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DIFFERENCES IN QUALITY OF WORK LIFE, TASK PERFORMANCE, AND TURNOVER INTENTIONS OF THE HEALTHCARE EMPLOYEES WITH RESPECT TO GENDER

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Abstract:
This study examines gender-based differences in the quality of work life (QWL), task performance, and turnover intentions among healthcare employees working in public hospitals in Ankara. A total of 318 participants were included in the study. Multivariate Analysis of Variance (MANOVA) and Multivariate Analysis of Covariance (MANCOVA) were employed to analyze gender differences while controlling demographic and organizational variables. The results indicated that gender differences were not statistically significant in the QWL dimensions of social needs, self-actualization needs, knowledge needs, and aesthetic needs. However, significant gender differences were found in the dimensions of health and safety needs, economic and family needs, and esteem needs, with male employees reporting higher levels of quality of work life in these areas compared to their female counterparts. These findings were supported by the MANOVA results, in which gender was the independent variable and the seven QWL dimensions were the dependent variables. Finally, no statistically significant differences were observed between male and female employees in terms of task performance and turnover intentions.

Keywords: gender, quality of work life, healthcare, task performance, turnover intention

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1. Introduction

The quality and efficiency of healthcare services are closely linked not only to clinical outcomes but also to patient satisfaction. However, patients often express their experiences ambiguously, making it challenging to assess service quality accurately. This ambiguity underscores the importance of examining the role of healthcare providers, particularly healthcare workers, in delivering quality care.

The work environment significantly influences individuals' physical and psychological well-being, directly affecting the Quality of Work Life (QWL) of healthcare professionals. Nowrouzi-Kia (2017) highlights that workplace violence adversely impacts healthcare workers' QWL, leading to diminished overall life quality and job performance. Gender-based occupational segregation has long been prevalent in the healthcare sector. Adams (2010) notes that men have traditionally dominated higher-status, higher-paying professions such as medicine and dentistry, while women have been concentrated in supportive roles like nursing. This segregation contributes to the underrepresentation of women in leadership positions and poses barriers to their career advancement.

Globally, women constitute approximately 70% of the workforce in the health and social services sectors. In Turkey, women represent 100% of midwives, 70% of nurses, and 50% of all doctors (UN Women, 2019). Despite this significant presence, women remain underrepresented in top leadership roles. Factors such as coworker acceptance, gender discrimination, inadequate training, and lack of support adversely affect women's professional development.

Female healthcare workers also face challenges in balancing work and family life. Vanitha (2022) discusses that women in service sectors often encounter difficulties in managing work-life balance due to additional responsibilities outside the workplace, impacting their social, familial, and personal relationships.

Studies on gender discrimination are significant in understanding the psychological effects on individuals. International organizations, including the World Health Organization, advocate for equal employment opportunities for men and women to meet workforce demands and establish a fair economic framework. However, limited research exists on the relationship between these structures and gender. Therefore, this study aims to provide insights into gender differences concerning QWL, task performance, and turnover intentions among healthcare employees in Ankara.

The primary objective of this study is to identify genuine gender differences related to these constructions (Figure.1). By analyzing demographic variables such as age, marital status, monthly income, and educational level, along with organizational variables like department type and tenure, the study examines existing disparities between male and female employees in the healthcare sector. Given the inconsistent findings in the current literature, this research is warranted. To achieve this, the study employs mixed statistical methods, including MANOVA and MANCOVA, providing robust methodological and analytical foundations for data analysis. From this evaluation,

conclusions can be drawn regarding gender equality and opportunities in Turkey's healthcare sector.

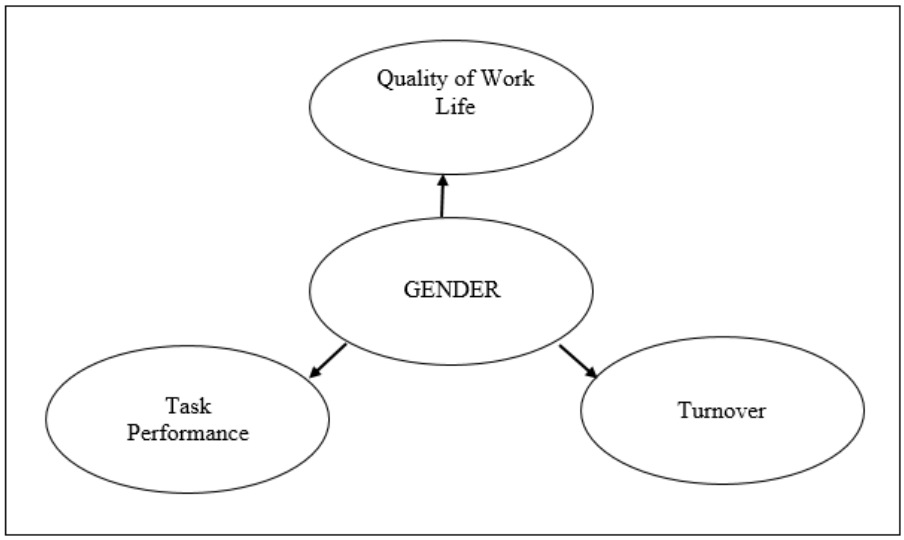

Figure 1: Research Model

2. Conceptual Development

Understanding gender-based differences in the quality of work life, task performance, and turnover intentions of healthcare employees is essential for developing inclusive human resource strategies and improving organizational effectiveness in the healthcare sector.

2.1 Gender and Quality of Work Life

Quality of Work Life (QWL) is a multifaceted construct that encompasses employees' perceptions of their work environment, including factors such as job satisfaction, work-life balance, and overall well-being. In the healthcare sector, QWL is particularly significant due to the high demands and emotional labor associated with the profession. Studies have consistently reported that healthcare employees often experience low levels of QWL, which can adversely affect their job performance and retention (Bragard *et al.*, 2012; Mosadeghrad, 2013; Rafiei *et al.*, 2019).

Gender plays a crucial role in shaping employees' experiences of QWL. Societal structures have historically assigned distinct roles to men and women, influencing their work experiences and perceptions of work-life balance. These gendered expectations can lead to disparities in job satisfaction, career advancement opportunities, and overall work-life quality (Haar, 2013; Williams *et al.*, 2016).

Research indicates that organizational factors, such as workplace culture and policies, account for a significant portion of the variability in employees' QWL. Individual factors, including education, marital status, and gender, also contribute to these differences (Mosadeghrad, 2013). For instance, studies have found that female healthcare

workers, particularly nurses, often report higher levels of QWL compared to their male counterparts, possibly due to greater emotional engagement and interpersonal skills (Heidari-Rafat *et al.*, 2010; Almalki *et al.*, 2012; Moradi *et al.*, 2014).

However, gender differences in QWL are not uniform across all healthcare roles. Skagert *et al.* (2012) suggest that while gender is socially constructed and subject to change, differences may persist between male and female managers due to varying working conditions and challenges in achieving work-life balance. Gonzales (2019) highlights that female healthcare workers often face dissatisfaction stemming from unequal opportunities and gender biases in QWL evaluations.

Work-family conflict (WFC) is a significant factor influencing QWL, particularly among female healthcare workers. Studies have shown that women experiencing WFC are more likely to report higher absenteeism and turnover intentions (Burke *et al.*, 2009; Wang & Chen, 2018). Abiodun *et al.* (2014) emphasize that the challenging working conditions for nurses not only lead to physical fatigue but also exacerbate work-family conflict. Nursing, being a female-dominated profession, often requires women to balance work responsibilities with family roles, intensifying family-work conflict.

Conversely, some studies have found no significant association between gender and work-related quality of life in healthcare organizations (Hsu & Kernohan, 2006; Moradi *et al.*, 2014; Jnaneswar, 2019; Dyrmishi *et al.*, 2022; Režić, 2022). These mixed findings suggest that the relationship between gender and QWL may be influenced by various factors, including organizational culture, job roles, and individual circumstances. Given these complexities, it is hypothesized that:

H1: There are differences in the quality of work life levels of healthcare employees with respect to gender.

2.2 Gender and Task Performance

Task performance is a critical determinant of organizational effectiveness, particularly within healthcare settings where service delivery directly impacts patient outcomes. Gender has been identified as a significant variable influencing task performance, though empirical findings remain inconsistent.

Some studies suggest that female healthcare professionals exhibit superior task performance. For instance, Khandan, Eyni, and Koohpaei (2017) found a positive correlation between gender and task performance among nurses, with women outperforming their male counterparts. Similarly, research by Pourteimour, Yaghmaei, and Babaohamadi (2021) indicated that higher task performance was associated with male gender, greater experience, and work shifts in their sample of nurses.

Conversely, other studies report no significant relationship between gender and task performance. Amarneh, Al-Rub, and Al-Rub (2010), Ufuophu-Biri and Iwu (2014), and Asiamah (2017) found no significant relationship between gender and task performance. Similarly, Al-Makhaita, Sabra, and Hafez (2014) reported no significant gender differences in task performance among nurses working at two different healthcare levels in Eastern Saudi Arabia.

These mixed findings underscore the complexity of the relationship between gender and task performance in healthcare settings. Factors such as organizational culture, role expectations, and individual competencies may mediate this relationship. Further research is necessary to elucidate the underlying mechanisms and to develop strategies that ensure equitable evaluation and enhancement of task performance across genders. Given these inconsistencies, the following hypothesis is proposed:

H2: There are differences in task performance levels of healthcare employees with respect to gender.

2.3 Gender and Turnover

Determining whether gender is a reliable predictor of turnover intentions has proven challenging. Nevertheless, gender plays a significant role in labor market dynamics, influencing how workers enter and exit workplaces (Weisberg & Kirschenbaum, 1993).

Suhyun and Hyeongsu (2019) investigated turnover intention and its related factors among employed doctors in Korea. Gender emerged as a significant factor, with males more likely than females to intend turnover. This finding aligns with prior research suggesting that female doctors tend to have lower expectations regarding work conditions, due to limited opportunities to secure better positions than their male counterparts, which may contribute to relatively higher job satisfaction among women. Similarly, Negrin (2003) found that objective labor market opportunities may better align with men's job needs than those of women.

Wu and Liu (2022) explored the relationships among organizational support for career development, organizational commitment, and turnover intentions among healthcare workers in township hospitals in Henan, China. Their findings revealed significant differences in turnover intentions according to gender, age, marital status, education, professional title, and organizational tenure. Notably, females exhibited higher turnover intention scores. Chao *et al.* (2015) also reported higher turnover rates and lower job stability among female workers. In a large-scale study involving 1,900 females and 2,000 males, Bardoel *et al.* (2020) found that women are approximately 85% more likely than men to leave their jobs after controlling for turnover intentions. Moreover, Nie, Lämsä, and Pučetaite (2017), studying 212 women across eight sectors in Finland, highlighted the importance of socially responsible practices that promote equal career opportunities and work-family integration in reducing turnover intentions. Institutional measures supporting work-family integration are therefore necessary to reduce female employees' turnover intentions.

Conversely, Dechawatanapaisal (2016) examined the effects of demographic and psychological factors on the relationship between job involvement and turnover, concluding that gender was not statistically related to any variable studied.Given these mixed findings, the following hypothesis is proposed:

H3: There are differences in turnover intentions of healthcare employees with respect to gender.

3. Method and Results

3.1 Data Collection Tools

The study population consisted of healthcare employees working in central public, university, and private hospitals in Ankara (N = 39,534), based on data published by the Turkish Statistical Institute in 2021. The required sample size was estimated as 1,045, with an alpha level of 0.03, according to the standard deviation table. However, only doctors and nurses employed in public hospitals were included in this study. The study's purpose was clearly explained to participants, and voluntary and informed participation was ensured. A total of 318 healthcare professionals participated in the study. Data was collected via Google's survey tool between November 2, 2023, and December 2, 2023.

The survey questionnaire consisted of two sections. The first section gathered general demographic and professional information such as gender, age, marital status, education level, tenure in the organization, and other related variables. The second section included scales measuring quality of work life, task performance, and turnover intention.

Quality of Work Life was assessed using a 16-item scale adapted from Sirgy *et al.* (2001). Responses were recorded on a 5-point Likert scale ranging from "I do not agree at all" (1) to "I agree completely" (5). The internal consistency of this scale was confirmed with a Cronbach's Alpha of 0.896, indicating acceptable reliability.

Task Performance was measured with a 6-item scale developed by Pradhan and Jena (2017), also using a 5-point Likert scale from "I do not agree at all" (1) to "I agree completely" (5). The Cronbach's Alpha for this scale was 0.748, demonstrating acceptable reliability.

Turnover Intention was evaluated using a 6-item scale developed by Gert Roodt. The scale used a 5-point Likert format ranging from "Never" (1) to "Always" (5). The Cronbach's Alpha for this measure was 0.465, which is considered marginal but acceptable for exploratory research.

Categorical variables were summarized using frequency counts and percentages, while numerical variables were described with means and standard deviations. To examine gender differences while controlling covariates such as age, marital status, monthly income level, organizational tenure, and overall time in the healthcare sector, Multivariate Analysis of Covariance (MANCOVA) was employed.

3.2 Results

The scale was sent to 1,045 volunteers, consisting of physicians and nurses, by online questionnaire method, and 30.43% (n = 318) were returned. Descriptive statistics of the sample demographics (see Table 1) reveal that 74.1% (n = 249) of the respondents were female, 40.9% were in the 41 and over age group (n = 130), 61.3% (n = 195) were married, 87.7% (n = 279) were nurses, 94.7% (n = 301) reported that the wage they receive is equivalent to the work they do, and 64.8% (n = 206) were undergraduates.

Gender differences in quality of work life, task performance, and turnover intentions were examined using independent sample t-tests. To detect "true" gender differences and possible interaction effects of covariates such as age, marital status, monthly income level, education level, department type, length of time in the organization, and length of time in the healthcare sector, multivariate analysis of variance and covariance (MANOVA and MANCOVA) were also employed.

Table 1: Gender Differences in Quality of Work-Life Factors

Quality of work-life factors	Female	Male	T Value	Sig.
Health & safety needs	2,9237	3,1353	-2,074	,040
Economic & family needs	2,1874	2,5990	-3,533	,001
Social needs	3,1727	3,2754	-,932	,354
Esteem needs	2,9096	3,2174	-2,520	,013
Actualization needs	3,0823	3,0797	,021	,984
Knowledge needs	3,5823	3,4783	,993	,323
Aesthetics needs	3,4900	3,3188	1,387	,168

*__Note:__ Scale ratings ranged from "I do not agree at all" (1) to "I agree completely" (5). *p < 0.05; **p < 0.01

According to the independent t-test results (Table 1), *Social Needs*, *Actualization Needs*, *Knowledge Needs*, and *Aesthetics Needs* did not differ significantly between female and male employees ($p > 0.05$). However, significant gender differences were found for *Health & Safety Needs* (Male M = 3.14, Female M = 2.92, $p = 0.04$), *Economic & Family Needs* (Male M = 2.60, Female M = 2.19, $p = 0.001$), and *Esteem Needs* (Male M = 3.22, Female M = 2.91, $p = 0.013$), with males reporting higher levels in these domains.

A one-way between-groups MANOVA was performed using gender as the independent variable and the seven quality of work life factors as dependent variables. The combined dependent variables showed a statistically significant difference between males and females, Wilks' Lambda = 0.95, $F(7, 310) = 3.51$, $p = 0.001$, partial eta squared = 0.07. When examining dependent variables separately with Bonferroni-adjusted alpha levels, significant differences remained for *Health and Safety Needs* ($F = 4.01$, $p = 0.046$, partial eta squared = 0.013), *Economic and Family Needs* ($F = 13.61$, $p < 0.001$, partial eta squared = 0.041), and *Esteem Needs* ($F = 2.995$, $p = 0.023$, partial eta squared = 0.016). Inspection of mean scores confirmed that males reported slightly higher levels in these areas than females.

Gender differences in task performance (H2) and turnover intention (H3) were analyzed using independent t-tests. No significant gender difference was found in task performance (Females: M = 3.63, SD = 0.61; Males: M = 3.76, SD = 0.62; $t(316) = -1.47$, $p = 0.147$; Wilks' Lambda = 0.992, partial eta squared = 0.008) or in turnover intentions (Females: M = 3.01, SD = 0.60; Males: M = 3.04, SD = 0.62; $t(316) = -0.42$, $p = 0.675$).

3.3 Gender Differences in Quality of Work Life, When Controlling for Other Factors

To examine gender differences in quality of work life while controlling for other demographic and professional variables such as age, marital status, profession, income level, education level, length of time in the organization, and length of time in the healthcare sector, a Multivariate Analysis of Covariance (MANCOVA) was conducted. Prior to analysis, assumptions including multivariate normality were verified through inspection of outliers, boxplots, and normal Q-Q plots. The data met these assumptions, allowing for a valid interpretation of the results.

As shown in Table 2, after controlling for covariates, a significant multivariate main effect of gender on quality of work life was still observed. Specifically, when controlling for income level, significant differences between male and female respondents emerged across multiple quality of work life factors, including health and safety needs, economic and family needs, esteem needs, social needs, actualization needs, knowledge needs, and aesthetics needs. Furthermore, the length of time in the organization was also significantly associated with differences in health and safety needs, as well as economic and family needs between genders. These findings suggest that male employees reported higher scores in quality of work life dimensions compared to female employees, even when controlling for other influential variables.

Table 2: Gender Differences in Quality of Work Life Factors Controlling for Other Variables

Item controlled	Health & safety needs	Economic & family needs	Social needs	Esteem needs	Actualization needs	Knowledge needs	Aesthetics needs
Age	,000 (0,993)	2,530 (0,113)	,112 (0,738)	,296 (0,587)	0,001 (0,976)	,850 (0,357)	,372 (0,542)
Marital status	0,123 (0,726)	,391 (0,532)	012 (0,914)	,102 (0,750)	1,353 (0,246)	3,644 (0,057)	0,104 (0,747)
Profession	0,671 (0,413)	,504 (0,478)	337 (0,562)	,857 (0,355)	,062 (0,804)	,003 (0,954)	2,110 (0,147)
Income	4,835 (0,029) *	15,387 (0,000) *	,777 (0,002) *	2,733 (0,009) *	4,432 (0,036) *	6,293 (0,013) *	4,206 (0,041) *
Education level	,236 (0,627)	6,295 (0,009) *	024 (0,877)	1,697 (0,194)	,819 (0,319)	,009 (0,926)	,029 (0,865)
Length of time org.	4,549 (0,034) *	4,962 (0,027) *	,345 (0,557)	0,625 (0,430)	3,103 (0,079)	3,017 (0,083)	,084 (,773)
Length of time in the healthcare sector	,967 (0,326)	0,196 (0,658)	,966 (0,326)	0,420 (0,517)	1,204 (0,273)	,016 (0,900)	,279 (0,598)

Note: Significance levels are indicated in parentheses (∗p, 0.05); ∗indicating the significant gender difference based on the previous independent t-test results in Table 1.

4. Conclusion

The healthcare industry worldwide has been grappling with an acute shortage of skilled healthcare professionals and increasingly high attrition rates, primarily driven by

elevated work pressure, prolonged work hours, overwhelming workloads, elevated stress levels, and insufficient work-life balance (Suresh, 2019). This study aimed to examine the role of gender differences in shaping the quality of work life (QWL), task performance, and turnover intentions among healthcare employees, with a particular focus on those working in Ankara, Turkey. The sample consisted of 318 healthcare workers, predominantly nurses, reflecting the sector's gender composition.

Gender-based analyses using independent t-tests revealed significant differences in several QWL dimensions, specifically Health & Safety Needs, Economic & Family Needs, and Esteem Needs, at the 0.05 significance level, thereby supporting Hypothesis 1. These results were corroborated by MANOVA findings, which indicated a statistically significant multivariate effect of gender on the combined QWL factors ($f = 3.511$, $p = .001$, Wilks' Lambda = .95, partial eta squared = .07). Male employees consistently reported higher satisfaction levels in these QWL dimensions compared to their female counterparts.

The predominance of women in the healthcare sector, often occupying precarious, low-paid, and low-status positions, provides a context for understanding these disparities (Di Martino, 2003). Women's perceptions of lower QWL may stem from the dual burden of professional and domestic responsibilities, such as motherhood and childcare, coupled with workplace discrimination and limited career advancement opportunities. Mumtaz *et al.* (2003) underscored the complex interplay between women's public and private spheres, highlighting how intersecting class and gender hierarchies influence employment experiences. Additionally, Tlaiss (2013) illustrated how cultural norms and gendered social roles prevalent in Middle Eastern societies act as significant barriers to women's professional progression. According to Hofstede's (1980) cultural dimensions theory, Turkey occupies a moderate position on the masculinity/femininity spectrum, with traditional gender roles deeply embedded in societal expectations, which likely shape these findings.

The use of MANCOVA, controlling for confounding factors such as age, marital status, profession, income, education, tenure in the organization, and tenure in the healthcare sector, further validated the persistence of gender differences in QWL. This strengthens the argument that male healthcare workers experience a higher quality of work life than females, independent of other demographic or professional characteristics. Conversely, no significant gender differences were found in task performance and turnover intentions, refuting Hypotheses 2 and 3. This aligns with prior empirical studies (Amarneh, Al-Rub & Al-Rub, 2010; Ufuophu-Biri & Iwu, 2014; Asiamah, 2017; Al-Makhaita, Sabra & Hafez, 2014; Dechawatanapaisal, 2016), indicating that gender does not significantly predict task performance in healthcare settings. While healthcare professions have historically been gender-segregated, the ongoing feminization of formerly male-dominated roles in Western countries, such as the United States and Canada, reflects shifting labor dynamics (Adams, 2010). This trend suggests that gender-based differences in performance may be diminishing globally.

Improving the quality of work life is critical not only for enhancing job satisfaction but also for reducing absenteeism and turnover rates (Gurudatt & Gazal, 2015). Healthcare organizations that cultivate supportive and responsive work environments enable employees to focus on professional development and team cohesion, which contribute to overall organizational performance and patient care quality (Srivastava & Kanpur, 2014). Consequently, healthcare managers should prioritize interventions addressing gender-specific needs, such as flexible scheduling, childcare support, career development opportunities, and policies combating workplace discrimination.

This study offers both theoretical and practical contributions. Theoretically, it expands the literature by empirically confirming persistent gender disparities in quality of work life in a culturally specific context. Practically, it provides actionable insights for healthcare administrators seeking to foster equitable and supportive work environments. However, the study has limitations that should be acknowledged. The sample's predominance of nurses limits generalizability across all healthcare professions. Future research should incorporate diverse healthcare roles, longitudinal designs to assess changes over time, and cross-cultural comparisons to deepen understanding of gender dynamics in healthcare workplaces.

In conclusion, addressing gender disparities in quality of work life remains a vital challenge for healthcare systems aiming to retain skilled professionals and enhance workforce well-being. Tailored organizational policies and culturally informed interventions are essential to promote equity, job satisfaction, and sustainable healthcare delivery.

4.1 Statement of Research and Publication Ethics

This study was conducted following the principles of research and publication ethics. All processes related to data collection, analysis, interpretation, and reporting were carried out with commitment to scientific integrity, transparency, and impartiality. The study does not involve any clinical practice, experimental intervention, or violation of personal data that would require approval from an ethics committee. Data were collected based on voluntary participation, and the principles of confidentiality and anonymity were strictly observed. The authors declare that all stages of the research were carried out in compliance with ethical standards.

Authors' Contributions

Laura Agolli: Conducted the literature review, contributed to data analysis, and provided overall input to the study.

Şule Kaptan: Responsible for data collection and analysis, and contributed to the literature review.

Orhan Pehlevan: Involved in data collection and analysis, and prepared visual materials (figures).

Derya Sivuk: Contributed data analysis and provided final approval of the manuscript.

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Availability of Data and Material (data transparency)
All data generated or analyzed during this study are included in this published article (and its supplementary information files).

Conflicts of Interest Statement
The authors have no conflicts of interest to declare.

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