# MASTER'S THESIS REFLECTION AND CRITICAL REVIEW

# What healthcare workers want: a cross-sectional investigation of rewards in healthcare

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***Abstract***

**BACKGROUND**: The healthcare staffing shortage is a worldwide issue: however, ageing, retirement, and early retirement of the healthcare workforce represent only a part of the grounds leading to this shortage, as many practitioners leave or intend to leave the profession because of a perceived effort-reward imbalance. Although this phenomenon is acknowledged, its causes are known, and reward schemes are in place, healthcare professionals are still fleeing away.

**AIM**: The aim of this study was multiple. On the one hand, we investigated what healthcare professionals consider as rewarding and, on the other hand, whether some rewards are more significant than others. Additionally, we also inquired whether the country of employment has an impact on reward significance and on the perception of being rewarded within their workplace. Finally, we also explored potential benefits of total reward schemes in healthcare.

**DESIGN**: A cross-sectional comparative study with quantitative design.

**METHOD**: Data were collected through the implementation of a structured online questionnaire proposed to healthcare professional ($n$=325) practicing in Finland, Sweden, and Switzerland and analysed through descriptive and multivariate statistical methods.

**RESULTS**: The obtained results indicate that healthcare professionals perceive many elements of their working life as significant rewards. However, the level of importance of a reward varies based not only on the reward's genre, but also on the country of employment. In fact, the findings demonstrate that healthcare professionals employed in different countries have different perceptions of what is "rewarding" and of reward significance. Overall, financial rewards – salary or other secure income in particular – seem to be the most significant reward overall, specifically in Finland. The obtained results also indicate that perception of being rewarded within the workplace varies depending on the country of employment, with Finland perceiving to be the least rewarded among the three countries in analysis. Nevertheless, the potential benefits of total reward schemes in healthcare seem to be cross-sectional among the three countries in analysis, thus attributing validity to total reward schemes.

**CONCLUSIONS**: For effective results in terms of staff attraction, retention, and motivation, healthcare practices should tailor their reward system according to reward significance and personal preferences, taking into consideration previous empirical research as well as carrying out an investigation within the organisation itself. Managers and leaders in healthcare should be taught about transformational leadership and trained on how to deliver workplace rewards effectively.



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## FOREWORD

This thesis was written for our Master's degree in Healthcare with specialisation in Leadership for Nordic Healthcare at Arcada University of Applied Sciences, Finland. The subject of this thesis is related to workplace rewards, reward significance, and factors influencing this latter. This is a very fascinating research topic, blending psychology, management, and drivers for motivation together in an integrative manner.

We would like to thank the following people for their help, support and precious feedbacks during our Master's thesis project. Our first thanks go to Dr. Maria Forss, our teacher and thesis supervisor who trusted and supported us throughout the whole project. We also would like to thank Filip Levälahti for his help with LimeSurvey, Tore Ståhl and Dan Granqvist for their support with IBM SPSS Statistics, and Heikki Paakkonen and Dr. Jyrki Kettunen for their support and valuable feedbacks on our work. Additionally, we also want to express our gratitude towards Dr. Ronel Nienabler and Dr. Mark Bussin for their interest in our research and their openness in sharing the RPQ questionnaire they developed with us, and Dr. Jaana Seitovirta for her take and comments on our questionnaire. In conclusion, we would also like to thank Hanna Alava for her help with the questionnaire's translation in Finnish.

# 1 INTRODUCTION

This report represents a reflection and critical review of the article "What healthcare workers want: a cross-sectional investigation of rewards in healthcare" elaborated as part of our Master's Thesis project. The document includes an introductory part covering the purpose of the research, the literature background and related key-concepts, as well as a description of the content of the article, the findings, and challenges and advantages that have been encountered. This report concludes with the contributions of the research within the Nordic healthcare.

## 1.1 Purpose of the research study

The purpose of this study was multiple. On the one hand, we investigated what is considered "rewarding" among healthcare workers and, on the other hand, whether the reward significance varied based on the reward type. Additionally, we also examined whether the country of employment influences reward significance and healthcare professionals' (HCPs) perception of being rewarded within the workplace. Finally, the last aim consisted in exploring potential benefits of total reward schemes in healthcare.

Therefore, the first set of objectives was focussed on rewards and on understanding what HCPs consider as rewarding, what rewards are considered as the most important, and the current state of reward strategies in healthcare structures. A further objective was to investigate whether reward significance and the perception of being rewarded vary based on country of employment, ultimately understanding what the potential benefits of rewards schemes in healthcare are according to HCPs. We are very aware that there are many theories and drivers for motivation. However, in this research, we decided not to focus on a specific motivational theory in order to investigate how phenomenon is perceived by HCPs.

To reach this latter objective, we decided to collect data from three different European nations, specifically Finland, Sweden, and Switzerland. The reasons underlying the countries choice are many and are further discussed in chapter *2.1. Countries selection*. Specifically, this study sought to answer the following research questions:

What do healthcare workers consider as rewarding?

Are some rewards more significant than others?

Does the country of employment influence reward significance and the perception of being rewarded in the workplace?

What are the potential benefits of total reward schemes in healthcare?

It is believed that a better understanding of HCPs reward preferences and reward significance, an analysis of the current state of reward strategies in healthcare structures, and a thorough examination of the potential repercussions of these rewards on HCPs' working life would be not only beneficial, but also trigger a positive change in the way healthcare structures reward its employees, ultimately tackling the issue of healthcare staffing shortage.

## 1.2 Main concepts and definitions

According to the Oxford online dictionary, a reward represents something given to anyone because of their contribution to the organisation ('Reward', 2021). Although often used as synonyms, rewards differ from incentives and compensations as incentives' scope is primarily to encourage and stimulate greater personal investment or, in other words, to motivate employees to do better ('Incentive', 2021), while compensations represent the total amount of financial and non-financial payments provided to an employee for performing their work as required ('Compensation', 2021). Nevertheless, rewards can have both a compensatory and motivational function. In fact, on the one hand they represent an exchange or retribution for the service offered and work accomplished while, on the other hand, the type of reward and the way in which it is delivered, can influence motivation (Jiang et al., 2009).

A reward could thus be anything – material and non-material – that an organisation provides to its employees either voluntarily or involuntarily in return for the employees' talent or contributions, and to which employees attribute a value that fulfils specific personal needs (Shields et al., 2015). Therefore, a reward could potentially be worthless if the receiver attributes little or no value to it. Additionally, not only the options to reward employees are multiple (Shields et al., 2015), but so can be the final objectives of workplace rewards. To this end, depending on the predominant organisational frame embedded within a company, a reward can be part of a method to exercise power, part of a ritual that reinforces organisational values, or part of a strategy to align the structure to long-term goals (Bolman & Deal, 2017).

However, workplace recompenses are specifically relevant in the context of a human resources organisational frame: in sum, people need careers, salaries, and opportunities to feel fulfilled in their working life, while companies need ideas, energy, and talents to grow (Bolman & Deal, 2017).

Reward management draws a great deal of its key concepts from the behavioural research started in the early 1900s, specifically from motivational theories, which are tightly linked to workplace recompenses (Latham, 2012). For instance, Maslow's hierarchy of needs, states that people want things that go beyond money such as empowerment, autonomy, challenges, and find meaning and purpose (Maslow, 1943). Therefore, rewards appear to represent a valid strategy to attract, retain, and motivate employees to perform at their best.

As a result, this broad definition of workplace rewards translates into varying and multiple options for rewarding employees (Shields et al., 2015), which encompasses total reward theory. Manus & Graham (2003) defined total reward as the interconnection of all types of rewards, including direct and indirect, as well as intrinsic and extrinsic rewards. This theory merges two major reward categories, namely *transactional rewards* (tangible and of financial nature) and *relational rewards* (intangible and of relational nature, such as learning and development opportunities) in an integrative manner, where both reward strategies operate simultaneously to maximise motivation, commitment, and engagement (Armstrong & Stephens, 2005). Hence, rewards do not only include measurable elements (i.e., base pay and bonuses), but also relational and non-financial elements such as responsibility, career opportunities, learning and development, work motivation, and the quality of working life within the organisation (Thompson, 2002). Especially with respect to relational rewards, leaders and managers play a fundamental role in their management and allocation because a great deal of relational rewards such as recognition, responsibility, autonomy, professional development, and professional growth see as their main source individuals in leadership positions (Armstrong & Stephens, 2005; Korlén et al., 2017) who, additionally, also hold the power to make or strongly influence financial decisions (Armstrong & Stephens, 2005).

## 1.3 Literature background

Ageing, retirement, and early retirement of the healthcare workforce represent only a part of the grounds leading to the shortage of healthcare staff (Schofield & Earnest, 2006). In fact,

many HCPs leave or intend to leave the profession for reasons other than seniority, as a result of a varying combination of factors.

For instance, Dopelt et al. (2019) acknowledged that out of 533 paramedics questioned, 200 had already left the profession, of which 73% within five years from graduation, and 93% within 10 years. Analogue results have been found among the nursing staff, in which the intention to leave the profession ranged from the lowest of 14% in the USA to the top of 49% in Finland and Greece (Aiken, 2012).

In this regard, the repercussions of the current COVID-19 pandemic – which have put under severe pression healthcare systems on a global scale – are also not to be overlooked. Specifically, the virus outbreak is exacerbating the shortage of healthcare staff through an increasing number of HCPs leaving or intending to leave the profession (International Council of Nurses, 2021; Labrague & Santos, 2021; Said & El-Shafei, 2021) making the development of strategies and actions aimed to attract, motivate, and retain qualified and competent staff more urgent and compelling than ever before.

Overall, it appears that the main reasons for such actions and/or intentions are attributed to scarce opportunities for professional growth and development (e.g., promotion, prospects, and career development), inadequate rewards for work efforts (e.g., salary), demanding work conditions (e.g., great workload and work-life interference, occupational stress), burnout, frustration (e.g., related to insubordination and poor recognition), low professional engagement, and lack of appreciation and intellectual challenges (Alilu et al., 2016; Dopelt et al., 2019; Flinkman et al., 2008, 2010, 2013; Hämmig, 2018; Moloney et al., 2018; Mosadeghrad, 2013).

Particularly, nurses who intended to quit either their position or their profession, perceived a significant effort-reward imbalance in their working life (Lavoie-Tremblay et al., 2008). Additionally, recent studies investigating nurses' turnover in relation to the COVID-19 pandemic have identified fear of the virus (Labrague & Santos, 2021) and changes in the physical, psychological, and social working environment caused by the pandemic as significant stressors among frontline workers, which ultimately may translate into HCPs leaving their position and/or profession as a result (Said & El-Shafei, 2021).

Nevertheless, just as much there are factors that negatively influence the retainment of qualified staff, there also are elements facilitating it. Specifically, positive management behaviours through rewards management and appropriate support, feelings of being valuable to the organisation (e.g., satisfaction and chances of professional development) (Alilu et al., 2016), greater challenges, and higher personal levels of self-efficacy have been identified as factors inhibiting nurses' intention to leave the profession (Moloney et al., 2018). Additionally, improving the psychological work environment through occupational rewards has been also identified as a protective factor able to retain nursing staff within the profession (Li et al., 2011). In this regard, a recent study has identified that a transformational and transactional leadership styles has the power to not only reduce stress in the workplace, but also to decrease nurses' intention to quit, ultimately improving job satisfaction and quality of care (Pishgooie et al., 2019).

Considering what has been highlighted so far, as well as according to Heilmann (2010), healthcare structures should reassess their strategy ensuring that HCPs are given the right set of rewards to improve not only their retainment, but also their attraction and motivation. Conversely to other professions, it is often believed that healthcare work is intrinsically and spiritually rewarding as a result of the nature of the job itself. In fact, nurses often motivate their career choice as their "*vocation in life*" and because eager to have the opportunity to care for others (Eley et al., 2012). However, focusing on the solely opportunity to care as strategy to attract, retain, and motivate employees is per se lacking since effort-reward imbalance is a common theme emerging from previous literature investigating the reasons making HCPs leave their profession.

Although reward strategies have been object of research since mid-60s' (Freedman & Montanari, 1980), studies investigating reward preferences and reward strategies among healthcare workers have been found to be, on the one hand, lacking in terms of diversity of design methods while, on the other hand, rather exclusive with respect to the representation of different healthcare professions. Nevertheless, the main topics emerging from such articles are to some extent recurring.

Specifically, it has been emphasised that financial (cash) rewards only are not sufficient to retain nursing staff, as other types of non-financial – or psychological – rewards are considered equally meaningful and needed (De Gieter et al., 2006; Korlén et al., 2017;

Seitovirta et al., 2017, 2018). In addition, financial rewards alone do not hold the potential to automatically motivate employees to perform better, unless combined with the managers' ability to act as intermediaries, linking such rewards to professional and personal values and preferences of each individual (Korlén et al., 2017). Similarly, Seitovirta et al. (2017), also emphasized the importance of listening to nurses' point of view and reward preferences to create a comprehensive reward system able to retain, fulfil, and motivate them in their position. Additionally, the latter author also acknowledged that non-financial rewards specifically, are an extremely valuable element of nursing management (Seitovirta et al., 2018), and that employees should know about and understand what kind of reward system their organisation has in place (Seitovirta et al., 2015). Beside these results, De Gieter et al. (2006) also evidenced that reward preferences can be influenced by demographic variables such as years of experience.

In conclusion, although reasons for HCPs quitting their profession and helpful measures to contrast this trend are well known, the phenomenon is still ongoing, which highlights the lack – or poor – implementation of such measures.

# 2 OUTLINE OF THE ARTICLE'S CONTENT

Within this chapter, the article's content will be discussed illustrating the reasons underlying the countries' selection, the sample's characteristics, the methodology, and how the data has been gathered and analysed.

## 2.1 Countries' selection

The reason underlying the countries choice are many. On the one hand, the inclusion of two Nordic countries with "analogues cultures" (Finland and Sweden) allows an accurate comparison of workplace rewards and reward preferences in Northern Europe while, on the other hand, the addition of a third, "neutral" country with nonetheless similar characteristics (Switzerland) provides additional data with respect to country-specific preferences and differences that might be culturally imprinted.

Although the population size of the latter nations varies from the 5.53 millions of Finland (Official Statistics of Finland (OSF), 2021) being the least populated country in-analysis, to the 10.41 millions of Sweden (Statistic Sweden, 2021) being the most inhabited, and

Switzerland right in-between the two of them with 8.67 million permanent residents (Federal Statistical Office, 2021), these states share many similarities when it comes to the efficiency of the healthcare systems, quality of life, and human development.

Specifically, in February 2000, the World Health Organisation carried out a study assessing health systems of 191 countries in the world implementing five performance indicators, namely population's health, health inequalities, responsiveness level and distribution of the healthcare system, and fairness in financing (Tandon et al., 2000). In the overall ranking, Switzerland positioned 20th, Sweden placed 23rd, and Finland was ranked 31st (Tandon et al., 2000). Moreover, the Human Development Index (HDI) and the Where-To-Be-Born Index of the three countries in-study are also relatively akin. The HDI, measuring life expectancy at birth, schooling years, and per-capita income, gives a summary measure of the mean accomplishments in the key elements of human development (United Nations Development Programme, 2020a). Within the latest HDI ranking carried out in 2020, Switzerland is occupying the 2nd place, Sweden the 7th, while Finland the 11th (United Nations Development Programme, 2020b). Similarly, the Where-To-Be-Born Index (previously Quality of Life Index) developed by the Economist Intelligence Unit (EIU), that analyses which nations provide the best opportunities for a healthy, safe, and prosperous life in the future ranked Switzerland, Sweden, and Finland at the 1st, 4$^{th}$, and 11th place respectively (Kekic, 2012).

A further reason behind the countries' selection, is that about 3'500 Finland-trained nurses worked overseas at the end of 2015, and among the most common targeted states we find Sweden and Switzerland (Virtanen, 2014).

In conclusion and in consideration of what has been emphasised so far, we believed that the applied countries selection could not only highlight patterns with respect to what healthcare workers consider a reward and reward preferences on a broader level, but also to observe any similarities, differences, and point out country-specific predilections and issues with respect to workplace rewards.

## 2.2 Subjects

The target group consisted in adult HCPs irrespective of their professional title, as long as they were educated in a healthcare area (e.g. nurses, practical nurses, physicians, physiotherapists, occupational therapists etc.). Inclusion criteria were: 1) adult individuals (over 18 years of age), 2) educated in a healthcare area and 3) employed in Finland, Sweden, or Switzerland. Individuals who did not conclude their basic education at the time of data gathering (e.g. nursing students) have not be included in the study. Additionally, no limitation in terms of professional title or healthcare area was set.

The participation in the study was voluntary and anonymous. An information sheet was provided to the participants as a foreword to the questionnaire, which clearly stated that by submitting the online questionnaire, one was giving their consent to take part as a subject in the research study.

## 2.3 Method

Given that the aim of observational studies is to describe facts and characteristics of a given population or area of interest systematically and accurately, portraying - to some extent - what "exists" (Dulock, 1993), we opted for a cross-sectional design to carry out the research project in discussion. Additionally, because previous literature on the subject was – for a greater part – carried out implementing qualitative methods and thus involving a relatively small number of HCPs (mostly nurses), we were willing to involve not only a wider range of healthcare professionals, but also to include a higher number of participants. Therefore, we implemented a quantitative approach through a questionnaire to gather data.

According to power analysis with G*Power 3.1.9.7 (Faul et al., 2007), the required sample size for F tests (one-way analysis of variance – ANOVA) at a 95% significance level ($\alpha$=0.05) with 95% statistical power (1–ß=0.05) was equal to $n$=252, while for $\chi 2$ tests (goodness-of-fit) at a 95% significance level ($\alpha$=0.05) with 95% statistical power (1–ß=0.05) with 16 degrees of freedom ($DF$) was equal to $n$=317.

## 2.4 Questionnaire

Although there are several survey forms investigating rewards available from previous literature (Nienaber et al., 2011; Stanhope, 2017), we developed an ad-hoc questionnaire tailored to the subject in-study since the analysed polls did not entirely fulfil our research objectives. We constructed the survey using the RPQ survey (Nienaber et al., 2011) as a reference with the authors' permission, as well as pre-existing research on factors inhibiting and facilitating the retention of healthcare staff.

The questionnaire has been structured into four parts and 63 questions: through the first section, general socio-demographic data was gathered.

The second part of the questionnaire ought to gather data to determine the importance of different reward types (17 in total) according to personal preferences. Participants were asked to think how much they would appreciate receiving and consider important the listed rewards using a scale from "extremely important" (assessment value: 5) to "not important at all" (assessment value: 1). The list included a comprehensive variety of both transactional (cash and cash-like rewards) as well as relational rewards. The objective of this part of the questionnaire was to answer the research questions: "*what do HCPs consider a reward?"*, *"are some rewards more significant than others?*" and "*does the country of employment influence reward significance?"*.

Furthermore, in the third part, participants were asked to rank 9 rewards categories from the most important (assessment value: 9) to the least important (assessment value: 1) according to their preferences. The reward categories were: 1) formal and informal recognition within the workplace, 2) responsibility and autonomy, 3) professional development and growth, 4) salary or other secure income, 5) bonuses and pay rises, 6) gift cards, discounted prices or reimbursements, 7) quality of the social environment within the workplace (i.e. good relationships with colleagues/managers), 8) work-life integration and balance and 9) quality of the physical environment of the service (i.e. good style, appearance, and efficiency of physical surroundings). The objective of this part of the questionnaire was to answer the research questions: "*are some rewards more significant than others*?" and "*does the country of employment influence reward significance*?"

Finally, the aim of fourth and last part of the questionnaire was double. On the one hand we wanted to examine personal experiences with workplace rewards and, on the other hand, evidence their potential advantages. Participants were thus provided with 17 statements (7 regarding personal experiences with workplace rewards and 10 investigating their potential advantages), to which they had to select whether they strongly agreed (assessment value: 5) or strongly disagreed (assessment value: 1) with. The objective of this part of the questionnaire was to answer the research questions: "*does the country of employment influence the perception of being rewarded in the workplace?*" and "*what are the potential benefits of total reward schemes in healthcare?*".

To ease the data collection process, the questionnaire – as well as the information sheet – have been proposed to the participants in four different languages (i.e. English, Finnish, Swedish, and Italian). Additionally, prior to the activation of the survey, a test has been carried out to check the questionnaire's logic, clearness, and quality of translation. However, the validity and reliability of the questionnaire have not been tested through a scientific pilot study.

## 2.5 Data collection and data analysis

To make the data collection faster and smoother and to allow the gathering of data from three countries simultaneously, we decided to implement the questionnaire online, specifically using LimeSurvey, an online statistical survey web app (LimeSurvey GmbH, 2020).

The questionnaire was activated online on the 1st of July 2021 and closed on the 20th of September 2021. The survey received a total of 449 answers, of which 124 were incomplete – and therefore discarded – and 325 complete. According to power analysis with G*Power 3.1.9.7 (Faul et al., 2007), the sample size of $n$=325 was appropriate for F tests (one-way ANOVA) and for $\chi 2$ tests (goodness-of-fit).

The data have been analysed implementing the software package IBM SPSS Statistics for Windows, version 28 (IBM Corporation, 2021) and MS Excel (Microsoft Corporation, 2018), implementing descriptive and multivariate statistical methods.

To begin with, we split the questionnaire into its four parts analysing the results of each section separately. Following this general examination, we split the data collected through

part two, three, and four based on the country of employment to assess each reward, rank, and statement for statistically significant differences between the three countries in analysis.

# 3 FINDINGS

## 3.1 Sample's characteristics

The population was relatively evenly distributed across the three countries in analysis, with 36.9% of the respondent based in Switzerland (n=120), 33.5% based in Sweden (n=109) and 29.5% in Finland (n=96). Most of the participants were nurses (43.3%) or specialist nurses (23.7%) either with a higher education diploma or a bachelor's degree in a healthcare area (63.1%). Just over a fifth (20.6%) had also completed a master's degree. Furthermore, the largest share pf participants stated to have from 3 to 6 years of experience within their profession (38.2%). Additionally, 35 participants (10.8%) claimed to be holding a managerial and/or leadership position. A clear majority (65,5%) of the participants is employed on a rotating work schedule. On average, respondents had 3.6 employers since graduation. The majority has either worked in public healthcare services exclusively (43.4%) or in both private and public healthcare structures (40.9%).

To conclude the sociodemographic part of the questionnaire, we asked the participants whether they had the feeling that they had received workplace rewards so far: 68.9% answered "no" to this question, while 31.1% replied "yes".

## 3.2 What is considered rewarding among healthcare workers and reward significance

The obtained results indicate that HCPs value and consider as rewarding many types of recompenses, varying from transactional (i.e., cash and cash-like) to relational rewards. This finding aligns not only with theoretical frameworks, but also with previous literature: on the one hand, a reward can be anything to which employees attribute a value that fulfils specific personal needs (Shields et al., 2015) and everything that employees value in the mutual relationship with their employer (O'Neal, 1998). On the other hand, analogues results were

obtained by De Gieter et al., (2006) and Seitovirta et al., (2017), who concluded that nurses value not only financial rewards, but also non-financial and relational rewards.

Moreover, we identified that the significance of a reward varies based on its genre, and thus some rewards are perceived as more important compared to others. However, we also evidenced that this is not always the case, as some rewards are considered equally significant. These findings translate in multiple options to reward HCPs, as well as reinforcing the assumption of rewards having different significance levels. It is our opinion that these results also highlight the importance of asking personal preferences when it comes to rewards' allocation and in developing an effective reward management system as Seitovirta et al., (2015) already claimed in their research.

In this regard, previous studies recommended future research to investigate preferences for different reward categories by introducing rewards in a way that makes the respondent prioritise them from the most to the least important (Nienaber et al., 2011), which is what we have performed through the third part of the questionnaire (ranking). Including such investigation in our research has been crucial in the understanding of rewards significance. In other words, if through the data gathered by means of the second part of the questionnaire, we evidenced that HCPs consider several elements of working life as a reward and some recompenses are equally significant, with the help of the data collected through the third part we were able to sort them in order of importance.

The following list shows the reward categories from the most to the least significant according to our results: 1) salary or other secure income; 2) quality of the social environment within the workplace (i.e., good relationships with colleagues and manager); 3) professional development and growth and work-life integration and balance (tie, no statistically significant difference between these rewards was detected); 4) bonuses and pay rises; 5) responsibility and autonomy; 6) formal and informal recognition; 7) quality of the physical environment of the workplace (i.e. good style, appearance, and efficiency of the physical surroundings of the department); and 8) gift cards, discounted prices in selected stores, and reimbursements for pre-determinate services. These findings reinforce the assumption of rewards having different significance levels as well as suggesting that some reward types and rewards categories are more important than others, such as financial ones (salary or other secure income).

## 3.3 Influence of employment country on reward significance

The findings suggest that not only the country of employment influences reward significance, but also that the degree in which the country of employment influences reward significance varies depending on the countries involved. Table 1 *(five rewards that obtained the highest mean in each country*) represents a summary of the 5 rewards that obtained the highest mean in each country inclusive of the means (*Ms*). When observing the data displayed in *Table 1*, one can easily identify how differently each country has assessed the listed rewards.

*Table 1: five rewards that obtained the highest mean in each country*

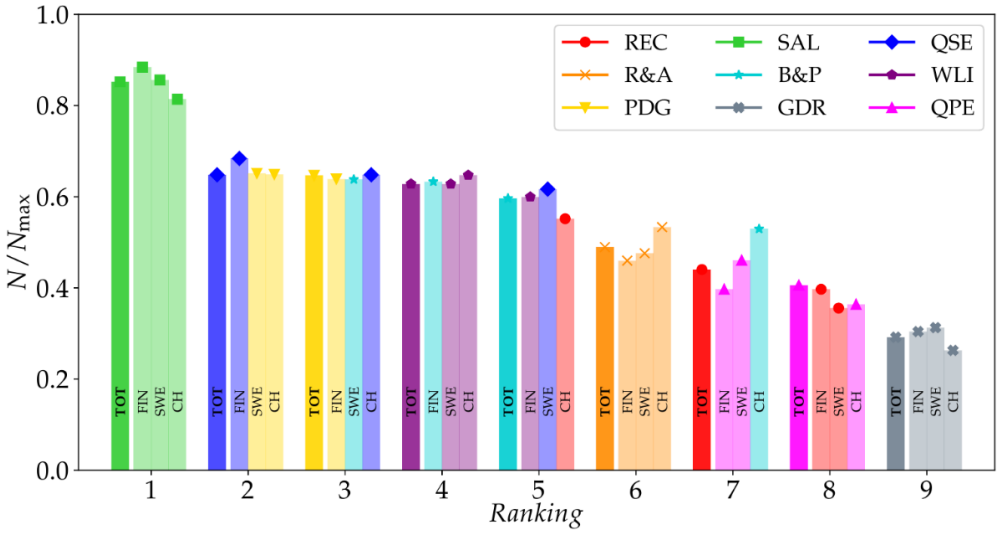
| N. | FINLAND | SWEDEN | SWITZERLAND |
|---|---|---|---|
| 1 | Salary or other secure income (M=4.83) | Salary or other secure income (M=4.72) | Undergo further trainings (M=4.74) |
| 2 | Use working hours for trainings (M=4.55) | Regular salary increases (M=4.67) | Workplace insurances (M=4.72) |
| 3 | Regular salary increases (M=4.54) | Undergo further trainings (M=4.55) | Salary or other secure income (Ms=4.66) and use working hours for trainings (M=4.66) |
| 4 | Informal recognition from line manager (M=4.52) | Workplace insurances (M=4.47) | Regular salary increases (M=4.57) |
| 5 | Undergo further trainings (M=4.48) | Use working hours for trainings (M=4.45) | Opportunity to take sabbatical leave (M=4.48) |

For instance, monthly salary or other secure income obtained the highest mean in Finland and Sweden, but the third highest – together with opportunity to use working hours for relevant trainings – in Switzerland. These dissimilarities have later been confirmed through a one-way ANOVA with Bonferroni correction in post-hoc analysis. The one-way ANOVA led to 7/17 statistically significant differences overall. To that end, the pair Sweden-Switzerland yielded to the highest number of statistically significant differences (5/7), while the pair Finland-Switzerland yielded to the lowest (1/7).

Similarly, if observing the data shown in Chart 1 (*ranking score results. All countries and country-specific results*, it is possible to identify how differently each country has ranked the 9 listed rewards. For instance, individuals based in Sweden ranked the reward "bonuses and pay rises" 3$^{rd}$ place, 4$^{th}$ place in Finland, and 7$^{th}$ in Switzerland. These dissimilarities have later been confirmed through a $\chi 2$ test of independence, which led to 4/9 statistically significant differences overall. To that end, the pair Sweden-Switzerland yielded to the

highest number of statistically significant differences (4/4), while the pairs Finland-Switzerland and Sweden-Finland yielded to the lowest (3/5).

*Chart 1: ranking score results. All countries and country-specific results.*




## 3.4 Influence of employment country on perception of being rewarded

Overall, the results show that HCPs do not feel particularly rewarded within their profession if they work hard, nor for their outstanding performances within the workplace, mainly perceiving that their workplace rarely rewards them or their colleagues, that their efforts often go unnoticed at work, and that their employer rewards more individuals in managerial or leadership positions. Additionally, it appears that respondents' job efforts are more appreciated by their colleagues rather than by their managers. Table 2 (*descriptive statistics for perception of being rewarded within the workplace inclusive of means and SDs*) shows means and SDs for each of the 7 statements in analysis.

*Table 2: descriptive statistics for perception of being rewarded within the workplace inclusive of means and SDs*

| Variable | N | Mean | SD |
|---|---|---|---|
| My own workplace rewards me if I work hard | 325 | **2.20** | 1.180 |
| My own workplace rewards me for my outstanding performances | 325 | **2.16** | 1.155 |
| My own workplace rarely rewards me or my colleagues | 325 | **3.81** | 1.202 |
| My own workplace rewards more individuals in managerial or leadership position/roles | 325 | **3.33** | 1.171 |
| I feel that my job efforts are appreciated by my colleagues | 325 | **4.18** | .770 |
| I feel that my job efforts are appreciated by my line manager/ward manager | 325 | **3.63** | 1.100 |
| I feel that my efforts often go unnoticed at work | 325 | **3.35** | 1.168 |

Moreover, the obtained results indicate country-specific differences with respect to the perception of being rewarded within the workplace. On the one hand, HCPs employed in Finland represent the group perceiving to be the least rewarded among the three countries in analysis while, on the other hand, HCPs employed in Switzerland – though still perceiving an effort-reward imbalance – feel to be more rewarded than individuals working in Finland and Sweden. These dissimilarities have later been confirmed through a one-way ANOVA with Bonferroni correction in post-hoc analysis. The one-way ANOVA test led to 4/7 statistically significant differences overall. To that end, the pair Finland-Switzerland yielded to the highest amount of statistically significant differences (4/4), while the pairs Finland-Sweden and Sweden-Switzerland yielded to a lower amount of statistically significant differences – 2/4 and 1/2 respectively.

## 3.5 Potential benefits of total reward schemes in healthcare

Through this research, we also investigated the potential benefits of reward management in healthcare. It appears that receiving workplace rewards in healthcare holds the potential to increase one's engagement, stimulate one to work better, attract new employees, retain, and motivate them to stay within the organisation, ultimately benefitting both employer and employees. Further potential benefits are creating healthy competition and promoting team building. Ultimately, workplace rewards are considered important to feel self-fulfilled. Most of the participants also believe important that their employer is aware their reward preferences, meaning that HCPs would favour, or value more individual solutions tailored to their preferences when it comes to workplace rewards, as already claimed in previous research (Seitovirta et al., 2017). The table below Table 3 (*descriptive statistics for benefits of reward schemes in healthcare inclusive of means and SDs*) shows means and SDs for each of the 10 statements in analysis.

*Table 3: descriptive statistics for benefits of reward schemes in healthcare inclusive of means and SD)*

| Variable | N | Mean | SD |
|---|---|---|---|
| I believe it is important that my employer knows what my reward preferences are (so that rewards can be tailored to what I appreciate the most) | 325 | **4.06** | .967 |
| I believe receiving workplace rewards has the potential to increase my engagement. | 325 | **4.27** | .950 |
| I believe receiving workplace rewards has the potential to stimulate me to work better | 325 | **4.14** | 1.033 |
| I believe workplace rewards have the potential to create healthy competition | 325 | **3.62** | 1.208 |

| | | | |
|---|---|---|---|
| I believe workplace rewards have the potential to promote team building | 325 | **3.60** | 1.125 |
| I believe workplace rewards have the potential to attract new employees | 325 | **4.45** | .742 |
| I believe workplace rewards have the potential to retain staff | 325 | **4.54** | .742 |
| I believe workplace rewards have the potential to motivate employees | 325 | **4.47** | .755 |
| I believe workplace rewards can benefit not only myself but also my employer | 325 | **4.53** | .739 |
| I believe workplace rewards are important to feel self-fulfilled | 325 | **4.34** | .819 |

Moreover, potential benefits of total reward schemes in healthcare seem to be cross-sectional across the three countries in analysis, except for creating healthy competition and promote team building, hence attributing validity, and great potential to total reward management schemes.

# 4 CHALLENGES AND ADVANTAGES

In this section, we will discuss challenges and advantages faced during the research process. For practical reasons, the latter will be split into three separate parts, specifically before data collection, during data collection, and during data analysis.

## 4.1 Before data collection

During the questionnaire's development, the challenges where many. For instance, since our aim was to collect data in three separate nations, we had to consider country-specific differences in terms of professional title and education. For instance, in Switzerland, one can obtain a higher education diploma in emergency care (paramedics) immediately after graduating high school if majoring in health and social care. In Sweden, on the other hand, one must work as registered nurse for a minimum of two years before entering the paramedic education, which corresponds to a one-year lasting master's degree. In Finland, four years of bachelor's studies are required to obtain the title of paramedic. This genre of issue was solved by adding one question to the survey within the socio-demographic section, asking for participants' highest level of education.

When developing the questionnaire, attention was drawn about whether to investigate gender of the participants, as the number of personal information collected was to be kept as low as possible to avoid subjects' identification. Since De Gieter et al. (2006) findings suggested that

gender did not seem to have any impact on reward preferences, this element was not further investigated.

Additionally, the only limitation that we set within our questionnaire in terms of population characteristic was "*educated in a healthcare area*" irrespective of professional title. To solve this issue, when asking "*what healthcare profession do you practice?*", other than listing the most common healthcare professions, we also included the option "*other*", where participants could enter their working title. However, this resulted in entire healthcare areas being neglected: for instance, although dentists and dental health nurses are educated in a healthcare area, none of them took part in our study. This could have been easily avoided by enforcing more rigid inclusion and exclusion criteria before publishing the survey, for instance by limiting professional titles or healthcare areas.

A further challenge was to ensure that the question we were posing to the participants could genuinely respond to the research questions. Thus, a great amount of care was placed into the development of the survey's questions. Specifically, we utilised the RPQ questionnaire (Nienaber et al., 2011) as a reference with the authors' permission as well as pre-existing research on factors inhibiting and facilitating the retention of healthcare staff.

Finally, to promote the participation, we decided to provide the questionnaire in four different languages (i.e., Finnish, Swedish, English, and Italian). The authors are native Italian and Swedish speakers, thus the translation from English to these two languages was taken on by themselves. Nevertheless, for the translation in Finnish, assistance from a certified translator was sought. Additionally, consideration was given into maintaining the meaning and sense of the questions in all four languages.

## 4.2 During data collection

To carry out this study, the authors decided not to formally request a research permit in any specific healthcare organisation for two main reasons: 1) including only a few healthcare structures within the study (i.e. one per each country) would have produced unrealistic data as the organisation's reward system would have been likely to be similar (Smith et al., 2019), and 2) requesting a formal research permit commonly involves a long waiting time that, if

summed with our inexperience in scientific research, would have taken a toll in the quality of the data analysis – to which we dedicated a considerable amount of time.

Nevertheless, after thorough consideration, we decided to reach out to Nurse Trade Unions in all three countries involved to boost our response rate, formally asking if they were willing to share our questionnaire and research with their members. Specifically, we contacted Tehy Ry, Svensk Sjuksköterskeförening, and the Schweizer Berufsverband der Pflegefachfrauen und Pflegefachmänner (SBK), representing Finland, Sweden, and Switzerland respectively. Tehy ry expressed a strong interest towards our research. However, to go further with Tehy sharing the questionnaire, we would have needed a positive answer from larger Unions in Sweden and Switzerland as well, which we did not have at the time (for instance the union Svensk sjuksköterskeförening, totally ignored our collaboration request, although several contact attempts have been made). As a result, we were compelled to turn the collaboration with Tehy down.
Nevertheless, the Nursing Trade Unions in Switzerland (SBK) and the Swedish speaking Nursing Union in Finland (Sjuksköterskeföreningen i Finland) expressed interest in sharing our questionnaire. We decided to go forth with this option since the response rate from these two countries was relatively low compared to Sweden. Sjuksköterskeföreningen i Finland advertised our questionnaire on their social media platforms on the 6$^{th}$ of September 2021, while SBK advertised it within the September edition of their monthly magazine.

Having two Nurse Trade Unions advertising our questionnaire has been of great help in terms of data collection. A further advantage in this sense was that both authors possess a wide network and are active on several social media platforms (i.e. Facebook, Instagram, LinkedIn), where the questionnaire was shared.

Although we collected a considerable number of full answers (325), the process of data collection has been a challenge, mostly because we wished to have a similar number of answers from each country to be able to analyse the data in the most trustful way. Additionally, according to the statistics, we clearly see a dominance of nurses and specialist nurses over other healthcare professions such as physiotherapists, occupational therapists, or physicians. Even though this reflects – to some extent – the reality of the healthcare system (e.g. there are more nurses than doctors), we could have reached out to Trade Unions or social media groups representing healthcare professions other than nursing. This resulted in an uneven

professional representation within our data as well as in turning down the collaboration with Tehy ry, otherwise easily surmountable if we would have allocated more time to data collection.

Nevertheless, we believe that our choice to offer the questionnaire in four different languages (Finnish, Swedish, English, and Italian) – although it required a longer preparation time – has facilitated the data collection by easing its comprehension and motivating a higher number of individuals to complete it as a result. Likewise, releasing the questionnaire through an online platform improved not only its accessibility, but also sped up the data collection process.

## 4.3 During data analysis

The main issue that we encountered during the data analysis process is related to the way we structured our questionnaire in LimeSurvey (LimeSurvey GmbH, 2020). For the most part, our questions were structured as *string* (word data), and not as *scale* (numerical data). This mistake translated into a major issue when trying to analyse the collected data through IBM SPSS Statistics (IBM Corporation, 2021), which was not able to process the needed statistical calculations (for instance means, medians, standard deviations, F tests, and $\chi 2$ tests). It might be worth mentioning that, before the activation of the survey, a meeting was organised with the LimeSurvey expert at Arcada UAS to ensure that the questionnaire was structured properly. However, at the time, the issue regarding the questions' structure was not detected, and led to an incorrect collection of data. Though we sought help from more experienced researchers at Aracda UAS to solve this issue, the problem initially appeared to be unsolvable because of the data's format. Nevertheless, we partially solved it implementing MS Excel (Microsoft Corporation, 2018) to manually code the data, and later importing the file into IBM SPSS Statistics (IBM Corporation, 2021).

Moreover, the analysis of a multiple-choice question represented a further challenge that we encountered (i.e. *in which healthcare sector have you worked?*), where participants had to choose between public, private, and self-employed options, but could select more than one answer. To overcome this, we firstly coded the three values and then analysed frequencies merging each possible combination in IBM SPSS Statistics (IBM Corporation, 2021).

Furthermore, within the socio-demographic part, we asked the participants about their family status, where they had to select – among the following options – the one best describing it: single, cohabiting, married/civil union/registered partnership, divorced/separated, and widowed. The aim of this question was to analyse how many respondents lived alone, and how many share household, and therefore more likely to share fixed expenses such as rent, with others. However, as result of the question's structure as well as the answer options given to the participants, this question's results were unusable, as we could not assume that all the respondents that selected married/civil union/registered partnership live with their partner for instance.

In conclusion, a final challenge was encountered during data analysis while carrying out $\chi 2$ tests of independence. Because the logical validity of the $\chi 2$ tests is greater when expected values *E* are higher than 5, the test is considered inappropriate if more than 1/5th of the cells have *E*-values smaller than 5 or any *E*-values smaller than 1 (Wechsler, 1997). Within our data, the distribution of votes was in some cases highly inhomogeneous, hence *E*-values smaller than 5 and/or 1 resulted. To overcome this issue, we neglected columns with *E*-values $< 5$ for all the 3 countries respectively, therefore having a $\chi 2$ test more reliable that reflected country-specific characteristics accurately. Additionally, in some cases, we favoured the $\chi 2$ test of independence over the one-way ANOVA because our aim was to determine any association between two or more nominal-scale variables comparing them, but the interval-scale variable was not evenly distributed (Gaussian distribution), which is a parametric assumption that must be satisfied when performing one-way ANOVA testing (McCrum-Gardner, 2008).

# 5 ALLOCATION OF RESPONSIBILITIES

Since the authors' list includes two writers, within this chapter we illustrate the allocation of responsibilities throughout the whole duration of the research study and writing process. To summarise these details, we prepared a table (see *Appendix 1/1(2)*) inclusive of what tasks each of the authors undertook, and what tasks have been competed together. Overall, Ellen focussed more on the article's reflective and critical review, while Simona concentrated more on the article itself as well as on the data analysis. The workload division, further actions, and responsibilities allocation were always discussed and agreed upon by both involved parties,

who met and kept in touch regularly. No kind of conflict emerged during the whole duration of the thesis project.

# 6 IMPLICATIONS OF THE RESEARCH FOR THE NORDIC HEALTHCARE SECTOR

The healthcare staffing shortage is a worldwide issue, particularly affecting nurses and midwives who constitute more than half of the current lack in HCPs (World Health Organization, 2020). It is estimated that approximately 13 million nurses will be needed in the future to fulfil the global shortage gap (International Council of Nurses, 2021). What makes this issue even more compelling, are the demographic changes touching the age structure of our societies, particularly with respect to the increasing number of older people requiring support and assistance for daily activities (World Health Organization, 2018).

A common solution adopted by many countries around the world to overcome the shortage of staff, is to increase the number of students in training, which represents nevertheless a long-term remedy since the length of nursing education programs – for instance – varies from three to four years (International Council of Nurses, 2021). Thus, a solution able to produce immediate results in this regard, would be prioritising nurses' retention (International Council of Nurses, 2021), not only within the healthcare structures themselves, but also within the country of training. The shortage of HCPs concerns not only our societies, but also researchers, who have started to draw their attention towards this phenomenon trying to understand the underlying reasons that make the retention of qualified HCPs increasingly difficult.

In addition, the repercussions of the current COVID-19 pandemic – which have put under severe pression healthcare systems on a global scale – are also not to be overlooked. Specifically, the virus outbreak is exacerbating this shortage, with an increasing number of HCPs leaving or intending to leave the profession (International Council of Nurses, 2021; Labrague & Santos, 2021; Said & El-Shafei, 2021).

## 6.1 Significance of the research in the Nordic context

At the end of 2015, about 3'500 Finnish-trained nurses were working overseas , of which 1'870 practiced either in Sweden or Norway (Pekurinen & Säkkinen, 2021). Among the most

common targeted countries we find Sweden, Norway, the United Kingdom, Switzerland, and the United States (Virtanen, 2014). Increased salary appears to be the most recurrent underlying reason making Finnish-trained nurses to leave their country of training (Yle, 2015). On the contrary, the percentage of foreign-trained nurses working in Finland is amongst the lowest found in OECD countries (1.8%): by contrast, this percentage is equal to 25.6% in Switzerland, which represents the highest in Europe (OECD, 2019).

Additionally, the COVID-19 outbreak is exacerbating the shortage of healthcare staff, and Finland is no exception in this regard. Specifically, the Finnish Nurses Association carried out a country-wide survey including approximately 2'300 nurses, to which more than half stated they had thought of changing jobs during the height of the pandemic (Yle, 2020). Additionally, the stressful working environment, combined with low salaries and COVID-19 burnout have, on the one hand, impelled many professionals to seek employment elsewhere while, on the other hand, forced several hospitals to lower the number of beds (Sequeira, 2021).

As a results of these repercussions, there is a strong urgency in finding strategies that work for the attraction, retention, and motivation of HCPs not only within their profession, but also within their country of training to fight the shortage of healthcare staff.

In this regard, workplace rewards have a lot of potential. Although we do know that HCPs are fleeing away leaving their profession, this phenomenon is well acknowledged, and its causes known, we also know that reward schemes are already in place. Thus, rather than questioning what we can do more do fight the shortage of healthcare staff, we should start thinking about what we are not doing, and what we are doing wrong. The COVID-19 pandemic has surely worsened the phenomenon, but the virus is not to be blamed as rather than being its root cause, it is more of an event that exacerbated pre-existing issues.

Likewise, because of the pandemic, healthcare structures and political bodies around the world have strengthen the allocation of workplace rewards (often in the form of one-off reward) to recognise HCPs. Some of them produced positive outcomes and feedbacks (laRegione, 2020; Sullström, 2021), while other reward strategies were rather perceived as a mockery. A flop example happened in Finland, where the Helsinki University Hospital (one of Finland's biggest healthcare employers) rewarded its employees with an online,

downloadable “thank you” card: the idea was quaint and perceived by many as an insult to their current job situation (Manninen & Vanhala, 2021). Hence, for effective results in terms of staff attraction, retention, and motivation, as well as to ensure that rewards produce positive outcomes for HCPs’ retention, healthcare practices should tailor their reward system according to reward significance and personal preferences, taking into consideration previous empirical research as well as carrying out an investigation within the organisation itself and including employees in the creation of reward systems.

# 7 CONCLUSIONS

This research focused on reward significance, reward preferences, and personal experiences with workplace rewards among HCPs, as well as on the potential benefits of implementing a total reward management scheme in healthcare. The aims were to investigate what is considered as a reward among HCPs, whether some rewards are more significant than others and to explore whether the country of employment has an impact on reward preferences and feelings of being rewarded within the workplace. Finally, the last aim consisted in exploring potential benefits of total reward schemes in healthcare.

We hope this study serves as an eyeopener to healthcare structures and healthcare managers/leaders, prompting them to review their reward management systems to create a healthy working culture where employees are rewarded through elements which are meaningful to them, and their efforts are valued. This is not only the right thing to do from an ethical standpoint, but the potential benefits also appear to be worth the effort in each country in analysis. It is also fundamental for healthcare structures not to rely too much on a single reward type (i.e., gift cards, discounted prices, and reimbursements) since allocating the same reward several times often leads to no benefits, if not being counterproductive (Pierce & Aguinis, 2013).

Besides ensuring that the financial rewards package is appropriate, HCPs in managerial and leadership position should be taught about workplace rewards and trained on how to deliver them effectively (Armstrong & Stephens, 2005), since amongst the most significant rewards we identified many of relational nature (such as professional development and growth). When developing recognition schemes for instance, it is necessary to ensure that they are perceived

and exposed to the employees not only within the scope of the reward strategy, but also worthful development per se (Armstrong & Stephens, 2005).

Additionally, just as well as HCPs would appreciate their employer to know what their reward preferences are, the same should be applied the other way around. In other words, it is essential to let not only people know how they will benefit, but also how the organisation will benefit from reward schemes (Armstrong & Stephens, 2005). In fact, although from our research it appears that some types of reward schemes are in place in several healthcare structures, HCPs are still leaving their positions and/or the healthcare sector and the reasons underlying this phenomenon could be multiple (i.e., allocated rewards not significant to employees, reward preferences not considered, failure in communicating effectively total reward schemes in a way that makes rewards meaningful, failure to involve HCPs in the creation of reward schemes, healthcare managers not trained in workplace rewards delivery).

Hence, successful leaders are sensitive, curious, and alert about employees' needs and keen to continuous learning. A transformational leadership style is thus a key factor to trigger change. Transformational leaders help employees grow and develop by responding to individual needs, by empowering them, and by aligning their goals with the leader, the group, and the organisation (Bass & Riggio, 2006). Transformational leadership is important in every sector and setting (Avolio & Yammarino, 2013), and in healthcare it holds the potential to improve job satisfaction, reduce work-related stress, and intention to leave the position and/or profession (Pishgooie et al., 2019). Hence, healthcare leaders should try to raise confidence in employees, respect and care for them, while also supporting their views and suggestions (Pishgooie et al., 2019).

We thus believe that future research should focus on understanding why, although reward schemes are in place, HCPs still do not feel rewarded and on practical interventions with respect to workplace rewards, for instance through a longitudinal study.

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## Appendix 1. Table 1: allocation of responsibilities

| Author 1 (Ellen) | Author 2 (Simona) | Both authors |
|---|---|---|
| Thesis's topic suggestion. | Prepared participants' information sheet in Italian and translated questionnaire in Italian. | Background research and written introduction and literature review. |
| Prepared participants' information sheet in English, Finnish, and Swedish and translated questionnaire in Finnish and Swedish. | Contact person for/with:<br>• R. Nienabler and M. Bussin (permission to use and edit RPQ questionnaire).<br>• J. Seitovirta (feedback on questionnaire used for research study).<br>• Schweizer Berufsverband der Pflegefachfrauen und Pflegefachmänner (union).<br>• Swiss Ethics and Coordination Office for Human Research (KOFAM – ethical permission).<br>• LimeSurvey Support (F. Levälahti).<br>• IBM SPSS Statistics support (Dr. J. Kettunen and H. Paakkonen) | Developed research's questionnaire in English. |
| Contact person for/with:<br>• Etikprövningsmyndigheten (ethical permission).<br>• Tehy (union).<br>• Svensk sjuksköterskeförening (union).<br>• Sjuksköterskeföreningen i Finland (union).<br>• IBM SPSS Statistics support (T. Ståhl and H. Paakkonen). | Performed the following data and statistical analyses in MS Excel and IBM SPSS Statistics:<br>• What is considered as rewarding among healthcare workers and reward significance.<br>• Influence of employment country on reward significance.<br>• Influence of employment country on perception of being rewarded.<br>• Potential benefits of total reward schemes in healthcare (country-specific differences). | Imported questionnaire into LimeSurvey. |

| | | |
|---|---|---|
| | • Coded data manually in MS Excel | |
| Performed the following data and statistical analyses:<br>• Socio-demographic data.<br>• Potential benefits of total reward schemes in healthcare (all countries). | References management. | Carried out testing of the questionnaire prior to its activation and survey advertisement on social media platforms. |
| Written challenges and advantages and implications of the research on the Nordic healthcare in article's critical review. | Language revision. | Meetings with experts and thesis supervisor (both authors were always present in thesis-related meetings). |
| | | Reviewed statistical analysis findings and wrote discussion's and conclusions' s outline |