
Occupational stress					
QWL4		.824			
QWL5		.826			
QWL6		.772			
QWL7		.670			
Professional development					
QWL8					.852
QWL9					.809
QWL10					.785
Compensation and rewards					
QWL11			.835		
QWL12			.864		
QWL13			.790		
QWL14			.738		
Social support					
QWL15	.786				
QWL16	.835				
QWL17	.843				
QWL18	.795				

Table 4: Factor Loadings after varimax rotation for employee commitment

Loaded Items	Factor Loadings		
	1	2	3
Affective commitment			
EC1	.791		
EC2	.836		
EC3	.784		
EC4	.783		
Normative commitment			
EC5			.821
EC6			.866
EC7			.880
Continuance commitment			
EC8		.799	
EC9		.709	
EC10		.810	
EC11		.765	

Unidimentionality of the items under each latent construct is a prerequisite for constructing parcels (Hall, Snell and Foust 1999). For WEM, we created four parcels by assigning four

items to dimensions of oppurtunity, information, resources and support. For self-leadership, we created five parcels by assigning four items to compensation and rewards, social support and occupational stress dimensions followed by three items for work environment and professional development dimensions. Employee commitment was based on three parcels with four items for affective and continuance commitment each and three items for normative commitment. Scores for each indicator were computed as the mean of the scores on the items that constituted each indicator.

6.2 Test for Measurement Model

Before examining specific relationships between variables in the research model, we examined the measurement model with confirmatory factor analysis. The model reflected a simple structure in which each indicator had only one path from the latent construct and all the latent constructs were permitted to correlate. The fit indexes demonstrated that the three factor model fitted the data well ($\chi 2[51] = 123.509$, $p < .001$;$\chi 2/df = 2.422$; RMSEA = .072, NFI=.94, IFI=.96, TLI=.953, CFI=.963). All three constructs in the study were verified as unique. As shown in table 5, all measurement items showed statistically significant loadings. The composite reliability of each construct ranged between 0.85 and 0.88, ensuring its unidimensionality. Discriminant validity was also ensured since the average variance extracted (AVE) of all constructs were greater than corresponding inter-construct squared correlation estimates (table 6). In conclusion, results of CFA, reliability estimates and measurement model analysis indicated that measures had sound psychometric properties.

Table 5: Properties of the Measurement Model

Constructs	Parcel Indicators	Standardized Estimates	AVE	CR	p Value
Workplace empowerment (WEM)	Opportunity	0.726	.668	.858	.000
	Resource	0.875			.000
	Support	0.834			.000
	Power	0.820			.000
Quality of work life (QWL)	Work environment	0.765	.611	.887	.000
	Occupational Stress	0.776			.000
	Professional development	0.765			.000
	Compensation and Rewards	0.784			.000
	Social Support	0.817			.000
Employee commitment (EC)	Affective	0.827	.665	.888	.000
	Continuance	0.830			.000
	Normative	0.797			.000

Table 6: Discriminant Validity

	WEM	QWL	EC
WEM	0.816		
QWL	0.597	0.782	
EC	0.549	0.640	0.817

6.3 Test of the Structural Model

We then tested the fit of the structural model that represented the hypothesized mediation model in Figure 1. All the model fit indexes indicates that the hypothesized model fitted the data well ($\chi 2$ [51] = 123.509, $p < .001$; $\chi 2$ /df = 2.422; RMSEA = .072, NFI=.94, IFI=.96, TLI=.953, CFI=.963). In the tested model WEM was allowed to make a direct impact on EC beside the impact through the mediator, QWL.

Table 7: Inferences drawn on Hypotheses.

Hypotheses	Relationship	Beta Coefficient	P value	Result
H1	WEM→ EC	.551	***	Accepted
H2	WEM → QWL	.597	***	Accepted
H3	QWL→ EC	.486	***	Accepted

6.4 Examination of the Mediation Effect

Table 4 on the path estimates between the constructs shows that they are all significant. Also, if we analyse the direct and indirect effects between WEM and EC in the mediated model (table 5), we find that direct effect is substantial (0.259) while indirect effect though less (0.290) is significant, further validating partial mediation model. Figure 2 presents the overall structural model with path coefficients for mediating role of QWL between WEM and EC.

Table 8: Results for Mediation

Relationships	OP→QWL	P value
Total Effects	0.549	***
Direct Effects	0.259	***
Indirect Effect	0.290	***
Test for Mediation	Partial	

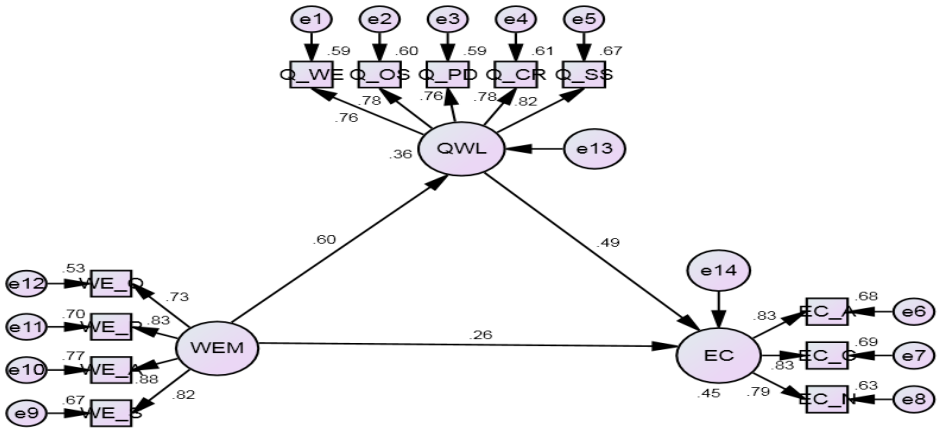

Figure 2: Structural model of mediation

Finally, we performed bootstrapping with 2000 samples to assess the overcome abnormality in the data as well as for stability of the indirect effects. The average bootstrap-based estimates were all close to values based ML estimates for all path coefficients (deviations in the range = .109 to .314, average = .194 in absolute value), and no estimates of the 95% bias-corrected confidence intervals included zero. From above discussions, it can rightly be established that hypothesis (H4) is supported.

6. MANAGERIAL IMPLICATIONS

The study establishes a triadic relationship between workplace empowerment, QWL and employee commitment. In other words, the amalgamation of access to empowering work conditions and better QWL can have an escalating impact on employee commitment. Thus, it advances the literature on mediating mechanisms of quality of work life (Cheung and Tang 2009, Totawar and Nambudiri 2014) and its effect on employee commitment (Sirgy, Reilly, Wu and Efraty 2008). The study offers the following practical and theoretical implications:

- The study suggests that concoction to empower employees will decrease the decision making hierarchy, thus enabling them to utilise their competence along with potency perform tasks and work roles.
- The research further testifies the proposition that workplace empowerment can catalyse the cognitive domain of the employees and augment their degree of perceived QWL. Additionally, when organisations foster the ether of empowerment, the employees will reciprocate by being more dedicated and committed. This indulgence in a symbiotic alliance will materialize as a win-win strategy altogether.

- Health care organisations, albeit slowly have begun to embrace the notion of empowerment, but often fail in practical realisation of the concept. This study provides a conceptual framework for the planning and implemention of empowerment efforts in these organsations.
- The results may also provide meaningful insights to healthcare managers, administrators, and practitioners to design appropriate strategies and interventions to make the working lives of the employees more meaningful and value driven.

7. CONCLUSION

Empowerment can helps to create the organisation culture of synergy, collaboration, flexibility and partnership. Further, better QWL can keep the employees focused and support them to strive effectively towards the organisation's vision. When QWL is coupled with empowerment, it will create a synergetic effect on employee's attitudes and organisational outcomes. As a result, employees will be motivated in body, mind and spirit to withstand work pressure, situations and challenges and turn them into life lessons that will allow them to grow and emerge as winners. This research is an attempt to integrate the employees as the core long-term assets of the healthcare system. This can only be conceivable by embedding high standards of practice and QWL initiatives within the strategic plans at the organisational and governance levels.

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9. APPENDIX

Appendix A: Measurment Instruments of the Study

Table 9:Workplace Empowerment Scale

Item No	Items
WEM1	Work is challenging.
WEM2	Utilise your knowledge, skills and abilities in tasks.
WEM3	Autonomy in doing the job.
WEM4	Gain new knowledge, skills and abilities on the job.
WEM5	Adequate time to accomplish job requirements.
WEM6	Informations needed to make good decisions.
WEM7	Able to access to supplies, equipment when needed.
WEM8	Aware of the values and goals of the management.
WEM9	Collaborate with physicians on patient care.

WEM10	Being sought out by peers and manager to help with problems.
WEM11	Amount of flexibility in your job.
WEM12	Initiatives are welcomed by superiors.
WEM13	Receive specific feedback on performance.
WEM14	Constructive criticism about the work.
WEM15	Problem solving advice or hints by superiors.
WEM16	Specific information about things you do well.

Table 10: Quality of work life Scale

Item No	Items
QWL1	Sufficient staffs to cover the current work load.
QWL2	Clean and healthy environment.
QWL3	Promotes flexible work schedules.
QWL4	Feeling of pressure at work.
QWL5	Long working hours.
QWL6	Health problems due to stress at work..
QWL7	Frustration from the job.
QWL8	Opportunities for continuing education.
QWL9	Attend job related training programmes.
QWL10	Receive support for professional development.
QWL11	Salary is according to prevailing market rates.
QWL12	Salary increases to a fair extent every year.
QWL13	Receive fair payment for overtime work and night shifts.
QWL14	Rewards are provided for good performance.
QWL15	Supervisor provides individual help and support..
QWL16	Supervisor treats fairly.
QWL17	Good working relationship with colleagues.
QWL18	Respected by the superiors, subordinates and pateints.

Table 11: Employee Commitment Scale

Item No	Items
EC1	Interested to continue in the current job for the rest of my career.
EC2	Promote my organisational facilities to outside people.
EC3	Strong sense of belonging to my organisation.
EC4	Emotionally attached to my organisation.
EC5	Feel a sense of moral obligation to remain.
EC6	My organisation deserves my loyalty.
EC7	I owe a great deal to my organisation.
EC8	Difficult to leave my organisation irrespective of a better job offer.
EC9	Staying in this organisation is a necessity as much as desire.
EC10	Too few options to consider leaving this organisation.
EC11	Too costly to leave my organisation right now.