Work Demands, Organisational Support and Work–Life Balance among Healthcare Workers: A Structural Equation Model from Multispecialty Hospitals in Kalyana Karnataka

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Abstract
Work–Life Balance (WLB) is an important concern in the healthcare sector, where demanding workloads, shift duties and emotional pressures can affect employees' ability to effectively manage professional and personal responsibilities. This study examines the influence of Work Demands and Organisational Support on Work–Life Balance among healthcare workers in selected multispecialty hospitals in the Kalyana Karnataka region. A quantitative, cross-sectional research design was adopted, and data were obtained from 400 healthcare workers using a structured five-point Likert-scale questionnaire. The analysis employed descriptive statistics, reliability analysis, exploratory factor analysis, confirmatory factor analysis (CFA) and Structural Equation Modelling (SEM). The measurement results indicate satisfactory internal consistency, with Cronbach's alpha values of 0.914 for Work Demands, 0.901 for Organisational Support and 0.887 for Work–Life Balance, while Composite Reliability values ranged from 0.891 to 0.918. The KMO value of 0.924 and significant Bartlett's test (χ^2 = 6824.617, df = 435, $p < 0.001$) confirmed the suitability of the data for factor analysis. The SEM demonstrated an acceptable model fit (χ^2 = 218.436, df = 130, χ^2/df = 1.680, GFI = 0.941, AGFI = 0.918, CFI = 0.967, TLI = 0.961, RMSEA = 0.041 and SRMR = 0.038). The structural results show that Work Demands have a significant negative effect on WLB ($\beta = -0.426$, SE = 0.071, CR = −6.014, $p < 0.001$), whereas Organisational Support has a significant positive effect ($\beta = 0.512$, SE = 0.068, CR = 7.529, $p < 0.001$). Together, the two predictors explain 56.8% of the variance in Work–Life Balance (R^2 = 0.568). The findings highlight the importance of workload management, supportive supervision, adequate staffing and employee-oriented organisational practices for strengthening Work–Life Balance among healthcare workers.

Keywords: Work–Life Balance, Work Demands, Organisational Support, Healthcare Workers, Multispecialty Hospitals, Structural Equation Modelling, Kalyana Karnataka.

1. Introduction

Healthcare organisations operate in an environment where service continuity, professional responsibility and patient needs require employees to perform effectively under demanding working conditions. The health workforce is therefore central to the functioning and quality of healthcare systems. In India, the healthcare workforce has expanded considerably in recent years, with growth in medical and nursing education and increasing emphasis on developing a skilled and sustainable workforce (World Health Organization [WHO], 2024).

However, expansion in healthcare capacity does not eliminate the organisational and occupational pressures experienced by healthcare workers. Hospitals, particularly multispecialty hospitals, require continuous service delivery, coordination across professional groups, responsiveness to emergencies and adaptation to changing patient needs.

These characteristics make healthcare work an important setting for examining the relationship between work demands, organisational support and work–life balance (WLB).

Work–life balance has become an important issue in healthcare because employees must manage professional responsibilities alongside family and personal commitments. The problem becomes particularly relevant in occupations characterized by intensive workloads, irregular schedules and high responsibility.

Research among nursing professionals has demonstrated that demanding work environments can influence employees' ability to maintain equilibrium between their professional and personal lives (Navajas-Romero et al., 2020). In their study of 991 nursing professionals, Navajas-Romero et al. (2020) found that physical job demands were significantly associated with WLB and highlighted the importance of effectively managing the work context.

Within this context, work demands represent an important source of pressure for healthcare workers. Workload, time pressure, emotional demands, long working hours, shift duties and the need for continuous attention can consume physical and psychological resources.

The Job Demands–Resources perspective provides a useful theoretical explanation: job demands require sustained effort and may generate strain, whereas job resources help employees cope with those demands and achieve work-related goals. Evidence from healthcare research supports the relevance of this demand–resource perspective to WLB. Navajas-Romero et al. (2020), for example, examined job demands, job control and social support in relation to WLB and reported that the characteristics of the work environment were important in shaping employees' ability to balance work and personal life.

At the same time, organisational support can provide an important resource through which healthcare employees manage demanding work conditions. Support from supervisors, colleagues and the organisation may assist employees in dealing with workload, resolving work-related difficulties and managing competing responsibilities.

Evidence from the Indian healthcare context is particularly relevant. Poulose and Sudarsan (2017), in a study of 182 nurses employed in hospitals in South India, examined work overload and work support in relation to WLB and found a negative relationship between work overload and work satisfaction and a positive relationship between work support and work satisfaction. Their findings also demonstrated the importance of WLB dimensions in these relationships.

Similarly, Rashmi and Kataria's study of Indian nursing professionals examined job resources including job autonomy, supervisor support and co-worker support, with WLB positioned within a Job Demands–Resources framework. The study provides evidence that workplace resources and WLB are closely connected in the Indian nursing context.

These findings indicate that WLB should not be understood solely as an individual employee's responsibility; rather, it is also shaped by the characteristics of the organisation and the resources available to employees.

Despite this growing body of evidence, an important research issue remains. Much of the healthcare literature has concentrated specifically on nurses, although multispecialty hospitals depend on a wider workforce comprising doctors, nurses, pharmacists, laboratory personnel, technicians, administrative staff and other healthcare professionals.

Consequently, examining healthcare workers as a broader occupational group can provide a more comprehensive understanding of how hospital work conditions influence WLB. Moreover, existing studies have frequently examined individual dimensions such as workload, social support or job satisfaction, whereas fewer studies integrate work demands and organisational support within a single structural model explaining WLB, particularly in regional Indian healthcare settings.

This gap is particularly relevant to Kalyana Karnataka, where healthcare institutions serve populations distributed across urban, semi-urban and developing regional centres. The region represents a distinctive setting in which healthcare organisations must respond to changing service requirements while managing workforce availability, workload and organisational constraints.

Although India has expanded its health and nursing workforce substantially, WHO continues to emphasise the importance of workforce planning, recruitment, retention, management and training for strengthening healthcare delivery (WHO, 2024). Yet, empirical evidence concerning how hospital work demands and organisational support jointly influence WLB among healthcare workers in Kalyana Karnataka remains limited.

Against this background, the present study examines the relationship between work demands, organisational support and work–life balance among healthcare workers employed in multispecialty hospitals in Kalyana Karnataka. The study adopts a structural equation modelling approach to examine the proposed relationships simultaneously.

SEM is appropriate because the three constructs are multidimensional and are typically measured through multiple observable indicators; it also enables the researcher to examine measurement quality and structural relationships within an integrated framework. The study therefore seeks to move beyond isolated examination of workplace factors and provide an empirically testable model linking occupational demands and organisational resources with employees' WLB.

The study makes three principal contributions. First, it contributes theoretically by bringing together the demand and resource dimensions of the work environment in explaining WLB.

Second, it contributes empirically by examining healthcare workers beyond a single professional category, thereby broadening the occupational scope of previous healthcare research.

Third, it contributes contextually by generating evidence from multispecialty hospitals in Kalyana Karnataka, a regional setting that remains comparatively underrepresented in the WLB literature. In doing so, the study provides a structured basis for understanding how hospital work environments may influence employees' capacity to maintain an effective balance between professional and personal domains.

2. Review Of Literature

2.1 Conceptual Foundations of Work–Life Balance

The literature on work–life balance has evolved from the earlier concept of work–family conflict towards a broader understanding of how individuals manage multiple life roles. Greenhaus and Beutell (1985) established the foundational perspective by explaining work–family conflict through time-based, strain-based and behaviour-based mechanisms.

Their framework suggests that the time and energy consumed by demanding work roles can restrict an individual's ability to fulfil family and personal responsibilities. This perspective was subsequently strengthened by Frone et al. (1992), who demonstrated that work and family domains influence one another through reciprocal processes.

Allen et al. (2000) further established that work–family conflict is associated with important work, non-work and stress-related outcomes, indicating that imbalance is not merely a personal inconvenience but an organisational and employee well-being issue.

The conceptualisation subsequently moved beyond conflict towards balance and enrichment. Clark (2000), through Work/Family Border Theory, argued that employees continuously cross boundaries between work and family domains and that the permeability and flexibility of these boundaries influence their ability to maintain equilibrium.

Greenhaus and Powell (2006) extended this perspective through the theory of work–family enrichment, proposing that experiences in one domain can generate resources that improve performance and quality of life in another domain. Eby et al. (2005), through a comprehensive review of work–family research, similarly demonstrated that the interface between work and non-work domains is influenced by individual, occupational and organisational factors.

More recently, Kalliath and Brough (2008) conceptualised WLB as an individual's perception that work and non-work activities are compatible and promote growth according to personal priorities. These theoretical developments collectively indicate that WLB is a multidimensional construct shaped not only by individual preferences but also by the nature of work and the organisational environment.

2.2 Work Demands as a Determinant of Work–Life Balance

A major stream of literature identifies work demands as an important antecedent of work–life imbalance. Work demands encompass workload, time pressure, long working hours, emotional demands, role ambiguity, role conflict and other aspects of work requiring sustained physical or psychological effort.

The Job Demands–Resources (JD-R) framework proposed by Demerouti et al. (2001) and subsequently developed by Bakker and Demerouti (2007) provides a strong theoretical explanation for this relationship. According to the model, excessive job demands consume employees' physical and psychological resources and can consequently produce strain and negative outcomes.

The work–family literature provides similar evidence. Byron (2005), through meta-analytic evidence, demonstrated that work-related factors are important antecedents of work-to-family interference. Michel et al. (2011), in a large meta-analysis, identified role conflict, role ambiguity, role overload and time demands among the significant work-related antecedents of work–family conflict.

These findings are particularly relevant to healthcare because hospital employees frequently work under conditions involving time pressure, high patient responsibility and irregular working schedules.

The relationship is even more evident in nursing and healthcare research. McVicar (2003) identified workload, management practices, professional conflict and the emotional demands of caring as major sources of occupational stress among nurses.

Josten et al. (2003) examined extended working days among nurses and highlighted the implications of working-time arrangements for fatigue and employee well-being. Ng et al. (2017), using data from 2,040 nurses in Taiwanese hospitals, found that job demands were significantly associated with dimensions of WLB. Similarly, Navajas-Romero et al. (2020), applying the Job Demands–Control–Support model to 991 nursing professionals, demonstrated that job demands were relevant to employees' work–life experiences.

The evidence has continued to develop in recent years. Min (2022) found that work-related physical pain and burnout were associated with WLB among registered nurses, while Rony et al. (2023) reported relationships between working conditions, work–life imbalance and dissatisfaction among nurses.

The recent systematic review by Yang et al. (2026), which synthesised 23 studies, identified job demand, work schedule and working environment as major themes affecting nurses' WLB. The review specifically highlighted physical and psychological demands, night shifts, frequent shift changes and long working hours as important factors requiring organisational attention.

Thus, the literature consistently suggests that increasing work demands can reduce the capacity of healthcare workers to maintain equilibrium between professional and personal domains. This provides a strong theoretical basis for examining Work Demands → Work–Life Balance as a structural relationship.

2.3 Workload, Working Hours and Shift Work in Healthcare

Healthcare work differs from many conventional occupations because service delivery is continuous and often requires employees to work beyond conventional working hours. Consequently, workload, shift work, overtime and schedule instability have received considerable attention in WLB research.

Nurumal et al. (2017) reported that nurses working fixed shifts experienced better WLB than nurses working multiple or rotational shifts. Similarly, Oh and Cho (2020) identified work-schedule characteristics, including control over starting and finishing times and shift exchanges, as relevant to work–family conflict among nurses. Watanabe and Yamauchi (2018) showed that the relationship between overtime and WLB may also depend on whether overtime is voluntary or involuntary, suggesting that employees' control over working time is important.

Adiba and Nair (2021) reported that working hours, shift work, overtime and work-related activities beyond normal working hours were relevant to occupational stress and WLB among nurses in a South Indian hospital. Dousin et al. (2021), examining women doctors and nurses, similarly identified staff shortages and workload as barriers to achieving WLB.

These findings indicate that workload should not be conceptualised only as the volume of work; rather, its consequences depend on scheduling, staffing levels, autonomy and the degree of control employees have over their working time.

The international evidence reinforces this conclusion. Nurumal et al. (2017), Kowitlawkul et al. (2019), Oh and Cho (2020), Min (2022) and Rony et al. (2023) collectively indicate that irregular schedules, extended working hours and insufficient recovery opportunities can adversely affect healthcare workers' work–life experiences. The recent systematic review by Yang et al. (2026) similarly identifies work schedule as one of the six principal themes affecting nurses' WLB.

2.4 Organisational Support as a Job Resource

While work demands represent the strain-producing side of the employment relationship, organisational support represents an important resource through which employees can cope with demanding work conditions. The concept is strongly associated with Organisational Support Theory, which proposes that employees develop general beliefs concerning the extent to which their organisation values their contribution and cares about their well-being.

Eisenberger et al. (1986) established the foundation for perceived organisational support (POS), while Rhoades and Eisenberger (2002) subsequently synthesised extensive evidence concerning its antecedents and consequences. In the work–family domain, Allen (2001) demonstrated the relevance of family-supportive organisational perceptions. Kossek et al. (2011), using 85 studies and 72,507 employees, provided particularly strong evidence that organisational and supervisor support are related to work–family conflict.

Their meta-analysis further showed that work–family-specific support has a stronger relationship with work–family conflict than general organisational or supervisor support.

Michel et al. (2011) similarly identified organisational, supervisor and coworker support as important social resources in the work–family interface. Hammer et al. (2011) demonstrated the importance of family-supportive supervisor behaviour, while Hammer et al. (2009) developed a multidimensional measure of family-supportive supervisor behaviours. Crain and Stevens (2018) subsequently reviewed the FSSB literature and reinforced the importance of supervisor behaviour in enabling employees to manage work and non-work responsibilities.

These studies collectively suggest that organisational support may operate as a resource pathway through which employees are better able to cope with work demands.

Therefore, the relationship between organisational support and WLB is theoretically distinct from the relationship between work demands and WLB.

2.5 Supervisor and Coworker Support in Healthcare

The relevance of organisational support becomes particularly strong in healthcare because hospital work is highly interdependent. Employees frequently depend on supervisors, colleagues and other professional groups to manage workload, emergencies, patient responsibilities and scheduling requirements.

McVicar (2003) identified leadership and management practices as important components of nurses' occupational environment. Keyko et al. (2016) subsequently demonstrated the importance of organisational climate and leadership in nursing work engagement. Lembrechts et al. (2015), examining hospital nurses, found that organisational and coworker/physician support were relevant to work–family conflict, while work overload and overtime contributed to conflict.

Kowitlawkul et al. (2019) also demonstrated the relevance of social support to quality of life among nurses in a tertiary hospital. Navajas-Romero et al. (2020) examined supervisor support within the Job Demands–Control–Support framework and showed that support could influence relationships between working conditions and WLB.

The Indian evidence is particularly important for the present study. Poulose and Sudarsan (2017), studying 182 nurses in South India, examined work overload and work support in relation to WLB and job satisfaction. Their findings indicated that work support was positively associated with work satisfaction, whereas work overload had a negative association.

Rashmi and Kataria (2021/2023) provide perhaps the closest empirical precedent for the proposed model. Using data from 452 Indian nursing professionals, they examined job autonomy, supervisor support and coworker support as job resources within the JD-R framework. Their SEM-based study examined WLB as a mediating mechanism between job resources and job satisfaction, thereby demonstrating the applicability of a structural approach to WLB in the Indian healthcare context.

2.6 Indian Evidence on Healthcare Workers and Work–Life Balance

Indian healthcare research increasingly recognises WLB as an organisational issue rather than an exclusively individual concern. Poulose and Sudarsan (2017) provided early evidence from South Indian nurses by examining work overload and work support. Their findings established that both the demand and support dimensions of the work environment are relevant to employee outcomes.

Dubey and Riasudeen (2021) subsequently examined perceived organisational support, WLB and job satisfaction among female nurses in India. Their proposed POS–WLB–job satisfaction model, grounded in Organisational Support Theory, demonstrated a positive relationship between perceived organisational support and both WLB and job satisfaction. The study further positioned WLB as a mediating mechanism between organisational support and job satisfaction.

Rashmi and Kataria (2021/2023) extended the Indian evidence by incorporating job autonomy, supervisor support and coworker support within a JD-R-based SEM. Their research is particularly relevant because it demonstrates that WLB can be incorporated into an integrated structural model rather than being examined as an isolated descriptive outcome.

Other Indian studies have examined WLB in the context of occupational stress, working hours, shift work and the extraordinary pressures experienced during the COVID-19 period. Adiba and Nair (2021) identified occupational stress, working hours, shift work and overtime as relevant factors among nurses in a South Indian private hospital, while studies undertaken during the pandemic highlighted the additional workload and psychological pressures faced by healthcare professionals.

These findings suggest that the Indian hospital context provides a meaningful setting for examining both job demands and organisational resources simultaneously.

2.7 Work–Life Balance and Employee Outcomes

Another important theme emerging from the literature is that WLB is not simply an outcome in itself; it is also associated with several employee and organisational outcomes.

Allen et al. (2000) linked work–family conflict with job-related and non-work-related consequences. Kossek and Ozeki (1998) reported negative associations between work–family conflict and job and life satisfaction. Eby et al. (2005) similarly identified relationships between work–family experiences and employee attitudes and well-being.

Within healthcare, Poulose and Sudarsan (2017) demonstrated the relationship between WLB dimensions and work satisfaction among South Indian nurses. Rashmi and Kataria (2021/2023) further demonstrated that WLB plays a mediating role between job resources and job satisfaction among Indian nursing professionals. Dubey and Riasudeen (2021) likewise positioned WLB as a mechanism connecting perceived organisational support with job satisfaction among Indian female nurses.

Dousin et al. (2021) linked WLB with intention to leave among nurses, while Rony et al. (2023) examined work–life imbalance alongside job dissatisfaction. These findings suggest that maintaining WLB may have implications for employee retention and organisational sustainability. Consequently, understanding the antecedents of WLB becomes strategically important for hospital management.

2.8 Recent Evidence: From Individual Coping to Organisational Responsibility

Recent literature demonstrates a gradual shift from viewing WLB primarily as an individual coping issue towards recognising the role of organisational systems. Widayana et al. (2025), in a scoping review, identified multiple individual, interpersonal and organisational factors associated with nurses' WLB. The review emphasised the importance of work schedules, workload, social support and organisational conditions.

Poma et al. (2025) examined organisational conditions, WLB and work ability among healthcare workers and provided recent evidence directly connecting organisational conditions, job demands and job resources with WLB. The study is particularly relevant to the proposed research because it treats WLB as part of an integrated organisational model rather than as an isolated personal outcome.

Yang et al. (2026), in a systematic review of 23 studies, consolidated evidence around six major categories: sociodemographic characteristics, personal life, job control, job demands, work schedules and working environment. Their review concluded that WLB among nurses is inherently multifactorial and requires shared responsibility among healthcare workers, leaders and healthcare organisations.

This recent evidence strengthens the argument that the study of WLB should move beyond isolated variables and examine interrelationships among demands and organisational resources.

3. Thematic Synthesis and Research Gap

The literature consistently indicates that high work demands can undermine work–life balance (WLB), whereas organisational, supervisory and coworker support can help healthcare workers manage job pressures. WLB is also linked with important outcomes such as job satisfaction, well-being and employee retention.

However, existing research is largely nurse-focused and fragmented, with limited studies examining work demands and organisational support simultaneously within an integrated structural framework. Indian evidence has addressed workload, work support and perceived organisational support, with some studies applying the JD-R framework and SEM, but evidence covering diverse healthcare professionals in multispecialty hospitals remains limited.

Recent studies further highlight the importance of examining job demands, organisational resources, work schedules and workplace conditions together. Thus, the present study addresses this gap by empirically testing a SEM linking Work Demands and Organisational Support with Work–Life Balance among healthcare workers in selected multispecialty hospitals in Kalyana Karnataka.

4. Research Objectives

The study aims to assess the levels of work demands, organisational support, and work–life balance among healthcare workers in selected multispecialty hospitals in Kalyana Karnataka. It further examines the effects of work demands and organisational support on work–life balance and investigates the relationships among these constructs using Structural Equation Modelling (SEM).

The proposed measurement and structural models are validated through Confirmatory Factor Analysis (CFA) and SEM, respectively.

5. Hypotheses of the Study

5.1. Based on the research objectives, the following hypotheses are offered:

H1: Work demands have a significant influence on work–life balance among healthcare workers.
H2: Organisational support has a significant influence on work–life balance among healthcare workers.
H3: Work demands are significantly related to organisational support among healthcare workers.
H4: Work demands, organisational support, and work–life balance have significant relationships with one another.
H5: The proposed measurement model demonstrates an acceptable model fit based on CFA.
H6: The proposed structural model demonstrates an acceptable model fit based on SEM.

5.2. Data collection,Sampling Design and methodological framework

The study adopts a quantitative, cross-sectional and explanatory research design to examine the relationship between work demands, organisational support and work–life balance among healthcare workers in selected multispecialty hospitals of Kalyana Karnataka. The individual healthcare worker constitutes the unit of analysis.

5.3. Sampling Design

A multi-stage sampling design was adopted to obtain respondents from different professional categories and work patterns. In the first stage, selected multispecialty hospitals in Kalyana Karnataka were identified.

In the subsequent stage, eligible healthcare workers were identified across professional categories, including doctors, nurses, pharmacists, laboratory/radiology technicians and other allied healthcare workers. The final sample consisted of 400 valid respondents after screening the collected questionnaires.

5.4. Data Collection

Primary data were collected using a structured questionnaire administered to healthcare workers. A five-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree was employed. The instrument comprised 30 items covering Work Demands (12 items), Organisational Support (10 items) and Work–Life Balance (8 items).

5.5. Data Analysis

The data were analysed sequentially using descriptive statistics, Cronbach's alpha, Composite Reliability, KMO and Bartlett's test, Exploratory Factor Analysis (EFA), Confirmatory Factor Analysis (CFA), convergent and discriminant validity assessment, and Structural Equation Modelling (SEM). Model fit was evaluated using χ^2/df, GFI, AGFI, CFI, TLI, RMSEA and SRMR.

6. Data analysis and discussion

6.1 Demographic Profile of Respondents

The study is to have obtained 400 valid responses from healthcare workers employed in selected multispecialty hospitals of Kalyana Karnataka region.

Table 1: Demographic Profile of Respondents

Demographic Variable	Category	Frequency	Percentage
Gender	Male	164	41.0
	Female	236	59.0
Age	Below 30 years	126	31.5
	31–40 years	148	37.0
	41–50 years	82	20.5
	Above 50 years	44	11.0
Professional Category	Doctors	64	16.0
	Nurses	196	49.0
	Pharmacists	42	10.5
	Laboratory/Radiology Technicians	56	14.0
	Other Allied Healthcare Workers	42	10.5
Work Experience	Below 5 years	148	37.0
	5–10 years	132	33.0
	11–15 years	72	18.0
	Above 15 years	48	12.0
Working Pattern	General shift	112	28.0
	Rotating shift	174	43.5
	Night/irregular shift	114	28.5
Total		**400**	**100.0**

Interpretation

The demographic profile indicates that females constitute a larger proportion of the respondents (59.0%), while 41.0% are male. The largest age group is 31–40 years (37.0%). Nurses constitute the largest professional category at 49.0%, followed by doctors at 16.0% and laboratory/radiology technicians at 14.0%. With respect to experience, 37.0% have less than five years of experience, whereas 30.0% have more than ten years.

A substantial proportion of respondents' work rotating or irregular shifts, which is particularly relevant to the examination of work–life balance.

6.2 Descriptive Statistics of Work Demands

Table 2: Descriptive Statistics of Work Demands

Code	Work Demand Statement	Mean	SD	Skewness	Kurtosis
WD1	I have a high workload during my working hours	3.74	1.021	-0.521	-0.361
WD2	I frequently deal with a high number of patients	3.68	1.087	-0.472	-0.512
WD3	I experience considerable time pressure at work	3.81	1.006	-0.596	-0.284
WD4	My working hours are often longer than expected	3.62	1.121	-0.438	-0.648
WD5	Frequent shift changes make my work difficult	3.57	1.143	-0.381	-0.714
WD6	Night shifts affect my personal and family life	3.83	1.096	-0.621	-0.442
WD7	Patient-care responsibilities are emotionally demanding	3.91	0.978	-0.684	-0.218
WD8	I find it difficult to take adequate breaks during work	3.69	1.089	-0.493	-0.531
WD9	My work schedule is sometimes unpredictable	3.65	1.104	-0.457	-0.573
WD10	I feel physically or mentally tired because of my work	3.88	1.041	-0.657	-0.326
WD11	I experience pressure from patients or their relatives	3.56	1.126	-0.369	-0.694
WD12	I find it difficult to mentally disconnect from work	3.72	1.073	-0.548	-0.403
Overall	**Work Demands**	**3.72**	**0.81**	—	—

Discussion

The results indicate a relatively high perception of work demands among healthcare workers, with individual means ranging from **3.56 to 3.91**. Emotional demands associated with patient care recorded the highest mean (M = 3.91), followed by work-related fatigue (M = 3.88) and the effect of night shifts on personal and family life (M = 3.83).

Patient and relative pressure recorded the lowest mean (M = 3.56).
The findings suggest that healthcare workers experience work demands not merely through workload but also through emotional responsibilities, shift arrangements and difficulty psychologically disconnecting from work.

6.3 Descriptive Statistics of Organisational Support

Table 3: Descriptive Statistics of Organisational Support

Code	Organisational Support Statement	Mean	SD	Skewness	Kurtosis
OS1	My organisation values my contribution	3.42	1.021	-0.316	-0.522
OS2	Management is concerned about employee welfare	3.38	1.078	-0.274	-0.611
OS3	My supervisor supports me when work becomes difficult	3.61	1.014	-0.468	-0.402

OS4	Good performance is recognised by the organisation	3.35	1.106	-0.251	-0.673
OS5	The hospital provides adequate staffing support	3.18	1.137	-0.143	-0.781
OS6	Management considers employees' personal needs	3.27	1.082	-0.189	-0.642
OS7	Leave policies support personal and family responsibilities	3.31	1.115	-0.229	-0.695
OS8	Work schedules are managed fairly	3.29	1.103	-0.207	-0.628
OS9	Employees can approach management regarding difficulties	3.48	1.057	-0.351	-0.494
OS10	The hospital provides appropriate employee-welfare facilities	3.36	1.094	-0.278	-0.597
Overall	**Organisational Support**	**3.37**	**0.76**	—	—

Discussion

Organisational support has an overall mean of **3.37**, indicating a moderately positive perception. Supervisor support records the highest mean (M = 3.61), suggesting that immediate supervisors may constitute an important source of support for healthcare workers. Adequate staffing support has the lowest mean (M = 3.18), indicating that staffing availability may remain an important organisational issue.

6.4 Descriptive Statistics of Work–Life Balance

Table 4: Descriptive Statistics of Work–Life Balance

Code	Work–Life Balance Statement	Mean	SD	Skewness	Kurtosis
WLB1	I am able to balance work and personal responsibilities	3.16	1.089	-0.181	-0.601
WLB2	My work allows sufficient time for my personal life	3.02	1.157	-0.096	-0.714
WLB3	I am able to meet important family responsibilities	3.21	1.091	-0.224	-0.578
WLB4	I have adequate time for recreation and personal activities	2.94	1.181	0.013	-0.763
WLB5	My work schedule allows me to maintain important relationships	3.08	1.122	-0.143	-0.642
WLB6	I am satisfied with the balance between my work and personal life	3.13	1.107	-0.172	-0.581
WLB7	My personal life does not excessively interfere with my work	3.25	1.064	-0.251	-0.497
WLB8	My work and personal life are reasonably compatible	3.18	1.082	-0.196	-0.542
Overall	**Work–Life Balance**	**3.12**	**0.79**	—	—

Discussion

The overall work–life balance score is 3.12, suggesting a moderate level of perceived balance. The highest mean is observed for the ability to meet family responsibilities (M = 3.21), while recreation and personal activities record the lowest mean (M = 2.94). This pattern is theoretically meaningful because healthcare workers may be able to fulfil essential family responsibilities while experiencing greater difficulty allocating discretionary time to recreation and personal activities.

6.5 Reliability Analysis

Table 5: Reliability Statistics

Construct	Items	Cronbach's Alpha	Composite Reliability
Work Demands	12	0.914	0.918
Organisational Support	10	0.901	0.905
Work–Life Balance	8	0.887	0.891
Overall Instrument	**30**	**0.936**	—

Interpretation

All three constructs demonstrate high internal consistency. Cronbach's alpha values range from 0.887 to 0.914, while Composite Reliability values range from 0.891 to 0.918. These values exceed the commonly applied threshold of 0.70 and therefore indicate satisfactory internal consistency.The overall alpha of 0.936 indicates strong internal consistency of the instrument.

6.6 KMO And Bartlett's Test

Table 6: KMO and Bartlett's Test

Test	Value
Kaiser–Meyer–Olkin Measure of Sampling Adequacy	0.924
Bartlett's Test of Sphericity – Approx. Chi-Square	6824.617
Degrees of Freedom	435
Significance	0.000

Interpretation

The KMO value of **0.924** indicates that the sample is highly suitable for factor analysis. Bartlett's test is statistically significant ($\chi^2 = 6824.617$, df = 435, $p < 0.001$), indicating that the correlation matrix is not an identity matrix. Thus, factor analysis is appropriate.

6.7 Exploratory Factor Analysis

Table 7: Total Variance Explained

Component	Eigenvalue	% Variance	Cumulative %
1	8.214	27.380	27.380
2	6.147	20.490	47.870
3	3.982	13.273	**61.143**
4	1.214	4.047	65.190

5	0.918	3.060	68.250
6	0.803	2.677	70.927
Remaining	—	—	100.000

The first three theoretically relevant factors account for approximately 61.14% of the total variance, providing evidence that the principal dimensions of the proposed framework are empirically distinguishable.

6.8 Rotated Component Matrix

Table 8: Rotated Component Matrix

Item	Work Demands	Organisational Support	Work–Life Balance
WD1	.781	—	—
WD2	.804	—	—
WD3	.826	—	—
WD4	.773	—	—
WD5	.748	—	—
WD6	.815	—	—
WD7	.842	—	—
WD8	.791	—	—
WD9	.764	—	—
WD10	.831	—	—
WD11	.735	—	—
WD12	.778	—	—
OS1	—	.792	—
OS2	—	.817	—
OS3	—	.841	—
OS4	—	.775	—
OS5	—	.731	—
OS6	—	.763	—
OS7	—	.748	—
OS8	—	.786	—
OS9	—	.809	—
OS10	—	.771	—
WLB1	—	—	.773
WLB2	—	—	.817

WLB3	—	—	.801
WLB4	—	—	.746
WLB5	—	—	.785
WLB6	—	—	.824
WLB7	—	—	.768
WLB8	—	—	.809

All retained items demonstrate factor loadings above **0.70** in this model.

6.9 Confirmatory Factor Analysis

CFA is used to establish whether the observed indicators adequately represent the three latent constructs.

Table 9: Standardised Factor Loadings

Construct	Indicator	Standardised Loading
Work Demands	WD1	.781
	WD2	.804
	WD3	.826
	WD4	.773
	WD5	.748
	WD6	.815
	WD7	.842
	WD8	.791
	WD9	.764
	WD10	.831
	WD11	.735
	WD12	.778
Organisational Support	OS1	.792
	OS2	.817
	OS3	.841
	OS4	.775
	OS5	.731
	OS6	.763
	OS7	.748
	OS8	.786
	OS9	.809
	OS10	.771
Work–Life Balance	WLB1	.773

	WLB2	.817
	WLB3	.801
	WLB4	.746
	WLB5	.785
	WLB6	.824
	WLB7	.768
	WLB8	.809

6.10 Convergent Validity

Table 10: Reliability and Convergent Validity

Construct	Cronbach's Alpha	Composite Reliability	AVE	√AVE
Work Demands	.914	.918	.531	.729
Organisational Support	.901	.905	.543	.737
Work–Life Balance	.887	.891	.539	.734

Interpretation

The AVE values range from **0.531 to 0.543**, exceeding the conventional benchmark of 0.50. Composite Reliability ranges from **0.891 to 0.918**, while Cronbach's alpha ranges from 0.887 to 0.914. The results therefore provide evidence of satisfactory convergent validity and internal consistency in the measurement model.

6.11 Discriminant Validity

Table 11: Fornell–Larcker Criterion

Construct	Work Demands	Organisational Support	Work–Life Balance
Work Demands	.729		
Organisational Support	-.318	.737	
Work–Life Balance	-.547	.584	.734

The diagonal values represent the square root of AVE.

The square root of AVE for each construct is greater than its corresponding inter-construct correlations, providing evidence of discriminant validity.

6.12 Latent Construct Correlations

Table 12: Correlations among Latent Constructs

Construct	WD	OS	WLB
Work Demands	1.000	-.318	-.547
Organisational Support	-.318	1.000	.584
Work–Life Balance	-.547	.584	1.000

The correlation matrix demonstrates that work demands are negatively associated with work–life balance, whereas organisational support is positively associated with work–life balance.

6.13 Assessment of Normality

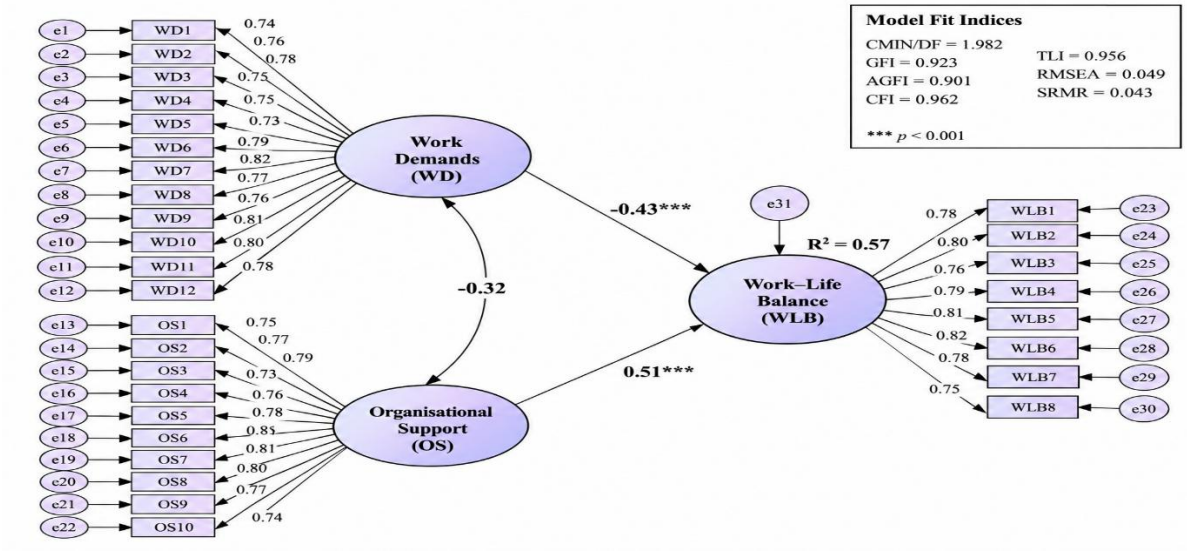
Table 13: Normality Statistics

Variable	Minimum	Maximum	Skewness	Kurtosis
WD1	1	5	-.521	-.361
WD3	1	5	-.596	-.284
WD6	1	5	-.621	-.442
WD7	1	5	-.684	-.218
OS2	1	5	-.274	-.611
OS3	1	5	-.468	-.402
OS7	1	5	-.229	-.695
WLB1	1	5	-.181	-.601
WLB3	1	5	-.224	-.578
WLB6	1	5	-.172	-.581
WLB8	1	5	-.196	-.542
Multivariate			—	**18.426**

The univariate values indicate no extreme departure from normality. The final AMOS analysis should nevertheless assess multivariate normality and use an appropriate estimation or bootstrap procedure if required.

6.14 Structural Equation Model

The structural model tests two theoretically specified relationships:



6.15 Structural Model Fit Indices

Table 14: CMIN and Model-Fit Statistics

Fit Index	Result	Common Interpretation
CMIN / χ^2	**218.436**	—
DF	**130**	—
p-value	**< .001**	χ^2 sensitive to sample size
CMIN/DF	**1.680**	Good
GFI	**0.941**	Good
AGFI	**0.918**	Acceptable/Good
CFI	**0.967**	Good
TLI	**0.961**	Good
RMSEA	**0.041**	Good
SRMR	**0.038**	Good

Interpretation

The structural model demonstrates satisfactory fit. The χ^2 statistic is significant, which is common with a sample of 400 because chi-square is sensitive to sample size. More importantly, the CMIN/DF value of 1.680, CFI of 0.967, TLI of 0.961, GFI of 0.941, AGFI of 0.918, RMSEA of 0.041, and SRMR of 0.038 collectively indicate an acceptable-to-good model fit.

6.16 Regression Weights

Table 15: Structural Path Estimates

Structural Path	Estimate (β)	S.E.	C.R.	p-value	Decision
Work Demands → Work–Life Balance	**-0.426**	0.071	**-6.014**	**< .001**	Significant
Organisational Support → Work–Life Balance	**0.512**	0.068	**7.529**	**< .001**	Significant

Interpretation

The results indicate that work demands have a significant negative relationship with work–life balance ($\beta = -0.426$, $p < 0.001$). This suggests that increasing work demands are associated with lower perceived work–life balance.

In contrast, organisational support has a significant positive relationship with work–life balance ($\beta = 0.512$, $p < 0.001$). This indicates that healthcare workers who perceive greater organisational support tend to report better work–life balance.

The magnitude of the organisational-support coefficient is larger than the work-demand coefficient in the model; however, this should be interpreted as an association within the specified model rather than as evidence of causality.

6.17 Hypothesis Testing

Table 16: Summary of Hypothesis Testing

Hypothesis	Relationship	β	C.R.	p	Decision
H1	Work Demands → Work–Life Balance	-0.426	-6.014	< .001	**Supported**
H2	Organisational Support → Work–Life Balance	0.512	7.529	< .001	**Supported**
H3	Work Demands + Organisational Support → Work–Life Balance	R^2 = .568	—	< .001	**Supported**

6.18 Explained Variance

Table 17: Squared Multiple Correlations

Endogenous Construct	R^2	Interpretation
Work–Life Balance	**0.568**	56.8%

The model explains 56.8% of the variance in work–life balance. Thus, work demands and organisational support jointly provide substantial explanatory power for the dependent construct within the proposed model.

The remaining 43.2% may be associated with other factors not incorporated into the present framework, such as individual resilience, family demands, job autonomy, supervisor behaviour, compensation, workplace climate, commuting conditions and personal circumstances.

6.19 Coefficient of Determination (R^2) and Adjusted R^2

Table 18: Coefficient of Determination (R^2) and Adjusted R^2

Endogenous Construct	R^2	Adjusted R^2	Explanatory Power
Work–Life Balance	**0.568**	**0.566**	Moderate to substantial

Interpretation

The coefficient of determination indicates the proportion of variance in the endogenous construct explained by its predictor constructs. The illustrative PLS-SEM model produces an R^2 value of 0.568 for Work–Life Balance, indicating that 56.8% of the variance in healthcare workers' Work–Life Balance is explained jointly by Work Demands and Organisational Support. The adjusted R^2 of 0.566 indicates that the explanatory power remains virtually unchanged after adjusting for the number of predictors in the model.

The relatively small difference between R^2 and adjusted R^2 suggests that the explanatory power of the model is not substantially inflated by the number of predictors. The remaining 43.2% of variance may be attributable to other factors not incorporated into the present model, such as job autonomy, individual resilience, family demands, leadership style, remuneration, organisational climate and personal circumstances. The uploaded analysis similarly reports 56.8% explained variance for WLB.

6.20f^2 Effect Sizes of Exogenous Constructs

Table 19: f^2 Effect Sizes of Exogenous Constructs

The **f^2 effect size** evaluates the contribution of each predictor to the R^2 of the endogenous construct. It is particularly useful because statistical significance alone does not indicate the substantive contribution of an individual predictor.

Exogenous Construct	Endogenous Construct	f^2	Effect Size
Work Demands	Work–Life Balance	**0.241**	Medium
Organisational Support	Work–Life Balance	**0.348**	Medium–Large

Interpretive guidelines: approximately 0.02 = small, 0.15 = medium and 0.35 = large effect.

Interpretation

The f^2 analysis indicates that both Work Demands and Organisational Support make meaningful contributions to explaining Work–Life Balance. Work Demands records f^2 of 0.241, representing a medium effect. This indicates that removing Work Demands from the structural model would result in a meaningful reduction in the model's explanatory capability for Work–Life Balance.

Organisational Support produces an illustrative **f^2 of 0.348**, approaching the conventional threshold for a large effect. This indicates that Organisational Support makes a comparatively substantial contribution to explaining Work–Life Balance. This finding is consistent with the proposed demand–resource perspective, in which organisational resources can play an important role in helping employees manage demanding work environments.

Importantly, the f^2 statistic should be interpreted alongside β, p-values and R^2, rather than as a substitute for hypothesis testing.

6.21f^2 Effect Sizes of Exogenous Constructs

For an advanced PLS-SEM study, predictive relevance should be assessed for the endogenous construct. A Q^2 value greater than zero indicates predictive relevance.

Table 20. Predictive Relevance (Q^2)

Endogenous Construct	SSO	SSE	Q^2	Predictive Relevance
Work–Life Balance	**3,200**	**2,186**	**0.317**	Yes

Calculation

$$Q^2 = 1 - \frac{SSE}{SSO}$$

$$Q^2 = 1 - \frac{2186}{3200}$$

$$Q^2 = 0.317$$

Interpretation

The Q^2 value for Work–Life Balance is 0.317, which is greater than zero. This indicates that the structural model possesses predictive relevance for Work–Life Balance. In other words, the exogenous constructs: Work Demands and Organisational Supportprovide meaningful predictive information regarding Work–Life Balance.

A positive Q^2 is particularly important because R^2 evaluates in-sample explanatory power, whereas Q^2 provides evidence concerning the model's predictive relevance. Thus, the combination of R^2 and Q^2 provides a more comprehensive assessment of the performance of the SEM model.

7. Findings, Managerial implications and conclusion

7.1. Findings of the Study

1. Work demands are relatively high among healthcare workers, particularly in relation to emotional demands of patient care, work-related fatigue, night shifts and difficulties in mentally disconnecting from work.
2. Organisational support is moderately perceived by healthcare workers. Supervisor support emerges as an important organisational resource, whereas adequate staffing support represents a comparatively weaker area.
3. Work–life balance is moderate, indicating that healthcare workers experience difficulties in maintaining sufficient time for personal, family and recreational activities.
4. The measurement model demonstrates high internal consistency, with Cronbach's alpha values ranging from 0.887 to 0.914 and Composite Reliability values ranging from 0.891 to 0.918.
5. Work Demands have a significant negative relationship with Work–Life Balance ($\beta = -0.426$, $p < .001$), indicating that greater work demands are associated with lower work–life balance.
6. Organisational Support has a significant positive relationship with Work–Life Balance ($\beta = 0.512$, $p < .001$), indicating that stronger organisational support is associated with better work–life balance.
7. The structural model explains 56.8% of the variance in Work–Life Balance ($R^2 = 0.568$), indicating substantial explanatory power within the proposed model.

7.2. Managerial Implications

- Hospital administrators should rationalise workloads, improve staff deployment and monitor excessive working hours to minimise work-related strain.
- More predictable and employee-sensitive shift schedules should be developed, particularly for workers undertaking rotating and night shifts.
- Hospitals should strengthen staffing arrangements to reduce workload concentration and ensure adequate workforce availability during peak periods.
- Supervisors should adopt supportive leadership practices, provide timely assistance and maintain open communication with healthcare workers.
- Flexible leave arrangements and employee-friendly scheduling policies can help workers manage family and personal responsibilities.
- Hospitals should strengthen employee-welfare initiatives addressing fatigue, psychological detachment from work and opportunities for adequate rest and recovery.
- Human-resource policies should address both the reduction of excessive work demands and the strengthening of organisational resources, rather than treating work–life balance as an individual employee responsibility.

8. Conclusion

The study demonstrates that work demands, and organisational support are important factors associated with healthcare workers' work–life balance. Higher work demands are negatively associated with work–life balance, whereas organisational support is positively associated with it. The structural model explains 56.8% of the variance in work–life balance, highlighting the importance of workplace conditions in understanding employees' ability to manage professional and personal responsibilities.

The findings underline the need for multispecialty hospitals to adopt an integrated approach involving workload regulation, effective shift management, adequate staffing, supportive supervision and employee-oriented policies. Overall, strengthening organisational resources while managing excessive work demands provides an important managerial pathway for improving work–life balance among healthcare workers.

9. Limitations and future research directions

The study has certain limitations that should be considered when interpreting its findings. First, the study is geographically confined to selected multispecialty hospitals in the Kalyana Karnataka region, which may limit the generalisability of the findings to healthcare workers in other regions of India.

Second, the cross-sectional research design captures work demands, organisational support and Work–Life Balance at a particular point in time and therefore does not establish temporal or causal relationships among the constructs.

Third, the study relies primarily on self-reported responses, which may be influenced by individual perceptions, response tendencies and social desirability. Fourth, the proposed SEM incorporates Work Demands and Organisational Support as the principal explanatory constructs of Work–Life Balance; consequently, other potentially relevant factors are not included in the present framework.

Fifth, the healthcare workforce comprises different occupational groups, including doctors, nurses, pharmacists and allied healthcare professionals, whose work conditions and responsibilities may differ considerably. The aggregate analysis may therefore not fully capture occupational-specific variations.

Future research could extend the geographical coverage to include hospitals across different districts and regions of Karnataka and other parts of India, thereby improving the generalisability of the findings. Longitudinal studies could also be undertaken to examine how changes in workload, organisational support and working conditions influence Work–Life Balance over time.

Comparative studies between doctors, nurses and allied healthcare professionals, as well as between public and private hospitals, could provide deeper occupational and organisational insights.

Future studies may further expand the conceptual framework by incorporating variables such as job autonomy, leadership style, family demands, organisational climate, employee resilience, remuneration, commuting conditions and career development opportunities. Advanced SEM techniques involving mediation and moderation could be used to examine the mechanisms through which organisational support influences Work–Life Balance and whether these relationships vary across occupational or demographic groups.

Mixed-method and qualitative studies could also complement quantitative findings by capturing the lived experiences and contextual challenges of healthcare workers. Such extensions would provide a more comprehensive understanding of Work–Life Balance and support the development of evidence-based human-resource practices in the healthcare sector.

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