INTRODUCTION

In all developed countries, the population aging is an inevitable process and depends on both the reduction of the birth rate and on longer life expectancy. Demographic aging inevitably leads to the progressive aging of the workforce: in particular, the data on employment in public health show an increase in the mean age of National Health Service (NHS) employees equal to 50.7 years. In 1980, the aging of the working population led the Finnish Institute for Occupational Health (FIOH) to develop the concept of work ability and the Work Ability Index (WAI) to measure workers' perceptions of their physical, mental and social health and their ability to meet work demands. Poor work
ability is predictive of sick leave, early retirement and disability pension as well as depression, work-related stress and emotional exhaustion. On the other hand, high work ability is associated with high productivity and worker well-being.

To understand the concept of work ability and the dimensions associated with it, the Finnish researchers presented a global conceptual model, the “Work Ability House”, represented by a four-story house and a roof, inserted in a generic external environment.

The surrounding environment also affects work ability, including the family. Making work and family life compatible has become increasingly important, considering the greater number of women engaged in work activities, the increasing number of single parents in the workforce, as well as the number of couples in which both partners are employed.

In the scientific literature this construct is called Work-Family Conflict. The first researchers who dealt with the work-family conflict were Greenhaus and Beutell, who defined it as “a form of inter-role conflict in which the role pressures from the work and family domains are mutually incompatible in some respect”.

The Work-Family Conflict consists of two dimensions: the conflict of working role on family role (Work to family conflict - WFC) and the conflict of family role on working role (Family to work conflict—FWC). The involvement of the person in more roles requires the attribution of resources more to one role than the other, therefore, the effectiveness of the individual in some roles is compromised and the experience of conflict is inevitable.

In this conflict, the organization plays a fundamental role: it is defined family-friendly when it supports the integration between family life and working life of its employees and guarantees fairness for the work expectations of employees.

We wanted to study the relationship between WAI and WFC in the healthcare sector due to both physical and emotional workload as well as to the social importance of the healthcare roles in the society. We explored indirect and direct associations between socio-economic variables and job roles and self-reported work ability and their impact on WFC.

Briefly, the objectives of this study are:

1. To identify the variables (ie, socio-economic variables and job roles) associated with Work Ability and with Work-Family Conflict;
2. To identify the inter-relationship between Work Ability and Work-Family Conflict.

2 | MATERIALS AND METHODS

2.1 | Study design and sampling

An observational prospective study was conducted between November 2019 and March 2020 to assess the perceived work ability and the conflict between work and family in the employees of the Teaching Hospital Policlinico Umberto I in Rome. Both questionnaires (Work Ability Index and Work-to-family conflict and family-to-work conflict scale) were inserted in a Google Form and administered by an interviewer to each employee through a tablet.

Data collection was carried out at the Unit of Occupational Medicine of the Teaching Hospital Policlinico Umberto I in Rome and the target population included all employees (physicians, nurses, other health professionals and administrative staff) who went to the Unit to perform blood sampling and/or medical examination with an Occupational Doctor during the study period. The source population was comprised by 6078 healthcare professionals, so we tried to involve 5% of the total sample population.

The choice of the sample is not subordinated to a selection but depends on voluntary adhesion of the interviewees. Employees were contacted personally and informed regarding the type of study and its objectives. The questionnaire included the confirmation of informed consent, specifying that participation is entirely voluntary, and that the compilation could be interrupted at any time. Furthermore, the participants were informed that the compilation is completely anonymous, and that the data would be processed in aggregate form.

Four hundred and thirty six employees of both sexes (182 men and 254 women) and aged between 21 and 67 were interviewed. They included physicians (40.6%; 7.7% of collection rate), nurses (31.7%; 7.7% of collection rate), other healthcare workers (23.9%; 9.9% of collection rate) and administrators (3.9%; 2.9% of collection rate).

2.2 | Data collection tools

Respondents were asked to indicate age, sex, civil status, if they have children, profession, location and department. The data collection tools used in this study were the Work Ability Index (WAI) and the bi-directional scale Work-to-family conflict and family-to-work conflict.

The Work Ability Index is a self-assessment made up of 7 parts: Current work ability compared with the lifetime best (0-10 points); Work ability in relation to the demands of the job (2-10 points); Number of current diseases diagnosed by a physician (1-7 points); Estimated work impairment due to diseases (1-6 points); Sick leave during the past year (12 months) (1-5 points); Own prognosis of work ability 2 years from now (1, 4 or 7 points); Personal resources (1-4 points). The WAI questionnaire score is obtained adding scores attributed to each question.

The score ranges from 7 to 49 points and four categories were suggested to describe the WAI levels: poor (7-27), moderate (28-36), good (37-43) and excellent (44-49). In our analysis, however, we treated the WAI score as a continuous variable.
The work-family conflict was investigated using the Italian version of the Work-to-family conflict and Family-to-work conflict Scale by Netemeyer et al.\textsuperscript{22}

This scale allows to evaluate the conflict in both directions: the work-to-family conflict and the family-to-work conflict. Five statements are related to the work-family conflict and the remaining five are related to the family-work conflict.\textsuperscript{22}

Responses are distributed on a seven-point agree/disagree scale, where (i) corresponds to completely disagree, (ii) to fairly disagree, (iii) to slightly disagree, (iv) to neither agree nor disagree, (v) to a somewhat agree, (vi) to fairly agree and (vii) to completely agree.

The study was approved by the Sapienza Ethics Committee (ref. 4991) and was carried out according to the Declaration of Helsinki protocols (1989) of the World Medical Association.

2.3 | Statistical analysis

Data were analyzed using Statistical Package for Social Sciences (SPSS) software version 25.

Two types of analysis were conducted: univariate analysis, which involved the use of analysis of variance (ANOVA) and multivariate analysis, which involved the use of multiple linear regression models, using both full models and stepwise models with backward elimination. In the multivariate analysis, the results are presented as β coefficients.

Finally, a Structural Equation Modelling (SEM) was carried out, following a Principal Component Analysis (PCA).

The multicollinearity was checked using the collinearity statistics (VIF values). In the regression analyses, the goodness of fit of the models was calculated using the R\textsuperscript{2}. The significance level was set at P < .05.

3 | RESULTS

3.1 | Sample characteristics

The sample included 436 employees, 254 (58.3%) were women and 182 (41.7%) were men. Table 1 shows the characteristics of the population studied.

3.2 | Results of the work-family conflict and family-work conflict

The means and standard deviations for each item were calculated according to the responses obtained.

By relating both scores (WFC and FWC scores) a direct relationship emerged, so as one increases, the other also increases. Subsequently, the WFC and FWC scores were related to the age variable: with increasing age the Work-Family conflict progressively decreases, while the Family-Work conflict is not influenced by the age variable.

The multivariate analysis (Table 2) confirmed what emerged in the univariate analysis (Table 3): a direct relationship of the WFC score with two variables (female gender and physicians) and an inverse relationship with other two variables (the age and administrative staff). A direct relationship emerged between the FWC score and the variable of having children. Both WFC and FWC scores show a direct relationship.

3.3 | Results of work ability

To obtain the WAI score, the qualitative variables were reconverted into quantitative variables and summed up. The WAI score had a normal distribution with a mean of 37.50 (SD = 4.26), with a minimum score of 15.67 and a maximum score of 48.67.

From the univariate analysis emerged that WAI has an almost significant association with the profession variable, in which administrative staff, followed by physicians, have a higher WAI score than other professional categories; in contrast, nurses have lower WAI scores. For the remaining variables, there are no statistically significant differences.

Consequently, the multivariate analysis confirmed what emerged in the univariate analysis.
The multivariate analysis (Table 4), which involved the use of linear regression models, made it possible to highlight an inverse relationship between the WAI and the FWC. Therefore, a high WAI score is significantly associated with a lower Family-Work Conflict (FWC).

The WFC and FWC scores, on the other hand, have a direct relationship: as the work-family conflict (WFC) increases, the family-work conflict (FWC) increases.

### Table 2: Multivariate analysis of WFC and FWC scores

| Independent variable | WFC Standardized Beta (P) | FWC Standardized Beta (P) |
|----------------------|---------------------------|---------------------------|
|                      | Full model                | Last step                 |
| Age                  | −.091 (.073)              | −.109 (.011)              |
| Female gender        | .047 (.275)               | —                         |
| HAVING SONS          | .003 (.951)               | —                         |
| MARRIED / COHABITING | −.029 (.546)              | —                         |
| PHYSICIANS           | .126 (.019)               | .101 (.019)               |
| NURSES               | .029 (.581)               | —                         |
| ADMINISTRATIVE       | −.102 (.021)              | −.108 (.011)              |
| FWC                  | .447 (.000)               | .450 (.000)               |

R² of the model: 0.269 0.265 0.229 0.227

### Table 3: Univariate analysis of WFC, FWC, and WAI scores

| Variables            | WFC Mean (SD) | WFC Mean (SD) | WAI Mean (SD) |
|----------------------|---------------|---------------|---------------|
|                      | P             | P             | P             |
| Gender               |               |               |               |
| Female               | 19.22 (6.94)  | 11.47 (5.85)  | 37.25 (4.26)  |
| Male                 | 17.96 (6.80)  | 10.62 (5.58)  | 37.91 (4.48)  |
| Age (years)          |               |               |               |
| <50                  | 20.16 (6.24)  | 11.34 (5.72)  | 37.80 (3.57)  |
| ≥50                  | 17.49 (7.18)  | 10.93 (5.77)  | 37.30 (4.74)  |
| Civil status         |               |               |               |
| Married/cohabiting   | 18.36 (6.70)  | 11.26 (5.50)  | 37.44 (4.39)  |
| Divorced or Separated| 17.81 (7.55)  | 10.82 (5.92)  | —             |
| Widower              | 19.58 (7.01)  | 10.90 (6.20)  | —             |
| Single               | 20.00 (8.88)  | 12.00 (6.27)  | —             |
| Other civil states   | —             | —             | 37.66 (4.06)  |
| Having sons          |               |               |               |
| No                   | 19.29 (7.03)  | 10.79 (5.74)  | 37.58 (3.97)  |
| Yes                  | 18.25 (6.78)  | 11.36 (5.76)  | 37.48 (4.46)  |
| Profession           |               |               |               |
| Physicians           | 20.13 (6.46)  | 11.57 (5.96)  | 38.00 (3.85)  |
| Nurses               | 18.44 (6.86)  | 11.10 (5.94)  | 36.91 (4.17)  |
| Other health         | 17.58 (7.02)  | 10.76 (5.28)  | 37.29 (4.65)  |
| professionals        | 12.55 (6.59)  | 8.76 (4.23)   | 39.07 (5.64)  |

### Section 3.4: Relationship between work ability, work-family conflict and family-work conflict

The multivariate analysis (Table 4), which involved the use of linear regression models, made it possible to highlight an inverse relationship between the WAI and the FWC.
The SEM was based on the following steps.

1. A PCA model identified three different variables that explained % of the total covariance of the models for WAI (Figure 1).
2. These three variables were used as independent variables for building two different linear regression models in which WFC and FWC were the dependent variables, respectively.

The variable “Socio-economic status” explained 50.97% of the variance of the WAI, while the variable “Senior administrative” and “Healthcare professional experienced” were responsible of 40.61% and 29.81% of the variance of WAI, respectively.

The results of the SEM are illustrated in Table 5. Apart from FWC, the only variable that has an influence on WFC is the Healthcare professional experienced ($\beta = -0.160; P < .001$). On the other hand the three variable coming out from the PCA analysis do not have any influence on FWC.

No collinearity was found in all the models (VIF values between 1.006 and 1.728).

4 | DISCUSSION

4.1 | Main finding of this study

This study was conducted to evaluate the variables associated with work ability and the conflict between work and family and to evaluate the relationship between these two constructs in the health professionals of a Teaching Hospital in Rome.

Socio-economic factors and job role in the healthcare sector are variables that have an influence on WAI and on WFC, using both traditional linear regression models and SEM:

The results of the present study highlighted, first of all, a direct relationship between the two directions of the work-family conflict. The variables that showed a statistically significant association with the work-family conflict were female gender and the physicians (both associated with higher WFC scores) and administrative staff with lower WFC scores. The nurses didn't score very differently from other healthcare professionals; however, they have a slightly higher WFC score.

In our sample, with increasing age the conflict between work and family (WFC) is progressively reduced. Instead, the family-work conflict (FWC) is not influenced by the age variable but has a statistically significant association with the variable of having children. In fact, workers with children...
have more family responsibilities, which lead to a greater family interference with work.²³

As far as concerns Work Ability, the present study has revealed an almost significant association only for the profession variable, with high WAI scores in the administrative staff and physicians and lower scores in the category of nurses. No significant association was demonstrated between WAI and age, gender, civil status and having children.

| Table 5 | Structural equation modelling analysis of WFC and FWC scores |
|---------|-------------------------------------------------------------|
| **Independent variable** | **WFC** | **FWC** |
| | **Standardized Beta (P)** | **Standardized Beta (P)** | **Standardized Beta (P)** |
| | **Full model** | **Last step** | **Full model** | **Last step** |
| Socio-economic status | .773 (.370) | | .778 (.375) | |
| Healthcare worker experienced | -.453 (.068) | -.160 (<.001) | -.047 (.851) | |
| Senior Administrative | -.477 (.545) | | -.681 (.395) | |
| FWC | .460 (<.001) | .463 (<.001) | | |
| WFC | | | .475 (<.001) | .469 (<.001) |
| R² of the model | .248 | .245 | .223 | .220 |

There are several studies on work-family conflict involving nurses or other health workers²⁴⁻²⁹ but only a few of these investigate the influence of individual characteristics such as gender and age in the work-family conflict, non-modifiable factors that cannot be used as a basis for a decisive intervention.

In line with our findings, the Treister-Goltzman study, examining the literature of the past two decades, reports a higher work-family conflict for the medical category, with a worse effect on female sex than on male.³⁰ In addition, the study conducted by Adâm et al, reported that female physicians showed significantly higher levels of WFC than male physicians.³¹

As far as concerns Work Ability, nurses showed moderate/poor WAI score also in other studies,³²,³³ probably because they are exposed to more stressful situations. In contrast, an average WAI level was reported in a study conducted on Taiwanese nurses.³⁴

Different studies in the literature report statistically and inversely significant associations between age and WAI,³⁵⁻³⁸ while our results did not report any significant associations between WAI and age, gender, marital status, and having children.

### 4.2 | What is already known on this topic?

The present study offers an important contribution to the research because there is only one other study³⁹ that investigates the relationship between Work Ability and work-family conflict. According to these results, it is necessary to act on modifiable factors that influence the working capacity and the work-family conflict of health workers. There are three modifiable factors on which it is possible to intervene: the organization, the workers and the family.

Factors such as age and gender cannot be changed, however it is necessary to ensure sustainable employability, considering the link between age and work ability.

Finally, it is interesting to underline the inverse significant correlation between WAI and FWC. An increase of the work ability is associated to lower scores of family to work conflict.
conflict, and this could be used in the prevention or the mitigation of the FWC phenomenon.40

4.4 | Limitations of this study

There were some limitations to this study. The low number of participants did not allow to generalize the results to all healthcare professionals; more research is needed to study the association of these two constructs in healthcare professionals. Secondly, the study design did not provide for the inclusion of other variables that can influence the work-family conflict.

Moreover, dealing with multiple occupations, like in this study, there is the need to consider the roles and experience of participants and we did not address deeply this issue. Future researches may include other individual variables such as household income or home-work distance to better understand these constructs.

5 | CONCLUSIONS

The Work Ability Index is considered the "thermometer" to measure the phenomenon of aging and to predict the incidence of inability to work.

A periodic analysis of the perceived ability of workers as well as the conflict they experience in daily life can be useful to understand the best actions to ensure the wellbeing of employees.

These findings suggest that interventions should be primarily directed to women, older workers and those with children. The latter seem to have, in fact, a greater difficulty in maintaining a balance between work and family.

At last, by relating the two constructs a significant inverse association emerged, supporting the idea of Ilmarinen et al, that work ability is not separated from life outside work and the balance between work and family is an important factor of work ability.41

DISCLOSURE

Approval of the research protocol: The study was approved by the Local Ethics Committee (ref. 4991) and was carried out according to the Declaration of Helsinki protocols (1989) of the World Medical Association. Informed consent: Written informed consent was obtained from all participants. Registry and the registration no. of the study/trial: N/A. Animal studies: N/A. Conflict of interest: The authors declare no conflict of interests for this article.

AUTHOR CONTRIBUTIONS

GLT, FR and AP conceived the ideas; GLT and DG collected the data; GLT and DG analyzed the data; GLT, FR and AP led the writing. All authors read and approved the final manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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