

Workplace Social Capital, Job Satisfaction and
Workplace Performance
in Developed and Developing Countries

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Contents

Abstract	13
Acknowledgment	17
The Author	19
1 Introduction	21
1.1 What is social capital?	22
1.1.1 Workplace social capital	23
1.2 What is job satisfaction?	31
1.3 What is workplace performance?	34
1.4 Individual characteristics	36
1.5 Contextual characteristics	41
1.5.1 Workplace characteristics	41
1.5.2 Other contextual characteristics	43
1.6 Existing relationships of social capital, job satisfaction and workplace performance	45
1.6.1 The relationships of social capital to job satisfaction	45
1.6.2 The effect of job satisfaction on workplace performance	46
1.6.3 The link between social capital and organisational performance	58
1.6.4 Social capital, job satisfaction and workplace performance: charted relationships?	60
1.7 Research gaps	62
1.8 Approach	65
1.8.1 Research questions	67
1.9 Layout of the thesis	68
1.10 Conclusion	70
2 Methodology	71
2.1 Data	71
2.1.1 Developed Countries	73
2.1.2 Developing Countries	75
2.1.3 Other data	79
2.2 Measures	80
2.3 Modelling strategy	83
2.4 Conclusion	86

3	The Settings	89
3.1	Developed countries	89
3.1.1	Europe	89
3.1.2	Britain	93
3.2	The developing country: Indonesia	103
3.2.1	East Java	117
3.3	Conclusion	120
4	Workplace social capital and well-being of workers across Europe	123
4.1	Introduction	123
4.2	Data and method	125
4.3	Results	128
4.3.1	The relationship between workplace social capital and well-being	132
4.3.2	The relationship of workplace social capital and job satisfaction	136
4.4	Discussion	140
4.5	Conclusion	145
5	Workplace social capital and job satisfaction in Britain	149
5.1	Introduction	149
5.2	Data and method	151
5.2.1	Dependent variable	153
5.2.2	Independent variable	154
5.2.3	Method	155
5.3	Results	158
5.4	Discussion	166
5.5	Conclusion	170
6	Workplace social capital and job satisfaction in Indonesia	173
6.1	Introduction	173
6.2	Data and method	175
6.2.1	Data	175
6.2.2	Method	177
6.3	Results	182
6.4	Discussion	189
6.5	Conclusion	195
7	Workplace social capital, job satisfaction and workplace performance in Britain	199
7.1	Introduction	199
7.2	Data and method	202
7.2.1	Data	202
7.2.2	Method	202
7.3	Results	207
7.3.1	General industry	209
7.3.2	Healthcare industry	216
7.4	Discussion	222
7.4.1	General industry	222

7.4.2	The healthcare industry	229
7.5	Conclusion	231
8	Workplace social capital, job satisfaction and workplace performance in Indonesia	235
8.1	Introduction	235
8.2	Data and method	239
8.3	Results	243
8.4	Discussion	252
8.5	Conclusion	258
9	Conclusions	263
9.1	Introduction	263
9.2	Findings	264
9.3	Implications	274
9.3.1	Contributions to the literature	274
9.3.2	Policy makers	276
9.4	Limitations	278
9.5	Directions for future research	280
	Appendices	325
A	Questionnaires for Indonesia (in Indonesian language)	325
A.1	Hospital characteristics	325
A.2	Hospital performance	355
A.3	Employee profile	362
A.4	Employees survey	366
B	Participant consent form	383
C	Districts and public hospitals surveyed in East Java	385
D	Unimputed results of Chapter 4	387
E	Regression models for Chapters 7 and 8	391
F	Codes for Chapter 4	397
F.1	Data preparation	397
F.2	Modelling	400
F.2.1	Unimputed models	400
F.2.2	Imputed models	401
F.3	Codes for graphs	402
F.3.1	Graphs for well-being, job satisfaction, social capital	402
F.3.2	Europe map	403
G	Codes for Chapter 5	405
G.1	Stata codes	405
G.1.1	Data preparation for WERS2011	405

G.1.2	Analysis	408
G.2	Mplus codes	409
H	Codes for Chapter 6	411
H.1	Stata codes	411
H.1.1	Data preparation for Indonesia	411
H.1.2	Analysis	414
H.2	Mplus codes	416
H.2.1	Factor analysis	416
H.2.2	Modelling	417
I	Codes for Chapter 7	419
I.1	The general industry	419
I.1.1	Financial performance	419
I.2	The healthcare industry	421
I.2.1	Productivity	421
J	Codes for Chapter 8	423
J.1	The subjective performance	423
J.1.1	Financial performance	423
J.2	The objective performance	425
J.2.1	Revenue per bed	425
	Word count: 58,795	

List of Tables

1.1	Social capital: definitions, forms and measurements	25
1.2	Social capital questions	31
1.3	Studies on workplace social capital, job satisfaction and workplace performance	47
2.1	Data used	72
2.2	Samples for Europe	73
2.3	Samples for Britain	74
2.4	Samples for Indonesia	76
3.1	GDP and health expenditure in Britain	97
3.2	Basic demographic indicators of selected European countries (2013)	98
3.3	Hospital beds and health workers density in EU, 2012	98
3.4	NHS Workforce* 2008-2013	99
3.5	GDP and health expenditure in Indonesia	105
3.6	Basic demographic indicators of ASEAN member states	105
3.7	Hospital beds and health workers density in ASEAN	106
3.8	Health education and their degrees as of 2010	108
3.9	Quality of public health services in 1997 & 2007	109
3.10	Hospital in Indonesia in 2012	114
3.11	Hospital in East Java in 2012	119
4.1	Sample characteristics and bivariate relationships (40,533 workers in 400 regions of 34 countries)	130
4.2	Activities outside work for workers (40,533 workers in 400 regions of 34 countries)	131
4.3	Multilevel models predicting well-being of workers in Europe - complete results	134
4.4	Multilevel models predicting job satisfaction in Europe - complete results	138
5.1	Analytic sample	152
5.2	Factor analysis of the variables with rotated factor loadings	156
5.3	CFA results	157
5.4	Job satisfaction in Britain - complete results	162
5.5	Job satisfaction in British healthcare industry - complete results	163
5.6	ICC for individual items	166
6.1	Analytic sample	176

6.2	Factor analysis of the variables with rotated factor loadings	179
6.3	CFA of job satisfaction and social capital in Indonesia	180
6.4	Social capital and job satisfaction in Indonesia	187
6.5	ICC of individual items	189
7.1	CFA of job satisfaction and social capital - general industry	204
7.2	CFA of job satisfaction and social capital - the healthcare industry	205
7.3	Workplaces in WERS2011	208
7.4	Bivariate analysis - general industry	209
7.5	Workplace social capital, job satisfaction and workplace performance in Britain (1) - structural model	212
7.6	Workplace social capital, job satisfaction and workplace performance in Britain (2) - structural model	213
7.7	Intraclass correlations (ICCs) for individual items - general industry	215
7.8	Bivariate analysis - the healthcare industry	216
7.9	Workplace social capital, job satisfaction and workplace performance in the healthcare industry (1) - structural model	218
7.10	Workplace social capital, job satisfaction and workplace performance in the healthcare industry (2) - structural model	219
7.11	Intraclass correlations (ICCs) for individual items - healthcare industry	220
7.12	Reaction related to recession and management changes in Britain	227
8.1	Comparison of studies on social capital and workplace performance in developing countries	238
8.2	Analytic sample	239
8.3	Individual CFA of social capital and job satisfaction in Indonesia	241
8.4	Bivariate analysis of workplace performance	244
8.5	Social capital, job satisfaction and objective workplace performance in Indonesia (1)	247
8.6	Social capital, job satisfaction and objective workplace performance in Indonesia (2)	248
8.7	Social capital, job satisfaction and subjective workplace performance in Indonesia	249
8.8	ICC of individual items	252
9.1	Overview of results on studies between workplace social capital, job satisfaction and workplace performance	271
D.1	Multilevel models predicting well-being of workers in Europe	388
D.2	Multilevel models predicting job satisfaction in Europe	389
E.1	Workplace social capital*, job satisfaction* and workplace perfor- mance in Britain - regression models ¹	392
E.2	Workplace social capital*, job satisfaction* and workplace perfor- mance in British healthcare industry - regression model ²	393
E.3	Social capital*, job satisfaction and subjective workplace performance in Indonesia (1) - ordered probit regression model	394

E.4	Social capital*, job satisfaction* and subjective workplace performance in Indonesia (1) - ordered probit regression model	394
E.5	Workplace social capital*, job satisfaction* and objective workplace performance in Indonesia (1) - linear regression model	395
E.6	Workplace social capital*, job satisfaction and objective workplace performance in Indonesia (1) - linear regression model	396

List of Figures

Figure 1.1 Framework of the study	66
Figure 2.1 Hospitals in <i>Jawa Timur</i> (East Java) based on class	78
Figure 3.1 GDP and unemployment in Europe 2008-2013	90
Figure 3.2 Unemployment in Europe by gender 2008-2013	91
Figure 3.3 GDP and unemployment in Britain 2008-2013	94
Figure 3.4 Unemployment in Britain by gender 2008-2013	95
Figure 3.5 Employment in selected industries 2007-2013	96
Figure 3.6 Distribution of health workers in Indonesia (2014)	110
Figure 3.7 Density of health workers in Indonesia (2014)	111
Figure 3.8 Distribution of healthworkers in East Java (2014)	118
Figure 4.1 Well-being of workers across regions (NUTS 2) in Europe	133
Figure 4.2 Job Satisfaction of workers across regions (NUTS 2) in Europe	137
Figure 5.1 Multilevel SEM model for job satisfaction in Britain	158
Figure 5.2 Social capital in Britain	159
Figure 5.3 Job satisfaction in Britain	160
Figure 6.1 Multilevel SEM model for job satisfaction in Indonesia	181
Figure 6.2 Job satisfaction in East Java	183
Figure 6.3 Vertical social capital in East Java	183
Figure 6.4 Horizontal social capital in East Java	184
Figure 7.1 Workplace social capital, job satisfaction and workplace performance in Britain	207
Figure 8.1 Workplace social capital, job satisfaction and workplace performance in Indonesia	242

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Doctor of Philosophy

**Workplace social capital, job satisfaction and workplace performance
in developed and developing countries**

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Abstract

Although social capital had been found to solve collective action problems, social capital at work or workplace social capital has only recently begun to be researched. This is noteworthy given that most of our waking hours are spent in the workplace. While workplace social capital is suggested to improve workplace performance, job satisfaction had been found to improve workplace performance. However, workplace social capital and job satisfaction have never been examined together with regard to workplace performance. Furthermore, most studies on workplace performance have focused on developed countries with evidence from developing countries is lacking.

The aims of this thesis were to investigate 1) whether workplace social capital affects job satisfaction; 2) the relationship of social capital, job satisfaction and workplace performance; 3) whether individual characteristics differ in determining job satisfaction in developed and developing countries; and 4) whether context of organisations in developed and developing countries differ in determining the relationship of social capital, job satisfaction and workplace performance. To achieve those aims, this thesis selects two sets of secondary data representing developed countries: EWCS2010 in Europe combining workers with their regions and countries and WERS2011 in Britain linking workers to their workplaces; while primary data from a developing country have been gathered from public hospitals in Indonesia associating workers with workplaces. As such, this thesis exploits two approaches using structural equation modelling in multilevel models. First, the customary Macro-micro approach is used to examine the relationship between workplace social capital and job satisfaction treating both variables as latent constructs. Second, the less common micro-Macro approach is exercised to investigate the relationship between workplace social capital, job satisfaction and workplace performance.

Results from developed countries show that workplace social capital is positively associated with individual outcomes such as job satisfaction and well-being even in times of financial crisis. Comparing the results between developed and developing countries, workplace social capital is positively significantly associated with job satisfaction in Britain and in Indonesia. With regard to higher level outcomes, workplace social capital is associated with better financial performance, while job satisfaction is associated with higher quality in British general industry. Turning to results from Indonesia, workplace social capital is associated with lower expenditure per bed; job satisfaction, however, failed to be associated with any workplace performance measures. Several individual and workplace characteristics in both developed and developing countries have similar influences on job satisfaction and workplace performance. Nevertheless, there are some contrasting results regarding the influence of those characteristics in developed and developing countries.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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The Author

I hold a bachelor degree in Accounting from University of Indonesia. For my thesis, I gathered responses from auditors and management of Indonesian listed companies to measure the audit expectation-performance gap in Indonesia. After a year working in an accounting firm and another year in a private management institute in Indonesia, I then continued my study at The University of Leeds getting an MBA as I explored the possibility of Ghanaian cashew fruit juice to be marketed in the United Kingdom for my thesis.

Completing my study in Leeds, I subsequently returned to work for the management institute and I was mostly responsible for managing and delivering executive training programmes. I worked there for more than a decade before I joined the doctoral programme in The University of Manchester in 2011. I collected data from Indonesian public hospitals in East Java during summer 2013 to answer my research questions, in addition to the use of secondary data from both European and British workers.

Using other data from Indonesia, I co-authored a paper with my colleague, Asri Maharani, and my supervisor, Gindo Tampubolon. The paper titled “Decentralization in Indonesia: lessons from cost recovery rate of district hospitals” is published in *Health and Policy Planning* (2014). eScholarID:225087. DOI:10.1093/heapol/czu049.

Chapter 1

Introduction

Social capital, understood as a combination of networks, norms and trust, is often seen as a solution to collective action problems (Putnam et al., 1993). The role of social capital as a solution is integral in many domains and its efficacy as such has been consistently documented. In the domain of politics, Putnam's works have been influential. In the context of business management, the discussion revolves around trust and its relationship with business performance (Rose, 2000; Sako, 1998). This raises the potential for social capital to reduce transaction costs in day-to-day workplace activities, which then can lead to improved workplace performance with particular emphasis on such measures as higher productivity (Bandiera et al., 2009) and learning and innovations (Nahapiet and Ghoshal, 1998; Sako, 1998).

However, the association between social capital and individual outcomes has rarely been investigated within the workplace. Many of the recent empirical and theoretical analyses of social capital have concentrated on interactions in families and communities, with only limited consideration of the nature and consequences of social capital in the workplace. This is puzzling given that we spend such large proportion of our waking hours in the workplace (Green, 2006; Warr, 2007). Collecting evidence about social capital in the workplace is likely to prove worthwhile as earlier research has showed the great importance of social capital to subjective well-being.

Job satisfaction, a specific domain of well-being in the workplace, is certainly

an important subject deserving research attention; as Web of Science showed 12,155 publications on job satisfaction appearing since 1900. Most studies look into job satisfaction in developed countries, such as Australia (Barling et al., 2003), the United States (US) (Harter et al., 2002; Ostroff, 1992), Canada (Lowe and Schellenberg, 2001; Zatzick and Iverson, 2011), Spain (Requena, 2003), Hong Kong (Yee et al., 2008) and Britain (Jones et al., 2009; Wood et al., 2012). Each of the aforementioned studies investigated the relationship between job satisfaction and diverse workplace performance measures and found that job satisfaction affects the workplace performance. However, examinations of the relationships between social capital, job satisfaction and individual or workplace outcomes in developed countries, let alone the developing countries, remain sparse.

This doctoral thesis will consider social capital, job satisfaction and workplace performance and their relationships in different economies. This introductory chapter begins by surveying previous research; it then identifies research gaps, describes the approach to be used and finally establishes the potential of this research to make a significant contribution to the body of literature and its implications.

1.1 What is social capital?

Putnam (1993, p.35) defined social capital as ‘features of social organization, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit’. Social capital can develop in any relationships or networks among individuals, such as family members, friends, neighbours, peers and colleagues; in religious places such as churches, or in civic associations (Helliwell and Putnam, 2004). Socialising with friends has been shown to improve one’s health (Verhaeghe and Tampubolon, 2012; Verhaeghe et al., 2012), while the presence of dense social networks in a neighbourhood can prevent crime, benefitting those in the area (Helliwell and Putnam, 2004). In addition, communities with high social capital measured in terms of civic involvement and social solidarity are better with their

representative governments (Putnam, 1993). Meanwhile, in terms of the economic development of a region, the norms of reciprocity and trust support efficiency as community members help each other and know that they can rely on others for future assistance (Knack and Keefer, 1997; Putnam, 1993). In addition, civic involvement provides a reference for future collaboration as networks and trusts have been built into the engagements (Knack and Keefer, 1997; Putnam, 1993). Coleman (1988) argued that social capital is just like any other forms of capital: it is productive and it contributes to the achievability of goals. However, unlike other forms of capital, social capital is a public good; everyone involved in the networks of trust can capitalise on it (Putnam et al., 1993). As social capital is used, it becomes increasingly abundant and self-reinforcing.

Community and social organisations are examples of social structure as described by Lin (2001). Lin further elaborated that a social structure consists of a set of social positions that are hierarchically related relative to the authority entrusted to people in those social positions; the individuals are then bound by certain rules and procedures. Although those who hold the positions are expected to act in accordance with the rules and procedures for the good of the social structure collectively, there is always a possibility that some individuals may place their own interests above those of the group or misinterpret the rules. According to Lin's definition, the workplace is also a social structure as it covers all of the aspects mentioned; however, empirical examinations of social capital in workplaces have begun to appear only in recent years (Lee, 2009). The next subsection will describe social capital in the workplace, or workplace social capital, for the purpose of this thesis.

1.1.1 Workplace social capital

Similar to the social capital seen in the community, workplace social capital consists of trust, norms, obligations, network ties and shared language among workers that enable them to work together for their organisations (Leana and van Buren, 1999;

Nahapiet and Ghoshal, 1998). Social capital in the workplace provides resources within a social structure that can be used by workers to achieve their interests (Coleman, 1988; Lin, 1999) which may also benefit the workplace as a whole as social capital is used through workers' social relations within the workplace (Leana and van Buren, 1999).

Different authors use different definitions of workplace social capital. Nahapiet and Ghoshal (1998) differentiate workplace social capital into three types: structural, relational and cognitive. The first type, structural social capital, refers to overall connections between individuals in the organisation, such as who one reaches and how (Burt, 1992). These connections show the existence of networks and an appropriate organisation built for one purpose but possibly useful for another purpose (Coleman, 1988). The second type, relational social capital describes the personal relationships formed between individuals through interactions (Granovetter, 1992). Trust, norms, obligation and identification are important facets of this type of social capital. The third type is cognitive social capital, which refers to shared language, codes and narratives within organisations.

Flap and Völker (2001) viewed social capital as the network that an individual has and the position of an individual in that network. They distinguish types of social capital within the workplace as cohesive social capital, structural holes and a bow-tie structure. The cohesive social capital exists when every individual is connected in the network (Coleman, 1988). In contrast, the structural holes consist of individuals connected with an individual but those other individuals are not connected to each other (Burt, 1992). Lastly, an individual may become a link for several separate cliques in the workplace in a bow tie structure (Krackhardt, 1999). Flap and Völker (2001) measured workplace social capital using nine questions about their colleagues for work-related and outside work matters. Agneessens and Wittek (2008) also use social relationships among colleagues as workplace social capital.

Table 1.1: Social capital: definitions, forms and measurements

Definition	Types/Forms	Measurement tools
Social capital is a variety of different entities, with two common elements: having some aspect of social structures and facilitating certain actions of actors, whether persons or corporate actors, within the structure (Coleman, 1988)	Obligations, expectations, trustworthiness of the structure, information channels, norms and effective sanctions	Not discussed
Social capital is features of social organization that facilitate coordination and cooperation for mutual benefit (Putnam et al., 1993)	Networks, norms, and trust	Civic engagement (voter turnout, newspaper readership, membership in choral societies and literary circles)
Social capital investment in social relations by individuals through which they gain access to embedded resources to enhance expected returns of instrumental or expressive actions (Lin, 1999)	composition (resource characteristics), heterogeneity (resources diversity) and upper reachability (best possible resources)	the name generator and the position generator
Social capital is the sum of the actual and potential resources embedded within, available through and derived from the network of relationships possessed by an individual or social unit (Nahapiet and Ghoshal, 1998)	Structural: density, connectivity and hierarchy Relational: personal relationships Cognitive: shared languages and codes	No measurements proposed
Social capital is a resource reflecting the character of social relations within the organization, realized through members' levels of collective goal orientation and shared trust (Leana and van Buren, 1999)	Associability and trust	Not discussed

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Definition	Types/Forms	Measurement tools
Horizontal associations among people who have effect on the productivity of the community according to Putnam et al. (1993) and a variety of different entities consisting of social structure which facilitate certain actions of actors within the structure as defined by Coleman (1988) (Serageldin and Grootaert, 1999)	Horizontal and vertical social capital	Not discussed
Social capital is personal networks as a means to achieve individual goals and the position someone has in the network of relationships (Flap and Völker, 2001)	Horizontal social capital: cohesive networks (Coleman, 1988), structural holes (Burt, 1992) and bow-tie structure (Krackhardt, 1999) (horizontal)	Name-generator based on nine questions
Social capital is the structure and context of individuals' networks and density of interaction (Kouivonen et al., 2006)	1. Structural social capital and cognitive social capital 2. Bonding, bridging and linking social capital	Psychometric evaluation using eight questions based on the inequality of social capital efficacy (Wilkinson, 2005)
Social capital is social relationships in organisations (Agnessens and Wittek, 2008)	Interpersonal trust among colleagues	Colleague closeness

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Table 1.1 – continued from the previous page

Definition	Types/Forms	Measurement tools
Bonding social capital refers to trusting and co-operative relations between members of a network with similar social identity. Bridging social capital, by contrast, comprises relations of respect and mutuality between people with dissimilar social identity. Linking social capital as norms of respect and networks of trusting relationships between people who are interacting across formal or institutionalized power in society. (Oksanen et al. (2010) following Szreter and Woolcock (2004))	Horizontal social capital (bonding and bridging social capital) and vertical social capital (linking social capital)	Eight questions by Kouvonon et al. (2006)
<i>This research</i> The relations of trust between individuals at similar and across hierarchical levels in the workplace	Horizontal social capital and vertical social capital (Oksanen et al., 2010)	Eight questions by Kouvonon et al. (2006)

Whilst the position of an individual in the social structure suggests that the concept of social capital comprises at least two dimensions: vertical and horizontal social capital (Engstrom et al., 2008; Serageldin and Grootaert, 1999). The vertical component refers to norms of respect and networks of trusting relations between people interacting across levels of formal or institutionalised power in society, also known as linking social capital. The horizontal component refers to the relations of trust and reciprocity between individuals and groups at the same hierarchical level, known as bonding and bridging social capital. In the work context, the vertical component refers to employees' relationships with their employers and supervisors, whereas the horizontal component refers to social contacts, friendships, cooperation and trust in relation to co-workers (Kouvonen et al., 2006).

Table 1.1 summarises definitions, forms and measurements used for social capital from previous studies. The table shows that different studies use different types of workplace social capital. Although there are different types of workplace social capital, they all represent social structure within the workplace and they enable individual's actions within the structure (Coleman, 1990 in Nahapiet and Ghoshal (1998); Lin (1999)). Any studies should remember these two points as they capture the essence of workplace social capital. Another point to remember is social capital is based on social relationships among individuals which include trust. Although Nahapiet and Ghoshal (1998) clearly defined three types of social capital, they admitted that those types are interrelated. Later types of social capital have embodied the structure, relations and sometimes cognitive dimension in their definitions such as bonding, bridging and linking social capital or vertical and horizontal social capital.

Previous studies commonly use the name generator approach as the means to measure the workplace social capital as Flap and Volker (2001) and Agneessens and Wittek (2008) did. However, this tool emphasises on the network and resources that other person has to offer to the respondents of the study. This tool seems to put the

respondent as the passive actor in the building of social capital. Whilst workplace is a specific social structure where workers spend most of their waking hours, workers may actively seek to build social relationships. To build such relationships, trust and reciprocity are essential and trust is not automatically gained in workplaces. Trust is built by establishing a history of interactions; it can only be drawn on once it has been created. Initial interactions may weigh the benefits and costs of maintaining a relationship, which renders trust is very fragile at the earliest stage (Lewicki and Bunker, 1996). At this point, individuals tend to prevent the negative consequences of not trusting (Shapiro et al., 1992). After this stage, trust relies on information built on regular communication and intense development of the relationships (Shapiro et al., 1992) which make trust stronger when there is an inconsistency in behaviours. The last stage is known as the identification-based trust; at this point, trust exists based on mutual understanding of each individual's desires and intentions. This may encourage effective acts on the part of people involved in the relationships (Lewicki and Bunker, 1996).

Apart from the difficulty of creating trust within the workplace, maintaining such trust can also be problematic. Helliwell et al. (2009b) explored possible reasons for failure to maintain trust within workplaces. First, the management may institute several means to prevent misconduct that unconsciously reduce trust within the workplace. Second, the management may mistakenly assume that economic rewards; such as pay are of paramount importance for their employees. In addition, they may prioritise short-term profits over developing good relationships; this may be due to the difficulty of choosing intrinsic needs over extrinsic desires for future advantage (Frey and Stutzer, 2014).

Leana and van Buren (1999) identified several advantages and disadvantages for maintaining of social capital in workplaces. The first advantage is that strong social capital encourages workers to become and remain highly involved in their work according to their roles in the organisation. This high level of involvement

may lead to more commitment toward the organisation. Second, workers commit not only to their workplaces, but also to other members which can ease progress toward common goals since workers may participate in collective actions. Lastly, intense relationships among members facilitate information and knowledge, which in turn leads to the development of intellectual capital (Nahapiet and Ghoshal, 1998).

With regard to the disadvantages of maintaining social capital, the first is that doing so may increase costs to cultivate the existing relationships and norms in the organisation (Brien and Smallman, 2011; Nahapiet and Ghoshal, 1998). Rapid climbing of the managerial ladder due to opportunities available may mean that managers lack the time to cultivate an appropriate managerial style that contributes to the development of their own and their employees' social capital (Brien and Smallman, 2011). Developing an appropriate managerial style requires time and effort, which will translate to costs for the organisation. Second, the existence of strong relationships within the organisation may also hinder innovations since such relationships may become a source of resistance to change (Lin, 2001; Nahapiet and Ghoshal, 1998). Third, strong relationships within highly cohesive management teams may hamper the achievement of improvements to the organisation. Highly cohesive management teams may restrain from challenging one another which then discourage innovations and support the wrong ideas (Prusak and Cohen, 2001). Despite the balances of advantages and disadvantages revealed in these studies, the researchers do not propose any means of measuring social capital.

In order to proposing a method of measurement, Kouvonen et al. (2006) explores the use of eight questions to measure social capital at the workplace. These questions represent bonding, bridging and linking social capital and at the same time reflect the cognitive and structural social capital. The components of cognitive social capital are the values, norms and reciprocity in the social networks, while structural social capital refers to the social networks that yield accessibility to resources (Harpham et al., 2002; Kouvonen et al., 2006; Subramanian et al., 2003).

The researchers find that these measures are a valid tool of measuring social capital, and Oksanen et al. (2010) use the questions to measure the vertical and horizontal social capital. They find that five questions relate to horizontal social capital whilst three questions measures vertical social capital. Table 1.2 below shows the questions used by Oksanen et al. (2010) to measure workplace social capital.

Table 1.2: Social capital questions

Items	Horizontal social capital	Vertical social capital
●People feel understood and accepted by each other	✓	
●People in the work unit cooperate in order to help develop and apply new ideas	✓	
●Do members of the work unit build on each other’s ideas in order to achieve the best possible outcome?	✓	
●We have a ‘we are together’ attitude	✓	
●People keep each other informed about work-related issues in the work unit	✓	
●Our supervisor treats us with kindness and consideration		✓
●Our supervisor shows concern for our rights as an employee		✓
●We can trust our supervisor		✓

Source: Kouvonen et al. (2006); Oksanen et al. (2010)

However, they then use both forms of social capital to predict various health problems among workers such as depression, mortality, hypertension, smoking and job strain (Oksanen et al., 2011a,b; Sapp et al., 2010). None of these studies uses the social capital measures to predict job satisfaction or workplace performance.

1.2 What is job satisfaction?

Job satisfaction is defined as a ‘pleasurable or positive emotional state resulting from the appraisal of one’s job or job experience’ (Locke, 1969, p.316). In the study of organisation and job satisfaction, job satisfaction emerged in the motivation-hygiene theory of Herzberg where job satisfaction and job dissatisfaction are produced by different work factors focusing on the worker’s needs fulfillment (Herzberg, 1974). Satisfaction from work comes from the content of the job, such as sense of achievement, recognition for achievement, work itself, responsibility, advancement

and growth; while dissatisfaction with work comes from the context of the jobs, such as working conditions and company policies. However, this need perspective tend to be criticised and replaced by the non-need perspective on job satisfaction (Hurlbert, 1991; Kalleberg, 1977). In contrast to Herzberg, Kalleberg (1977) explained that Locke's definition of job satisfaction consists of two factors: the job characteristics and the values that the workers attach to those characteristics. The values depend on not only demands and opportunities in the job, but also its consequences (Warr, 2007). Thus, although job satisfaction is an overall feeling of one's job, it is assessed through an examination of various aspects of the job. An awareness of this point is important in the present study. Moreover, workers compare their expectation with their jobs (Green, 2006) and also compare their experiences between past jobs and the current job (Lévy-Garboua and Montmarquette, 2004) when asked about job satisfaction.

Job satisfaction may be measured using either the global approach or the facet approach. The global approach uses a single question to measure the overall job satisfaction, while the facet approach employs different facets of the job to be measured (Spector, 1997). The facet approach will help organisations to identify important job aspects for the workers. There are scales commonly used by researchers to assess job satisfaction: the Job Satisfaction Survey (JSS) with nine facets of job satisfaction: pay, promotion, supervision, benefits, contingent rewards, operating procedures, co-workers, nature of work and communication (Spector, 1997); the Job Descriptive Index (JDI) uses five facets: work, pay, promotion, supervision and coworkers (Smith et al., 1969); the Minnesota Satisfaction Questionnaire (MSQ) has twenty facets including independence, supervision, coworkers, authority, advancement and recognition (Weiss et al., 1967), while the Job Diagnostic Survey (JDS) has growth, pay, security, social and supervision (Hackman and Oldham, 1976).

Green (2006) discussed skill, discretion, work effort, pay and security as aspects of job satisfaction. Investigating workers' skills, Allen and van der Velden (2001)

found that workers whose jobs are mismatched with their skills are dissatisfied. In contrast, those who have autonomy over their jobs are more satisfied (Hackman and Oldham, 1976; Karasek, Jr, 1979). Similarly, more work effort is associated with job dissatisfaction (Jeurissen and Nyklicek, 2001) and pay is modestly associated with higher job satisfaction, although pay from a job can provide for the family or buy pleasures (Warr, 2007). Lastly, job insecurity is commonly associated with job dissatisfaction (Green, 2006). Using data from the Work Employment Relationship Survey 2011 (WERS2011) in Britain, this doctoral research uses more or less similar facets mentioned by Herzberg (1974) and included in those aforementioned job satisfaction scales. Job satisfaction will be measured through pay, training received, opportunity to develop skills, sense of achievement, scope of using own initiative, influence over job, job security and work itself.

Although the facet approach may give more information than the global approach by indicating the importance of job aspect for workers to help the organisation, most surveys use existing job facets such as JSS, JDI, JDS or MSQ when they collect data on job satisfaction. This approach may be costly for the researchers (and the organisation) as they only get similar job satisfaction facets for different industries. This data collection assumes that every job in every industry has similar sets of job aspects. This assumption may still be debatable. To be able to elaborate more, researchers may need to develop facets in accordance with the industry investigated by modifying the existing scales. However, developing facets of job satisfaction require knowledge, effort, time and validation which may not always available for each research.

Job satisfaction is also considered a measure of well-being in a specific domain, work, based on its breadth of scope (Warr, 2007). The broadest scope of well-being is the context-free well-being known as life satisfaction (Warr, 2007). Diener (2000) refers to well-being as an individual's evaluation of his or her life both cognitively and affectively. Well-being may also include life satisfaction, satisfaction in a specific

domain (such as job satisfaction) or a particular facet (such as satisfaction with pay), positive affect, and low levels of negative affect (Diener et al., 1999; Diener, 2000; Warr, 2007). Job satisfaction has been found to contribute to life satisfaction, which is not surprising given that individuals spend on average one-third of their days in the workplace (Helliwell and Huang, 2010; Keon and McDonald, 1982; Tait et al., 1989). Although life satisfaction is included in well-being, this thesis uses the terms ‘life satisfaction’ and ‘well-being’ interchangeably.

Well-being also stems from relationships such as marriage, kinship and friendship. Marriage and kinship offer social support and emotional protection for individuals (Allan, 1996; Argyle, 2001; Diener et al., 1999; Merz et al., 2009; Ochieng, 2011), while friendships provide mutual understanding, caring and respect (Diener and Biswar-Diener, 2008). Friendships, as a form of social relation, can also thrive in a workplace since workers are increasingly spending a significant proportion of their day in the workplace (Parris et al., 2008). As well-being and job satisfaction are related and social relations take place both in specific and general domains, one chapter (Chapter 4) of this thesis can explore both using data from Europe.

1.3 What is workplace performance?

Workplace performance is considered as business outcomes (Harter et al., 2002) or ‘social and economic outcomes resulting from the interplay among on workplace’s attributes, actions, and environment’ (Combs et al., 2005, p.261). As businesses vary, workplace performance takes different measures according to the sector of industry or field of study (Jones et al., 2009). These different measures reflect the multidimensional workplace performance (Combs et al., 2005). There are financial measures such as profits, share price, turnover/sales, and dividend yield as well as productivity measures such as labour productivity, efficiency scrap rates, organisational effectiveness, occupational injuries; quality measures for products and services such as customer satisfaction and reliability; and human resource perspectives that

consider labour turnover, absenteeism and job satisfaction (Barling et al., 2003; Grugulis and Stoyanova, 2011; Korunka et al., 2003; Ostroff, 1992). Most of these measures are objective, however, there are other measures referred to as perceived (subjective) organisational performance based on the management's assessment of its organisation's performance compared to that of competitors in the industry, such as those used in WERS in Britain. Likewise, job satisfaction may also individually assessed by employee. These various performance measures are used in studying partial relationships of social capital, job satisfaction and workplace performance and will be elaborated upon in the next section (section 1.6).

Literature shows that different studies use different measures of workplace performance depending on industries and data availability. The preferred measure is the objective performance as it provides non-bias measurement. However, objective workplace performance data (profits, sales, etc.) may not always be available other than those for public listed companies as it is a sensitive or sometimes confidential issue. This issue is more problematic in developing countries as policy makers may not be aware the importance of keeping and publishing such data. Hence, researchers alternatively use subjective performance measures for workplace performance. Using this method, the managers or the employees are asked to assess their workplace performance based on their knowledge. However, the quality of the response heavily depends on that person's familiarity with the measure (Wall et al., 2004). Although previous studies found that there are similarities in answers between subjective measures and subjective measures (McCracken et al., 2001; Forth and McNabb, 2008; Wall et al., 2004), finding the right person to assess the workplace performance and finding the right measurement for each industry to study pose a challenge for researchers. To overcome this problem, national surveys use generic terms such as financial performance, productivity and quality for example. Nevertheless, these generic terms may have different measures in different industries, which may temporarily resolve the problem of performance measurement, but

it needs cautious interpretation for different industries and in different economies.

Workplace performance depends on the fit of workplace resources to the workplace environment (Makkonen et al., 2014). A workplace can opt to adapt to the changing environment in order to survive. The ongoing economic crisis has contributed to a number of environmental changes that influence workplace performance. The economic crisis has in some cases weakened demand for goods or services which in turn lowers workplace performance in terms of finances and productivity. However, workplaces with a strong market presence and customer loyalty are able to maintain crisis levels of performance similar to those found in normal economic condition (Notta and Vlachvei, 2014). Most importantly, workplaces that are able to adjust to the changing environment are successful in overcoming the crisis (Makkonen et al., 2014). In addition, workplaces may capitalise on stakeholder trust in order to survive the economic crisis (Lins et al., 2015).

Workplace survival and performance in different economies may vary according to resource availability and institutions (Makino et al., 2004). In the developing countries, the government takes the role of allocating resources more than any other entity (Karabag and Berggren, 2013; Yaprak and Karademir, 2010). The institutional environment in developing countries is typically characterised by extensive state intervention in business and a lack of effective mechanisms to enforce contracts among others (Khanna and Palepu, 1997). However, Knack and Keefer (1997) found that when formal institutions are unreliable, interpersonal trust or social capital may replace it in economic activity. Reflecting on the economy success of some Asian countries, Biggart and Hamilton (1992) showed that social relationships tend to be institutionalised in these countries.

1.4 Individual characteristics

As explained previously, job satisfaction is individualistic as it considers one's feeling. Green (2006) emphasises that an individual's personality, aspects of his or her

job, and the match between the job and the individual determine job satisfaction. Previous studies have investigated the relationship of job satisfaction with both personal and job characteristics. Personal characteristics include gender, age, marital status, health, education and skill, while job characteristics involve rank/position, tenure, employment contract, income, advancement opportunities, the size of the organisation and its formal status.

Women experience higher levels of job satisfaction as they have lower expectations from their jobs, a situation resulting from women's traditionally poor position in the labour market (Clark and Oswald, 1996; Clark, 1997) and the flexibility they have customarily sought because their need to balance responsibilities at work and at home (Bender et al., 2005). Both young and older employees tend to have higher job satisfaction than those in between (Clark et al., 1996); married employees usually reported higher job satisfaction as married individuals are generally happier than those who are single or separated (Dolan et al., 2008). Higher job satisfaction is also more prominent among employees without health problems (Clark et al., 1996; Gazioğlu and Tansel, 2002). Healthy employees may experience fewer obstacles in the performance of their work; additionally, they have more flexibility to advance their careers, which leads to higher job satisfaction. Whilst being the main earner in the households is associated with a high correlation between job satisfaction and well-being for men (Georgellis and Lange, 2012).

Turning to the qualification of employees, having higher levels of education and skills is found to have a significant association with lower job satisfaction (Clark et al., 1996; Clark, 1997; Frey and Stutzer, 2001; Jones et al., 2009). Clark et al. (1996) argued that these inverse relationships depend on the gaps between the expectations and the results and aspirations of employees as highly educated and skilled employees have higher expectations than those with less education and fewer skills. Allen and van der Velden (2001) found that employees experiencing skill mismatch i.e. those with under utilised skills, tend to have lower job satisfaction, while

education mismatch is more associated with wages differentials.

Various job characteristics, as well as personal characteristics, affect job satisfaction. Having higher rank and having access to training opportunities are positively related to job satisfaction (Clark et al., 1996; Gazioğlu and Tansel, 2002, 2006; Jones et al., 2009; Oshagbemi, 2003) as these may reflect both benefits received from the organisation and the self-esteem employees gain from their positions. Those with longer tenure have also been found to have higher levels of job satisfaction and more autonomy at work contributes positively to job satisfaction (Clark et al., 1996; Nguyen et al., 2003; Oshagbemi, 2000). Having a fixed-term employment contract is found to be associated with higher job satisfaction in several European countries compared to those with permanent contracts (De Cuyper and De Witte, 2007; De Witte and Näswall, 2003; Mauno et al., 2005). However, higher income is not necessarily associated with higher levels of either well-being or job satisfaction as evidenced by the results of previous studies (Clark et al., 1996; Easterlin, 1974; Frey and Stutzer, 2001).

Aside from working, individuals also have other responsibilities and activities in other domains in their lives. The relationship between work and non-work domains affects well-being and job satisfaction (Argyle, 2001). From work domains, for example, reduced hours worked and flexible work schedule are associated with higher well-being and job satisfaction as both means have enabled workers to fulfill demands from workplace and family (Byron, 2005; Costa et al., 2006; McNall et al., 2010). Whilst several activities in non-work domains are particularly popular among workers including watching TV, reading, doing household duties, cooking, gardening, engaging in sport or do-it-yourself projects (DIY) and volunteering (Fletcher et al., 1993). Not all of these activities contribute to the well-being of individuals. Watching TV has shown mixed results in terms of effect on well-being. Earlier studies tended to find that watching TV provides relaxation and gives individuals the opportunity to spend time with family, thus contributing to their well-being (Argyle,

2001; Hills et al., 2000). More current studies show that watching TV has reduced time available for building relationships which is harmful to well-being (Bruni and Stanca, 2008; Frey et al., 2007).

With regard to household duties, existing studies are most likely to look into the effect of both domains on the female's well-being. Gjerdingen et al. (2000) have found that women contribute more time to household work than their husbands or male partners, even if they are employed. Taking on greater shares of household duties, females may intentionally decrease their working time outside the home which then may determine the types of jobs they can attain and consequently their levels of job satisfaction. Another study suggests that the contribution of husbands to household work is unrelated to the well-being of their wives, but that sharing child-care tasks substantially increases the well-being of wives (Goldberg and Perry-Jenkins, 2004).

On the other hand, many studies find a strong relationship between physical activity and reported well-being (Blomstrand et al., 2009; Kuh and Cooper, 1992). Physical activity such as sport may evoke enjoyment, possible social relations and a feeling of accomplishment, all of which increase well-being (Argyle, 2001). Likewise, gardening and DIY which involve some degree of physical activities make individuals healthier and consequently improve their well-being, although the increased well-being may depend on the age of the individuals (Ferrer-i-Carbonell and Gowdy, 2007; Hawkins et al., 2011; van der Berg et al., 2010). Nevertheless, all these studies measure only general well-being and none of them measures job satisfaction. Moreover, these studies use the general population or a gender-specific sample.

In samples of older population as well as in multi years and in multi countries, voluntary work has been shown to improve individuals' well-being; those with higher well-being also invest more time in volunteering (Helliwell, 2003; Meier and Stutzer, 2008; Thoits and Hewitt, 2001). In addition, those who are actively involved are often individuals at or near retirement age, peaking up at the 59-63 age range (Bec-

chetti et al., 2012; von Bonsdorff and Rantanen, 2011). A rare study investigated the relationship of voluntary work after working hours to the well-being of workers and found that workers' well-being is improved on the working day following the carrying out of the voluntary work (Mojza et al., 2011).

From the perspective of developing countries, job satisfaction is determined by age, gender, tenure, education, rank, employee status, matching skills with job, job security and the placement location (Adzei and Atinga, 2012; Agyepong et al., 2004; Asegid et al., 2014; Blaauw et al., 2013; Chirdan et al., 2009; Hagopian et al., 2009; Pillay, 2009; Tran et al., 2013). Hagopian et al. (2009) found that older Ugandan workers were more satisfied with their work than younger Ugandans and that they had better relationships with their supervisors. Studies of the relationship between gender and job satisfaction have showed mixed results as many studies have found no significant differences between females and males (Blaauw et al., 2013; Chirdan et al., 2009; Hagopian et al., 2009) whilst more current study found that females are less likely to be satisfied when compared to their male colleagues (Asegid et al., 2014). Similarly, work experience has showed contradicting results among developing countries studied. Work experience had been found to have a significant association with higher job satisfaction in South Africa (Pillay, 2009), but not in Ethiopia and Nigeria (Asegid et al., 2014; Chirdan et al., 2009). While higher professional education is associated with lower job satisfaction (Tran et al., 2013), a good match of skills with the job as well as the fitness of work schedule with home responsibility improves job satisfaction (Hagopian et al., 2009). However, a study in Nigeria found that job satisfaction was not related to gender, type of profession, age or number of years in one's current job (Chirdan et al., 2009).

In addition to those characteristics mentioned above, lack of promotions, unclear paths of career development and unavailability of continuing education have consistently been found to be associated with job dissatisfaction (Abushaikha and Saca-Hazboun, 2009; Adzei and Atinga, 2012; Agyepong et al., 2004; Chirdan et al.,

2009; Dieleman et al., 2003; Ebuehi and Campbell, 2011; Kekana et al., 2007; Kotzee and Couper, 2006; Manongi et al., 2006). As working in a hospital is considered a stable and good job in developing countries (Hagopian et al., 2009), employees want to have opportunities for career advancement and for attaining higher rank. Hospital employees working in rural and remote areas are less satisfied with their jobs than those in other locations (Pillay, 2009; Tran et al., 2013) and they experience concern regarding a lack of essential equipment, tools and supplies at work. Workers in rural and remote areas also worry about their children's education provision (Agyepong et al., 2004; Ebuehi and Campbell, 2011; Olsen et al., 2005).

1.5 Contextual characteristics

1.5.1 Workplace characteristics

In his motivation-hygiene theory, Herzberg (1974) posited that factors within the workplace may trigger job dissatisfaction as opposed to job satisfaction. In recent years, several authors have included contextual factors including workplace size and sectors (public or private) as controls when investigating job satisfaction. Working in a large organisation is associated with lower job satisfaction (Clark et al., 1996; Benz and Frey, 2008; Gazioğlu and Tansel, 2002; Idson, 1990), although Wood and de Menezes (2011) found otherwise. Other findings regarding the relationship between working in the public sector and job satisfaction have been mixed: Ghinetti (2007), Heywood et al. (2002), Markovits et al. (2007) and Requena (2003) all found positive associations, in contrast to Solomon (1986), who found a negative association.

Similarly, some of these factors have been used as control variables in previous studies investigating workplace performance. They include workplace size, private or public sector, amount of training provided to employees, proportion of employees provided with training opportunities, proportion of female workers, percentage of tenured employees, percentage of skilled employees, introduction of management

changes and the existence of performance-related pay system. Wood et al. (2012) found that larger workplace is positively and significantly associated with higher financial performance and higher absenteeism, while certain industry i.e. the electricity and public utilities have a negative association with absenteeism. Working in the public sector is negatively associated with quality (Wood et al., 2012). Training opportunities have generally been found to have positive associations with productivity, financial performance and workplace survival (Barrett and O'Connell, 2001; Collier et al., 2011; Dearden et al., 2006; Glaveli and Karassavidou, 2011; Jones et al., 2009), although several authors have found no associations (Dermol and Čater, 2013; Jones et al., 2011). An equal gender mix in a team or a workplace leads to better financial performance (Ellison and Mullin, 2014; Hoogendoorn et al., 2014).

According to Medoff and Abraham (1981), the productivity of longer-serving employees tend to decline. Strober (1990) and Ellison and Mullin (2014) found that tenure diversity in a workplace hurts financial performance. The relationship between employees' skills and workplace performance is difficult to examine due to the problematic nature of measurement (Grugulis and Stoyanova, 2011) with previous studies having yielded contrasting results. Hoyt and Matuszek (2001) failed to find any relationship in the United States, yet Jones et al. (2009) found that having a higher proportion of over-skilled workers in the workplace are associated with both higher financial performance and quit rate in Britain. Applying a performance-related pay system aims to improve individual performance which may lead to improved workplace performance, while changes in the workplace may affect workplace performance for better or for worse (Lavoie-Tremblay et al., 2010; Sverke et al., 2008).

Brien and Smallman (2011) took a unique step of adding the importance of an appropriate leadership style in organisations or workplaces to these characteristics discussed above. In order to be effective, a leadership style must take into account the culture within the community as an organisation represents the commu-

nity within which it operates (Carl et al., 2004; Dorfman et al., 1997, 2004; Hayes and Prakasam, 1989; Pekerti and Sendjaya, 2010). Other research has confirmed that leader behaviour influences subordinates' job satisfaction (Barling et al., 1996; Chong et al., 2015; Rad and Yarmohammadian, 2006). According to Ferris and colleagues (as cited in Hall et al., 2004, p.518), the combination of leader behaviour, personal characteristics and accomplishments defines a leader's reputation; this in turn leads to trust in leadership (Burke et al., 2007).

Taking this proposition into account, Galli and Müller-Stewens (2012) explored the necessity of offering leadership development opportunities to ensure the growth of social capital within organisations and thus improve organisational effectiveness, which has consistently been called for (Day, 2001). Their findings indicate that leadership development may require different methods to achieve the social capital needed for the business of organisations which furthers the notion that leadership development a requirement for growth of social capital within organisations (Cohen and Prusak, 2001; Day, 2001). While Cohen and Prusak (2001) emphasised the need of investing in social capital for the organisation, Day (2001) proposed that leadership development effort must be part of any effort to increase leadership effectiveness for the organisation. As an organisation is based on interactions and relationships (Walumbwa and Christensen, 2013); trust is then built within the organisation according to the norms of the organisation and the obligations of each members which then develop identification for the members (Dutton et al., 1994; Kramer et al., 1996; Turner, 1982). Trustworthy leaders have been found to make organisations more productive and more likely to attain better outcomes (Dirks and Ferrin, 2001, 2002), even in a distress situation (Cho and Ringquist, 2011).

1.5.2 Other contextual characteristics

Workplaces and organisations may experience changes in response to changing economic condition and this may influence job satisfaction. Studies in the United States

and Australia have found that when workplaces experience downsizing, job satisfaction in those workplaces declines (Luthans and Sommer, 1999; Travaglione and Cross, 2006). In contrast, Sahdev (2004) found downsizing to have mixed results in two companies in Great Britain. Employees in a bank showed lower levels of job satisfaction, while employees in a manufacturing company showed relatively stable job satisfaction when downsizing was implemented. The major organisational change of privatisation has also been found to lead to mixed results: in one study, job satisfaction tended to decrease significantly for all members at all employment levels during the process, but job satisfaction subsequently improved in the reorganisation stage following privatisation (Nelson et al., 1995).

Workplaces downsizing is more likely to increase unemployment in times of crisis; however, studies examining the effects of such changes on job satisfaction in crisis are still a rarity. Comparing job satisfaction before and during the recent and ongoing crisis, Markovits et al. (2014) found that job satisfaction in Greece is significantly lower during the crisis than before it. Focusing on a transition economy and using five years' worth of longitudinal data, Seršić and Šverko (2000) found that employees in general were fairly satisfied with their jobs during a crisis. However, employees with higher occupational levels and those working in the private sector were significantly more satisfied than other types of employees.

Whilst current unemployment clearly cannot lead to job satisfaction, studies also have found that job satisfaction is also significantly and negatively associated with the perception of the likelihood of future unemployment (Clark, 2001; Lange, 2013). Fear of losing one's job may be stressful for an employee (Ferrie et al., 1995) which may lower both job satisfaction and overall well-being (Oesch and Lipps, 2012). In contrast, employees are found to have higher levels of job satisfaction in times of high unemployment; this may result from the feeling that one is lucky to have a job in a time of high unemployment and job insecurity (Nandi et al., 2004).

1.6 Existing relationships of social capital, job satisfaction and workplace performance

1.6.1 The relationships of social capital to job satisfaction

Various studies link social capital with job satisfaction with mixed results. A 1995 study used friendships at work to predict job satisfaction in the United States (Riordan and Griffeth, 1995). The perceived opportunities associated with friendships were found to have a direct influence on the job satisfaction and job involvement of the employees. However, another study found that the more tension reported in the friendships the lower the job satisfaction, especially for Canadian male workers (Markiewicz et al., 2000). Each of these previous studies used samples from a specific city in a single country, and both ignored the effect of places (whether workplace, city, region or country) on job satisfaction. In the Netherlands, Flap and Völker (2001) found that social capital is positively associated with certain aspects of job satisfaction such as income, security and career opportunities. Whilst in a longitudinal study, with whom the workers have trust ties were most likely determine their levels of overall job satisfaction (Agneessens and Wittek, 2008). Workers who had trust ties with satisfied colleagues would have higher job satisfaction. In contrast, workers with lower level of job satisfaction tend to develop more interpersonal trusts with their colleagues than those with higher job satisfaction (Agneessens and Wittek, 2008).

A more recent study uses common values and perceived trust among the employees as measures of social capital to investigate its association with job satisfaction among physicians (Ommen et al., 2009). The research indicated that social capital in a workplace has a significant positive association with job satisfaction among physicians after accounting for their workload and professional experience. Extending this type of investigation to the life satisfaction of workers, a study in Australia showed that a satisfying relationship with a co-worker improves both job and daily-

life satisfaction (Simon et al., 2010).

Table 1.3 shows an overview of studies using various dimensions of workplace social capital, job satisfaction and workplace performance and their findings. The table summarises three common relationships investigated: the relationships between social capital and job satisfaction, those between job satisfaction and workplace and those between workplace social capital and workplace performance. Studies that combine workplace social capital, job satisfaction and workplace performance are at the end of the table including this doctoral research. As this subsection has discussed the relationships between social capital and job satisfaction, the next three subsections will explain the rest of the relationships.

1.6.2 The effect of job satisfaction on workplace performance

The relationship of job satisfaction to performance has been repeatedly examined since the beginning of the industrial-psychology field with findings that there is a relationship between satisfaction and performance (Iaffaldano and Muchinsky, 1985; Judge et al., 2001). One attempt to explain the relationship of job satisfaction to workplace performance at the organisational level examined the relationship between job satisfaction, other job-related attitudes and workplace performance using a data set of 298 US secondary schools and 13,808 teachers within those schools (Ostroff, 1992). Five measurements of workplace performance were used: academic achievement, student behaviour, student satisfaction, teacher turnover and administrative performance. This study recognized that teachers are nested within schools; however, it aggregated job satisfaction and job-related attitudes to the organisational level. The study concluded that organisations with more satisfied employees tend to be more effective than organisations with less satisfied employees (Ostroff, 1992) and found that there are strong relationships between dissatisfaction, attitudes and turnover. However, this study was limited to a particular industry.

Table 1.3: Studies on workplace social capital, job satisfaction and workplace performance

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
<i>Studies on workplace social capital and job satisfaction</i>				
Riordan and Griffith (1995), United States	friendships at work	global job satisfaction with aspects on pay, coworkers, work itself and growth opportunities		positive
Markiewicz et al. (2000), Canada	friendships network	a job satisfaction scale of MSQ 20 items		negative
Flap and Völker (2001), Netherlands	1) openness of network 2) density of network 3) separate cliques 4) solidarity ties 5) strategic ties 6) advice ties 7) openness of strategic ties 8) closeness of solidarity ties 9) strategic network - cliques	1) instrumental job satisfaction		positive negative (n.s) negative negative (n.s) positive positive (n.s) positive positive (n.s) positive negative
	1) openness of network 2) density of network 3) separate cliques 4) solidarity ties 5) strategic ties 6) advice ties	2) satisfaction on social aspect of work		negative positive (n.s) negative positive positive (n.s) positive (n.s)

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Table 1.3 – continued from the previous page

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
	7) openness of strategic ties			negative (n.s)
	8) closeness of solidarity ties			negative (n.s)
	9) solidarity network - cliques			positive
Agneessens and Wittek (2008), Netherlands	interpersonal trust mechanisms:	overall job satisfaction		
	1) popularity			positive
	2) contagion			positive (n.s)
	3) attractiveness			positive (n.s)
	4) homophily			negative
	5) satisfaction spillover			positive (n.s)
	6) trust spillover			
Ommen et al. (2009), Germany	common values, perceived trust & reciprocity	overall job satisfaction		positive
Simon et al. (2010), United States	a scale on coworker relationship (based on three items)	1) job satisfaction (a five-items scale)		positive
		2) life satisfaction (a five-items scale of Diener et al. (1985))		positive
<i>Studies on job satisfaction and workplace performance</i>				
Ostroff (1992), United States		aggregate job satisfaction with aspects on: coworkers, career advancement opportunities,	combined school performance (academic achievement, student behaviour, student satisfaction,	positive

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Table 1.3 – continued from the previous page

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
Harter et al. (2002), United States		supervision, pay, etc single item job satisfaction	teacher turnover, administrative performance 1) customer satisfaction 2) productivity 3) profitability 4) employee turnover 5) overall performance	 positive positive positive negative positive
Barling et al. (2003), Australia		three items: satisfaction with management, feeling toward workplace and intention to leave job	occupational injuries last year and lost-time injuries	negative
Yee et al. (2008), Hong Kong		employee satisfaction: salary, job nature, promotion, peers and supervision (JDI)	1) service quality 2) subjective profitability (includes ROA, ROS, ROI & overall profitability)	positive positive
Zhou et al. (2008), China		aggregated job satisfaction	1) product quality 2) ROA	positive positive

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Table 1.3 – continued from the previous page

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
Jones et al. (2009), Britain		satisfaction with:		
		1) achievement	1) productivity 2) financial performance 3) quality of service/product 4) absenteeism 5) quit rate	positive* positive positive (n.s)
		2) influence over job	1) productivity 2) financial performance 3) quality of service/product 4) absenteeism 5) quit rate	positive (n.s) positive (n.s) negative (n.s) negative negative (n.s)
		3) initiative	1) productivity 2) financial performance 3) quality of service/product 4) absenteeism 5) quit rate	negative (n.s) negative positive (n.s) positive (n.s) positive (n.s)
		4) training	1) productivity 2) financial performance 3) quality of service/product 4) absenteeism 5) quit rate	negative (n.s) positive positive (n.s) positive (n.s) positive (n.s)
		5) pay	1) productivity 2) financial performance 3) quality of service/product 4) absenteeism 5) quit rate	positive (n.s) positive (n.s) positive (n.s) positive positive (n.s)
		6) job security	1) productivity 2) financial performance 3) quality of service/product 4) absenteeism 5) quit rate	negative negative (n.s) positive (n.s) positive
			1) productivity 2) financial performance	positive positive

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Table 1.3 – continued from the previous page

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
			3) quality of service/product	positive (n.s)
			4) absenteeism	negative (n.s)
			5) quit rate	negative (n.s)
		7) work itself	1) productivity	negative (n.s)
			2) financial performance	negative (n.s)
			3) quality of service/product	positive (n.s)
			4) absenteeism	negative (n.s)
			5) quit rate	negative (n.s)
		8) composite index of job satisfaction	1) productivity	positive
			2) financial performance	positive
			3) quality of service/product	positive
			4) absenteeism	negative
			5) quit rate	negative (n.s)
Wood et al. (2012), Britain		mean scores of satisfaction on 8 facets: influence over job, pay, initiative, achievement, training, job security, decision making	1) productivity	positive
			2) financial performance	positive
			3) quality of service/product	positive
			4) absenteeism	negative
		involvement and work itself		
<i>Studies on workplace social capital and workplace performance</i>				
Barr (2000), Ghana	1) diversity of managers' contacts		productivity	positive
	2) number of contacts			positive
Peng and Luo (2000), China	1) ties with other managers		1) market share	positive

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Table 1.3 – continued from the previous page

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
	2) ties with government officials 1) ties with other managers 2) ties with government officials		2) ROA	positive positive* positive*
Acquaah (2007), Ghana	relationship with: 1) government officials 2) other top managers at other firms 3) community leaders		combined performance measure (sales growth, net income, ROA, ROS, productivity)	positive positive positive
Bandiera et al. (2008), Britain	friendships between workers and supervisor		productivity	positive
Andrews (2010), Britain	1) joint and cross-departmental working 2) trust between management and staff, between management and politicians 3) clearly understood mission, values and objectives		core service performance	negative (n.s) positive positive

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Table 1.3 – continued from the previous page

Reference	Workplace social capital	Job satisfaction	Workplace performance	Associations
<i>Studies on workplace social capital, job satisfaction and workplace performance</i>				
Lowe and Schellenberg (2001), Canada	employment relationships summary scale includes trust, commitment, communication and influence	a scale summing the feeling of accomplishment, motivation to go to work and overall job satisfaction		positive
	employment relationships summary scale		1) individual turnover 2) individual absenteeism	negative negative
Requena (2003), Spain	1) trust 2) social relations 3) commitment 4) communication 5) influence	overall job satisfaction		positive
	1) trust 2) social relations 3) commitment 4) communication 5) influence		quality of life at work	positive positive positive (n.s) positive positive positive positive (n.s) positive
This study	1) vertical social capital 2) horizontal social capital	1) overall job satisfaction 2) satisfaction with pay, achievement, initiative, influence, training, job security, work itself	1) subjective performance 2) objective performance	

Note: n.s = not significant.* p<0.10

Another specific industry considered is the high-contact industries in Hong Kong. The authors of one study examined the impact of employee satisfaction on service quality and firm profitability through customer satisfaction in those industries (Yee et al., 2008). They collected data from 618 employees of 206 small shops in shopping centres in Hong Kong. Different measures were used for each variable; for example, employee satisfaction was measured by satisfaction on salary, job nature, promotion, relationships with peers and supervision at work according to JDI (Smith et al., 1969). Service quality was measured by means of the five dimensions of perceived service quality: tangibles, reliability, responsiveness, assurance and empathy. Lastly, firm profitability was measured using a comparison of perceived financial performance and the industry norms for return on assets (ROA), return on sales (ROS), return on investment (ROI) and overall profitability of each firm. Their findings showed that employee satisfaction is important to the achievement of quality and profitability in the service industry. Increased profitability of firms is only possible with increased sales due to high customer satisfaction with better quality service (Yee et al., 2008). The authors also found a reverse link indicating that firm profitability affects employee satisfaction.

Additional studies have considered the importance of the level of unit analysis to an understanding of the relationship between job satisfaction and outcomes or performance in the United States (Harter et al., 2002). In a meta-analysis of such research Harter et al. (2002) used 7,939 business units in 36 companies to examine the relationship of job satisfaction and business-unit outcomes, namely customer satisfaction, productivity, profit, employee turnover and accidents, from 42 studies. The analysis found that overall satisfaction has the strongest effects on customer satisfaction and employee turnover, with the least significant correlation was that between job satisfaction and profitability. This was the basis for the authors' argument that employee satisfaction increases employee engagement which in turn affects business-unit outcomes. Although the authors found the relationships, they were

unable to justify the causality or directionality of those relationships. However, they agreed that the managers' actions towards the employee may influence the result for an individual company.

Using data from WERS2004, Jones et al. (2009) investigated the association of employee training with job satisfaction and workplace performance. They used seven aspects to measure job satisfaction: employees' satisfaction with their own achievements, influence, initiative in their jobs, training received, salary, job security and the work itself. As for workplace performance, Jones et al. (2009) used productivity, financial performance and product or service quality as in previous research; however, they added absence rate and quit rate as job satisfaction has been robustly used to predict job mobility in the labour market (Green, 2006). The researchers found evidence that training is significantly positively related with job satisfaction and that job satisfaction is positively significantly related to productivity, financial performance and the quality of service or product as measures of workplace performance. Job satisfaction is negatively associated with absenteeism, but not with quit rate. These findings confirm some previous research with regard to, for example, the relationship between job satisfaction and intentions to quit (Koster et al., 2009; Shields and Ward, 2001); the relationship between job satisfaction and product or service quality (Yee et al., 2008; Zhou et al., 2008) and the relationship between job satisfaction and organisational effectiveness (Ostroff, 1992).

Examining further into the aspects of job satisfaction, Jones et al. (2009) found that certain aspects are associated positively with workplace performance. Satisfaction with job security and pay are positively associated with financial performance. Satisfaction with their own achievements is associated positively with both financial performance and productivity. Satisfaction with initiative is positively associated with quit rate, while satisfaction with influence is negatively associated with both quit rate and financial performance. Satisfaction with pay is also negatively associated with absence rate.

However, several authors hypothesize that job satisfaction has a mediating role toward organisational performance rather than a direct link (Barling et al., 2003; Wood et al., 2012; Zhou et al., 2008). One such study used data from the 1995 Australian Workplace Industrial Relations Survey and focused on the relationship between high-quality work, job satisfaction and occupational injuries to measure organisational performance. They found that job satisfaction mediates the relationship between qualities of jobs on occupational injuries (Barling et al., 2003).

The second study of job satisfaction as a mediator used multilevel analysis to examine the relationship of enriched job design and high-involvement management to organisational performance in Britain (Wood et al., 2012). The researchers found that enriched job design and high-involvement management contribute to higher levels of job satisfaction. In turn, better job satisfaction is related to better financial performance, higher labour productivity, higher product or service quality and lower absenteeism. These results emphasise that job satisfaction has a mediating role toward economic performance (Wood et al., 2012).

Using a sample of manufacturing firms in a developing country, a team of researchers examined the potential of job satisfaction and product quality to take a mediating role between market orientation behaviour and workplace performance in China (Zhou et al., 2008). Similar to the study in New Zealand (Brien and Smallman, 2011), this study investigated the effect of leadership quality on job satisfaction and product quality and subsequent yields with respect to financial performance. They found that leadership quality does affect job satisfaction and product quality. They concluded that market orientation culture at the organisational level together with leadership quality generate market orientation behaviours that cultivate job satisfaction and product quality resulting in improved financial performance at the firm level. Notably, this study used aggregated job satisfaction in the analysis since performance was measured at the organisational level.

1.6.3 The link between social capital and organisational performance

The third link in Table 1.3 shows the relationships between social capital and organisational performance. The link between social capital and organisational performance has increasingly become the focus of studies both in developed and developing countries (Acquaah, 2007; Andrews, 2010; Bandiera et al., 2008, 2009; Barr, 2000; Brown et al., 2011; Ofori and Sackey, 2010; Peng and Luo, 2000). Exploring the network ties within organisations, one study in the developed world explored social capital within an organisation, such as friendships among short-term contract workers and their correlation with workers' productivity as a measure of organisational performance (Bandiera et al., 2008, 2009). These contract workers may be hired as managers in this particular industry. The researchers found that workers' productivity is significantly higher when they are socially connected to their superiors or their colleagues. However, the firm's productivity tend to depend on the wage system of the managers. Fixed-wage managers tends to select workers connected socially with them although they have lower ability, while managers with performance bonus opted to have workers with higher ability regardless of the social connection (Bandiera et al., 2009). Whilst using three types of social capital (Nahapiet and Ghoshal, 1998), Andrews (2010) found that both relational and cognitive social capitals are associated with higher performance of English local governments, but not structural social capital.

Some more recent studies have looked into the healthcare industry, using different measures of workplace performance i.e. management quality and emotional exhaustion among the employees. A study in Germany (Driller et al., 2011) examined the relationship of social capital and emotional exhaustion of clinicians in hospitals. Using measures of social capital similar to those of Ommen et al. (2009), they suggested that lower social capital significantly increases the odds of emotional exhaustion of workers by 62%. The sociodemographic status of workers and the

location of the hospital have no significant association with emotional exhaustion. This study only used single level regression for the analysis disregarding the fact that clinicians are nested within hospitals. Extending the analysis using multilevel modelling, a more recent study used similar measures of social capital and examined their association with the effectiveness of hospital management system (Hammer et al., 2013). This study used data from seven countries in Europe and also took contextual factors into account. These included hospital characteristics, organisational culture type and number of board members. The authors found the presence of greater amounts of social capital to have a positive association with the quality of management system, although there was a great deal of variation between countries.

After finding that perceived trust influences workers' commitment (Brown et al., 2011), Brown et al. (2013) used trust in the workplace to predict workplace performance in Britain based on data from WERS2004 and WERS2011. They measured trust by means of the perceived relationships between subordinates and superiors. They used managerial assessments on productivity, financial performance and quality of service or product to evaluate workplace performance. They found that higher levels of trusts had a positive relationship with all three workplace performance measures in both years, although workplace performance in 2011 was influenced by the economic crisis in Britain. The authors argued that perceived trust helped workplace performance in the period economic crisis that was taking place in Britain in 2011.

In the research on emerging economies, four studies are distinct from others in that they look into social capital among large entities by examining managerial social capital and its relationship to strategic orientation and organisational performance in Ghana and China (Acquaah, 2007; Barr, 2000; Ofori and Sackey, 2010; Peng and Luo, 2000). All of the authors used managerial social capital defined as the set of social relationships between top management and government officials, other top executives and community leaders in their studies. Ofori and Sackey

(2010), however, also included relationships within workplace in their assessment of social capital. The studies in Ghana found that trust is consistently positively associated with workplace performance (Ofori and Sackey, 2010) and that social capital created from the networking relationships among the top executives of different firms is more beneficial than that developed from relationships with government officials. Moreover, Acquah (2007) also identified that although social networking with community leaders is costly for firms, the advantages of the networking more than compensate for the costs. Contrasting results found in China have indicated that social capital created from networking with government officials is more beneficial than that developed from relationships with top executives of other firms, especially for those firms which are owned by the state (Peng and Luo, 2000). Peng and Luo (2000) also found social capital gained from networking with other top executives to be beneficial only among firms in low-growth industries.

1.6.4 Social capital, job satisfaction and workplace performance: charted relationships?

Previous parts of this section have shown that most previous studies have opted to examine the relationship either between job satisfaction and workplace performance or between social capital and job satisfaction. Those studies also have found that job satisfaction may influence workplace performance as does social capital. However, the studies discussed thus far have not included both job satisfaction and social capital to predict workplace performance. This section will examine rare studies that consider all three variables: social capital, job satisfaction and workplace performance as summarised on the last part of Table 1.3.

A study in Canada used elements of social capital such as trust, commitment, influence and communication as core dimensions of employment relationships (Lowe and Schellenberg, 2001). Collapsing all four elements into one employment relationships summary scale, the authors then explored the associations between the em-

ployment relationships and the organisational and individual outcomes. They used skill use, absenteeism, turnover, morale and propensity to unionise for organisational outcomes; for individual outcomes, they selected job satisfaction and career and skill development. Lowe and Schellenberg (2001) concluded that employment relationships, hence social capital, influence both organisational and individual outcomes. It is important to note that although they divided the outcomes into organisational and individual outcomes, the authors still measured the outcomes at the individual level only by asking the employees for their individual responses in order to obtain those measurements.

This model in Canada was adapted in an empirical study of relationships between social capital, satisfaction and quality of life in the workplace using the Spain's 2001 Quality of Life at Work Survey (Requena, 2003). This Spanish study added social relations into the measures of social capital, consisting of trust, commitment, communication and influence. Requena (2003) specified two measures of quality of life in the workplace: job satisfaction and the index of quality of life at work. The index consists of three components: a stimulating work factor (e.g. working with independence, working in an encouraging work environment), an exhaustion at work factor (e.g. not being exhausted at the end of the work day) and a comfort factor (e.g. not having to work on weekends).

The Spanish study shows that social capital elements are positive predictors of the index of quality of life at work and that they have positive impacts on job satisfaction. Two social capital elements with the strongest contribution are trust and commitment; this commitment or identification of the workers with the organisation, tends to generate job satisfaction. Workers in the public sector have a higher level of job satisfaction than private sector employees. The results of social capital associations with quality of life in this study confirms previous findings. However, both the Canadian and Spanish studies measured performance only at the individual level.

1.7 Research gaps

Table 1.3 shows that previous studies have examined different relationships between social capital and workplace performance or between job satisfaction and workplace performance. Although the concept of social capital had been studied in diverse contexts and its association with organisations, attempts to explain its joint relationship to job satisfaction and workplace performance is remain rare. This neglect is particularly acute given that studies have found separately that job satisfaction and workplace social capital contribute to workplace performance with the exceptions of two studies in Canada and Spain (Lowe and Schellenberg, 2001; Requena, 2003). It is unsurprisingly that most such studies take place in developed countries such as Canada, Hong Kong, New Zealand, Spain, Britain, Germany and the United States. As a result, workplace social capital, job satisfaction and workplace performance in these countries have been more explored in greater depth; thus, the connections have been revealed to a greater extent than in developing countries.

Although studies investigating social capital and workplace performance are appearing in developing countries ¹ i.e. Argentina, China, Ghana, Thailand and Vietnam (Acquaah, 2007; Barr, 2000; Fornoni et al., 2012; Ofori and Sackey, 2010; Qiao et al., 2013; Santarelli and Tran, 2013; Wu and Leung, 2005; Yokakul and Zawdie, 2011), most of them use networks with outside parties to measure social capital. Only one of these studies investigated social capital within the workplace; the others, by failing to do so, also weakened their assessment of another important aspect of performance that is affected by relationships within the workplace, job satisfaction. In addition, most of these studies focused on workplaces with fewer than ten employees. It is apparent that more study on developing countries is needed using trust as a measure of social capital measurement and investigating social capital within the workplace instead of outside the workplace. Although findings in developed countries showed that workplace social capital may influence workplace

¹The country classification is based on World Bank (2014a)

performance, further investigation in developing countries is required to determine whether different economic environments produce similar findings.

A country like Indonesia is important to investigate since it is a developing country and that is rich in social capital (Lont, 2000; Putnam et al., 1993). Despite its richness of social capital, most studies on social capital in Indonesia focus on its existence within community groups and social networks in various societies (Alawiyah, 2013; Lont, 2000; Miguel et al., 2005, 2006; Miller et al., 2006; Sujarwoto and Tampubolon, 2013; Tampubolon and Hanandita, 2014). The well-known example is that of rotating credit associations or *arisan* in Java, which have made use of strong norms and dense reciprocal networks to minimise default on the part of their members (Putnam et al., 1993). Members of these *arisan*, though, join the associations not only for the economic benefits they provide, but also for social and cooperative aspects such as sense of neighbourliness (Geertz, 1962). These social and cooperative aspects are reflected in the socio-cultural ethic called *gotong-royong* or mutual and reciprocal assistance which is equivalent to the reciprocity described in the literature of social capital (Beard, 2005; Bowen, 1986). Based on this ethic, community-based organisations in Indonesia may be established by the state, or by non-governmental organisations; alternatively, they may simply just indigenous (Beard, 2005).

Community social capitals has been studied to predict health and the effect of industrialisation in Indonesia (Alawiyah, 2013; Isham and Kahkonen, 1999; Miguel et al., 2005, 2006; Miller et al., 2006; Sujarwoto and Tampubolon, 2013; Tampubolon and Hanandita, 2014). Isham and Kahkonen (1999) used density of membership of local groups or associations, number of joint village activities and meeting attendance, among other factors, to measure social capital and its influence on user involvement and the performance of water-services projects. They found that village-level social capital can improve levels of households' participation in service design of water-services projects, which then led to households' willingness to

pay for more expensive water systems and improved health. Miller et al. (2006) used community-level social capital and investigated its relationships to individuals' health. They found a positive association between community-level social capital and good health and weak evidence for an interrelationship between human and social capital and mental health. Participation in different community organisations as the proxy of social capital was found to be associated with mixed health outcomes for women (Alawiyah, 2013), while social capital measured by social trust was associated with better mental health (Tampubolon and Hanandita, 2014).

Despite her findings, Alawiyah (2013) suggested the use of multilevel models to improve on her results, which were obtained using logistic regressions analysis. Using multilevel models with instrumental variables and measuring the social capital of mothers through their participation in five community activities, Sujarwoto and Tampubolon (2013) found that mothers' social capital indeed improved health as measured by their children's weights. Putnam (2000) posited that social capital buffers the health shocks experienced in economic crisis as experienced by women and children in this study.

In addition to individual outcomes, some studies have used the number of organisations in districts to measure community social capital and the number of informal networks to examine the effect of industrialisation in Indonesia (Miguel et al., 2005, 2006). Covering 274 districts, these studies have yielded three main findings: first, districts that experienced rapid industrialization showed significant increases in most social capital measures; second, districts neighbouring rapidly industrializing areas exhibited high rates of out-migration, significantly lowering levels of the community social capital; and finally, initial social capital in a district did not predict subsequent industrial development.

As previously mentioned, social capital is rarely investigated in association with business entities in Indonesia. Turner (2007) observed informal networks, linkages and trust for small-scale businesses' survivability in Makassar, Eastern Indonesia.

She tested for the presence of three different types of social capital in those enterprises: bonding, bridging and linking social capital. Although bonding social capital is common, bridging social capital is less so, and linking social capital was found to be virtually absent in this study. A lack of the latter, combined with widespread corruption in the city, hinders livelihood progress for many local entrepreneurs.

Investigating social capital within individual business entities, Marzuki et al. (2012) used relations with superiors and co-workers as factors of job satisfaction in the Indonesian construction industry. Relations with superiors were measured by means of several aspects such as communication, task delegation and decision-making assistance, while relations with co-workers included cooperation, communication and support received. The authors found that both kind of relationships influence job satisfaction; however, they did not use relationships with superiors and co-workers as measures of social capital. This fact encourages the initiation of a new investigation of social capital including these factors. In addition, Marzuki et al. (2012) included only one industry with eight workplaces consisting of state-owned and private companies as samples. More studies using a variety of industries should be conducted in order to obtain more generalised results.

1.8 Approach

This research will extend the scope of the existing literature in several ways: first, workplace social capital, job satisfaction and workplace performance are being considered together in a single research project. This study will predict job satisfaction using workplace social capital; subsequently, both job satisfaction and workplace social capital will be used to predict workplace performance. By doing so, this research can investigate their relationships together. Second, this research is inspired by the premise that ‘observations from one country, culture, or context are not necessarily applicable to other countries, cultures, or contexts’ (Ng et al., 2009, p.780). This research examines countries at different levels of economic development, enabling

a comparative study. The countries investigated in this thesis also differ greatly in terms of the employment relationships which may affect workers' attitudes and performance (Hofstede et al., 2010; Ng et al., 2009); thus, investigating the two together can enrich the body of knowledge, a step that urgently needs to be taken (Tsui et al., 2007). Britain is considered a society that emphasises individual self-interest, assertiveness and material success as well as a society with relatively more equal power distribution between subordinates and superiors; while Indonesia, on the other hand, is regarded as a country that emphasises individuals' adherence to a group, relationships and harmony with others and unequal power distribution in organisational hierarchies. The extreme selection of countries has been practiced in cross-countries study (Bagozzi et al., 2003; Ng et al., 2009; Robert et al., 2000; Vlachos et al., 2014). Third, this study recognises that both workplace social capital and job satisfaction are multidimensional constructs. Lastly, as social capital and job satisfaction refer to individuals, this study uses multilevel modeling capturing the nested structure of employees within workplaces. The multilevel modelling will be explained in Chapter 2 (Methodology).

Figure 1.1 Framework of the study

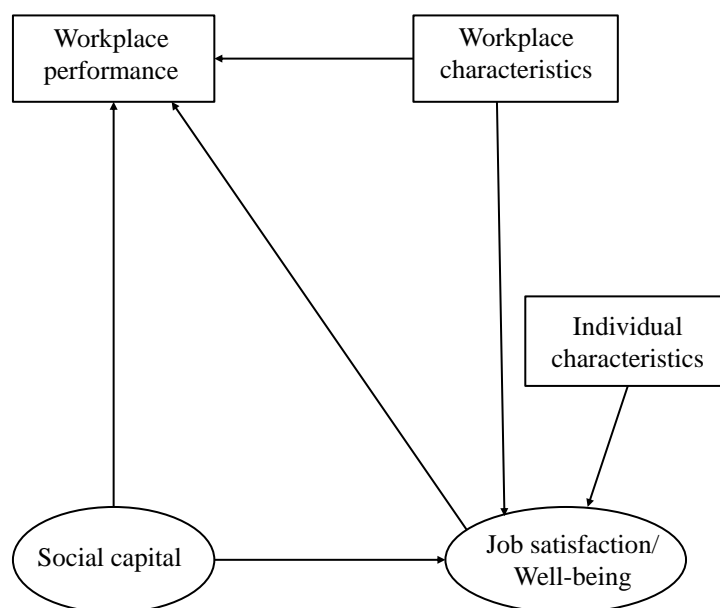


Figure 1.1 shows the framework of this study including the variables and their hypothesized relationships. Both workplace social capital and job satisfaction will be measured at workers' level (individual level), while workplace performance is measured at the higher level: the workplace level. Workplace social capital is measured with the relationships among workers and between workers and their superiors. Job satisfaction is measured either by the workers' general satisfaction at work or by the workers' satisfaction on different facets of their works such as pay, achievement, training opportunities, and so on. Job satisfaction is influenced by both individual characteristics of the workers and workplace characteristics as workers are nested within their workplaces. This framework hypothesizes that individual workplace social capital is suggested to lead to higher job satisfaction for workers. Both workplace social capital and job satisfaction then are hypothesized to be associated with higher workplace performance.

1.8.1 Research questions

This research aims to investigate the relationships between workplace social capital, job satisfaction and workplace performance in developed and developing countries by answering the following questions:

- Does workplace social capital affect job satisfaction?
- What is the relationship of social capital, job satisfaction and workplace performance?
- How do individual characteristics differ in determining job satisfaction in developed and developing countries?
- How do contexts of organisations in developed and developing countries differ in determining the relationship of social capital, job satisfaction and workplace performance?

1.9 Layout of the thesis

The layout of this thesis is as follows. The first three chapters are the building blocks of this thesis. This chapter, Chapter 1, reviews the existing literatures on social capital, job satisfaction and workplace and their relationships in both developed and developing countries. Based on this review, the research gaps are identified, leading to the research questions for this thesis. Following the identification of the research gaps, Chapter 2 introduces the data and the analytic method to be applied in this thesis. The chapter explains the types and sources of the data from both developed and developing countries. The data for developed countries are secondary data from 34 European countries and Britain using the latest available surveys, while the data from Indonesia, representing developing countries, is primary data from public district hospitals in one province, East Java. Chapter 3 introduces the settings of the countries examined in this study, including the European labour market conditions from 2008 to 2013 and a comparative introduction of European welfare regimes, followed by a description on the British labour market for the same period as well as introduction to its healthcare system and the condition of its workplaces. The last section of the chapter describes the conditions in Indonesia and its healthcare system in general and, in particular, the same with respect to East Java. These settings provide important foundation for the different empirical studies considering the different levels of economy in developed and developing countries.

Chapter 4 is the first empirical chapter of this thesis. It examines the relationships between workplace social capital, well-being, job satisfaction and activities outside work among European workers. This chapter explores those relationships in a time of economic crisis and investigates the interaction of different domains in the lives of European workers as it considers factors both in workplaces and out of the workplaces. This approach provides a more complete perspective of workers' general and specific-domain well-being. Moreover, this chapter offers insights on the effects of economic crisis on European workers' well-being and job satisfaction.

Chapter 5 shifts the study to a single developed country, Britain, while continuing to examine the relationships between workplace social capital and job satisfaction. Using a large amount of industry data also collected in a time of crisis, the study shows results regarding these relationships amidst the associated changes in workplaces and the labour market in Britain. The study includes individual characteristics as well as workplace characteristics and more general environmental conditions to grasp the associations in a changing environment using the Macro-micro multilevel modelling.

Following the study of Britain, Chapter 6 investigates the associations between workplace social capital and job satisfaction in Indonesia, the developing country considered in this thesis. Distinct from the study of Britain, this study uses primary data collected from public hospitals in the province of East Java. This chapter extends previous studies conducted in Ghana and China (Acquaah, 2007; Barr, 2000; Ofori and Sackey, 2010; Peng and Luo, 2000) by measuring workplace social capital from within the workplace from the employee perspective. This study is the first to predict job satisfaction in Indonesian public hospitals using workplace social capital.

After the investigation of individual outcomes in the first three empirical chapters, Chapter 7 examines the associations between workplace social capital, job satisfaction and workplace performance in Britain. Although workplace performance in Britain has been investigated before, previous studies tended to use either job satisfaction or trust to predict workplace performance (Brown et al., 2013; Wood et al., 2012; Jones et al., 2009). This study differs from previous ones in that it uses both social capital and job satisfaction as latent variables with the micro-Macro approach in multilevel analysis following Croon and van Veldhoven (2007). By using the micro-Macro approach, this study avoids aggregating job satisfaction and social capital as has commonly been done in the past.

Completing the research, Chapter 8 examines the associations between workplace

social capital, job satisfaction and workplace performance in Indonesia. It is similar to Chapter 7 in its use of job satisfaction and social capital as latent variables and its concurrent accommodation of the nested structure of employees within their workplaces. Certain individual and workplace characteristics are included in the analysis.

The final chapter, Chapter 9, discusses the extent to which the research questions can be answered and summarises what each chapter has contributed to the scholarly knowledge of the relationships between workplace social capital, job satisfaction and workplace performance in different economies with implications for existing literature and policy makers. Several limitations of this research are also identified before concluding with the direction for future research.

1.10 Conclusion

This chapter reviewed the existing literature on: first, definitions of workplace social capital, job satisfaction and workplace performance; and second, findings on the relationships between workplace social capital, job satisfaction and workplace performance in both developed and developing countries. The review finds that there are some gaps to fill in this avenue of research. Most notably, most research focus in developed countries. Whilst studies in developing countries mostly use relationships with outside parties to describe workplace social capital neglecting social relationships within the workplace. Furthermore, although both workplace social capital and job satisfaction are suggested to have positive associations with workplace performance, both variables are rarely investigated together in a study. Based on this examination of the extant scholarship, it is clear that there are research gaps to be filled.

This thesis is an attempt to fill those gaps using suitable data and analyses. The data and types of analyses used to answer the research questions are presented in the next chapter.

Chapter 2

Methodology

To empirically test the relationship between workplace social capital, job satisfaction and workplace performance, this thesis analyses data from both developed and developing countries. Data from those countries are carefully selected to represent the working population. Data from developed countries are secondary data from European and British workers. Europe has collected data on workers since 1990 with the European Working Conditions Surveys (EWCS); Britain has surveyed employment relations since 1980 using the Workplace Employment Relations Study (WERS). This research uses the latest waves of both EWCS and WERS. While studies on developed countries in this thesis use secondary data from European and British workers, the studies on developing countries in this thesis use primary data from hospital employees in Indonesia collected in 2013.

This chapter gives an overview on the data, measures and modelling techniques for this thesis. However, each empirical chapter includes its own data and methods section to clarify the data and methods used in that particular chapter.

2.1 Data

All of the empirical chapters use the most current data available from both developed and developing countries with all data provide information on the workers and their workplaces or environment. The following subsections will describe data used in this research as summarised in Table 2.1 below.

Table 2.1: Data used

	Europe	Britain	Indonesia
Data source	EWCS 2010	WERS 2011	Primary data 2013
Number of countries	34	1	1
Number of regions	400	10	38
Number of individuals	40,533	21,981	1,282
Number of workplaces	n.a.	1,923	54
Social capital	horizontal or vertical	vertical	horizontal and vertical
Job satisfaction	overall	8 aspects	8 aspects
Well-being	general	n.a.	n.a.
Workplace performance	n.a.	financial	financial
		quality of service/product	quality of service/product
		productivity	productivity
		absenteeism	revenue per bed
			expenditure per bed
			bed occupancy ratio
			length of stay
			classes of public hospital
			workplace characteristics
Contextual factors	sectors	sectors	
	growth	workplace characteristics	
	regional unemployment	industrial unemployment	
	welfare regime		
	Gini coefficients		
Other data source	Eurostat	Office for National Statistics	
	International Monetary Fund		

Note: n.a.: not available.

2.1.1 Developed Countries

Table 2.2: Samples for Europe

Country	Male	Female	Total
<i>EU countries:</i>			
Austria	422	477	899
Belgium	2,060	1,721	3,781
Bulgaria	447	519	966
Cyprus	537	443	980
Czech Republic	444	476	920
Denmark	509	485	994
Estonia	347	578	925
Finland	398	528	926
France	1,298	1,548	2,846
Germany	1,020	915	1,935
Greece	589	405	994
Hungary	469	472	941
Ireland	489	463	952
Italy	697	692	1,389
Latvia	340	608	948
Lithuania	371	563	934
Luxembourg	501	415	916
Malta	609	356	965
Netherlands	509	424	933
Poland	616	670	1,286
Portugal	425	480	905
Romania	501	406	907
Slovenia	580	663	1,243
Slovakia	464	471	935
Sweden	405	474	879
United Kingdom	697	771	1,468
<i>Non-EU countries:</i>			
Croatia	536	479	1,015
FYROM	599	380	979
Turkey	1,512	474	1,986
Norway	487	529	1,016
Albania	592	340	932
Kosovo	734	186	920
Montenegro	463	478	941
Total samples	21,159	19,374	40,533

Source: Gallup Europe (2010), author's calculation.

Table 2.2 shows the European samples from the EWCS 2010 for workers according to gender and countries. EWCS 2010 is the fifth wave of its kind and covers a larger geographical area than any previous wave, including 27 member of European Union and seven other countries: Norway, the Former Yugoslav Republic of Macedonia (FYROM), Croatia, Turkey, Albania, Kosovo and Montenegro (Eurofound, 2010). The data collection was carried out between January and June 2010 using a stratified

sampling method for each country. Gallup Europe (2010) explained that for each country, sample was allocated proportionately based on the numbers of workers in the regions (NUTS2/NUTS3 or equivalent), except for Denmark and Finland that used a one-stage random stratified sampling for registered individuals with 43,816 surveyed individuals. For the purpose of this research, the samples only consist of workers aged below 65 years resulting in 40,533 respondents of 21,159 males and 19,374 females.

Table 2.3: Samples for Britain

Industries	Male	Female	Total
Construction	572	165	737
Financial activities	418	548	966
Human health services	657	2,972	3,629
Manufacturing	1,546	529	2,075
Utilities	600	190	790
Wholesale and retail	751	939	1,690
Transportation and storage	1,097	277	1,374
Accommodation and food service	321	385	706
Information and communication	249	219	468
Professional, scientific and technical	526	518	1,044
Administrative and support service	309	290	599
Public administration	1,066	1,437	2,503
Education	893	2,922	3,815
Arts, entertainment & recreation	350	521	871
Other service activities	217	351	568
Total	9,572	12,263	21,835

Source: van Wanrooy et al. (2013), author's calculation.

For Britain, the sixth wave of WERS in 2011 (WERS2011) is used since it includes different data sets for managers, worker representatives and employees. Released in 2013, WERS2011 offers the latest data set on the British working conditions. The survey uses different questionnaires for managers, employee representatives and employees. Managers were asked to complete the employee profile questionnaire and the management questionnaire, the employee representatives filled the worker representative questionnaire and employees responded to the employees' questionnaire. For the trading sector, there was a financial performance question-

naire to be completed. By its design, WERS2011 enable researchers to link the data from employees and their workplaces. Workplaces included in this survey have five or more employees. Data collection was carried out during March 2011 and June 2012 resulting in responses from 2,680 workplaces with 21,981 employees (van Wanrooy et al., 2013). However, only 1,923 workplaces have linking responses from managers and employees for the purpose of this thesis. Table 2.3 shows that the samples consist of 9,572 males and 12,263 females in various industries with 146 individuals failed to report their gender.

2.1.2 Developing Countries

For the data on Indonesia, a new survey was conducted based on the questionnaires of WERS2011 (Department for Business, Innovation and Skills, 2011a,b) with four sets of questionnaires aimed at management and employees. The management answered three questionnaires profiling employees, hospital performance and hospital characteristics. Included in the hospital characteristics questionnaires is the details of the director of the hospital such as age, gender, education and previous directorship experience. These variables were not asked in WERS2011. The employees only answered the employee questionnaires. Although the actual fieldwork was done during summer 2013, the process of preparing data collection has begun in 2012. The process started with translating the WERS2011 questionnaires into Indonesian. In addition to the existing social capital module in the questionnaires of WERS2011, the Indonesian questionnaires incorporated social capital measures including both vertical and horizontal social capital (Kouvonen et al., 2006; Oksanen et al., 2010). Similar measures have been used among health workers in another developing country: Mexico (Idrovo et al., 2012).

Before the questionnaires were distributed during fieldwork, a pilot study was conducted to ensure the understandability of the questionnaires for Indonesian respondents. The pilot study took samples from hospitals in West Java and East Java.

The results of pilot study inspired confidence that the questionnaires were usable for the fieldwork. The questionnaires and participant consent form in the Indonesian language as well as the complete list of districts with their public hospitals in East Java are available in Appendices A, B and C of this thesis.

The area of the survey is East Java in Indonesia and questionnaires are distributed to all 55 public hospitals in the province after receiving approval from each local government. Before data collection, I had a discussion with each hospital management representative on the requirement of the respondents for the employee survey. Each hospital agreed to provide respondents comprising of doctors, nurses/midwives, medical support staffs and administrative staffs as there are different occupations within the hospital. The surveyed individuals consist of different occupations within the hospitals: 128 doctors (including specialist doctors), 719 nurses (including midwives) and 431 administrative staffs with 4 respondents did not report their occupations. As I couldn't personally select the respondents, the management may possibly choose employees with good track record or those who are close to the management or any other unknown reasons. As a result, the survey responses may be biased toward positive responses which may affect the results of this research.

Table 2.4: Samples for Indonesia

Public hospitals	Samples			Employees		
	Males	Females	Total	Males	Females	Total
RS Dr. Soetomo	5	10	15	n.a	n.a	4,285
RS Haji	4	20	24	404	595	999
RS Dr. M. Soewandhi	4	21	25	287	458	745
RS Bhakti Darma Husada	4	20	24	188	299	487
RS Dr. Saiful Anwar	11	14	25	959	1,403	2,362
RS Kepanjen	10	12	22	277	347	624
RS Jiwa Lawang	13	12	25	445	384	829
RS Paru Batu	7	13	20	85	133	218
RS Dr. Soebandi	8	17	25	449	585	1,034
RS Balung	14	15	29	99	179	278
RS Kalisat	9	14	23	90	126	216
RS Paru	11	13	24	124	102	226
RS Dr. Soedono	6	13	19	376	559	935
RSU Kota Madiun	8	15	23	107	160	267
RS Kabupaten Madiun	9	11	20	117	186	303

Continued on the next page

Table 2.4 – continued from the previous page

Public hospitals	Samples			Employees		
	Males	Females	Total	Males	Females	Total
RS Paru Dungus	13	16	29	61	46	107
RS Dr. Soegiri	8	13	21	n.a	n.a	600
RS Kusta	9	12	21	96	94	190
RSUD Pare	7	15	22	189	233	422
RSUD Sidoarjo	7	18	25	458	734	1,196
RSUD Ibnu Sina	7	17	24	n.a	n.a	729
RSUD Dr. Wahidin Sudiro Husodo	7	16	23	n.a	n.a	600
RSUD Prof. Dr. Soekandar	12	18	30	n.a	n.a	358
RSUD RA Basuni	8	16	24	52	82	134
RS Kusta Sumber Glagah	7	8	15	90	95	185
RSUD Dr. R. Soedarsono	6	15	21	126	310	378
RSUD Bangil	6	19	25	240	286	526
RSU Dr. Sosodoro	12	11	23	215	269	484
RSU Sumberrejo	12	6	18	28	26	54
RSU Padangan	5	21	26	23	37	63
RSUD Dr. R. Koesma	4	18	22	275	297	572
RSUD Dr. Soeroto	11	13	24	165	200	365
RSUD Dr. Moh. Shaleh	8	17	25	267	375	636
RSUD Waluyojati Kraksaan	12	18	30	126	186	312
RSUD Tongas	7	19	26	68	122	190
RSUD Dr. Haryoto	13	12	25	288	323	611
RSUD Dr. H. Koesnadi	8	11	19	208	370	578
RSUD Abdurrahem	12	18	30	207	386	593
RSUD Blambangan	10	7	17	167	219	386
RSUD Genteng	10	17	27	n.a	n.a	338
RSUD Dr. Sayidiman	9	14	23	167	286	453
RSUD Prof. Dr. Harjono, SpOG	6	18	24	249	325	574
RSUD Pacitan	5	21	26	188	266	454
RSUD Mardi Waluyo	11	10	21	n.a	n.a	477
RSUD Ngudi Waluyo	12	14	26	209	286	495
RSUD Dr. Iskak	10	17	27	414	583	997
RSUD Nganjuk	8	17	25	207	339	546
RSUD Kertosono	9	15	24	101	157	258
RSUD Jombang	11	11	22	370	586	956
RSUD Syarifata Rato Ebuh	6	16	22	288	489	777
RSUD Sampang	11	9	20	n.a	n.a	335
RS Slamet Martodirjo	6	9	15	216	259	475
RSUD Dr. Moh. Anwar	9	15	24	222	199	421
RSUD Soedomo	15	15	30	129	191	321
Total *	472	792	1,282			31,954

Notes: * 18 respondents failed to report their gender. n.a = not available.

RS = *rumah sakit* or hospital. RSU = *rumah sakit umum* or public hospitals.

RSUD = *rumah sakit umum daerah* or district public hospitals.

With one public hospital refused to participate, Table 2.4 shows the 54 participating public hospitals with 1,282 employees in this survey which represents 12% of morning shift employees on the day of the survey. The morning shift employees are one third of the total employees in each hospital as there are three shifts of

work as the hospitals operate 24 hours a day. As employees have rotating shifts, their answers may also represent those working in the afternoon and at night shifts. Furthermore, studies involving relationships between individuals and organisations they belong to should consider sample size at the organisation level (Maas and Hox, 2005). This survey fulfilled the requirement as there were more than 50 hospitals involved covering 99% of all public hospitals in East Java. Figure 2.1 shows the locations of public hospitals in East Java according to their classes. The hospitals are classified based on the number of beds and facilities a hospital have. Detailed explanation on this classification is available in the following chapter, Chapter 3.

Figure 2.1. Hospitals in East Java based on class



Source: Geospatial Information Agency (2010)

Although Indonesian healthcare service is provided by both public and private sectors (see Chapter 3 for details), this study focused on the public hospitals as those hospitals employed more individuals than the private sector as they provide

58% of beds with 44% share of healthcare sector while the number of beds determines the number of employees in a hospital. As the Indonesian government allows dual practice for physicians, specialist doctors and midwives (Ministry of Health, 2007, 2010c), most of physicians and specialist doctors in public hospitals are also employed in private hospitals (Rokx et al., 2010). Despite public sector is considered more bureaucratic in Indonesia (Suryani et al., 2012) and in other parts of the world (Solomon, 1986; Lowe et al., 1996), this focus may serve a better comparison with the British study as the healthcare services in this country are mostly provided by the public sector.

It is parsimonious to collect Indonesian data within a single industry for this research. Though doing so may make generalising the results difficult, there are some reasons to pursue this focus. First, the healthcare industry comprises 14% of the establishments in WERS2004 (Kersley et al., 2006) and approximately 17% of those in WERS2011 (van Wanrooy et al., 2013). Second, the measures of social capital used in this thesis are applicable to diverse industries (Kouvonen et al., 2008) which may minimise the problem of generalisation (Vokurka and O’Leary-Kelly, 2000). Third, data from the healthcare industry have been used to explore many strategic topics in the past (Boyd and Reuning-Elliott, 1998) and other recent studies have made use of the healthcare industry to study social capital (Ansmann et al., 2014; Hammer et al., 2013; Idrovo et al., 2012; Driller et al., 2011; Ommen et al., 2009). Fourth, this study considers the perception of both the management and employees in healthcare, and as such the results may apply to other industries as well. Lastly, the workplace performance measures used in this research are those commonly found in other industries such as manufacturing and other services.

2.1.3 Other data

In addition to the most current working population data for this thesis, data from other sources are utilised in this thesis. As the data for Europe and Britain were col-

lected during a recession, several macro-level data related to the economic conditions were also sourced, as well as regional unemployment and growth rates with GINI coefficients and welfare state types of each country in the European study (Bambra and Eikemo, 2009; Bambra et al., 2014; Eurostat, 2013, 2012; World Bank, 2013). The unemployment rates by industry (Office of National Statistics, 2012) are included in the British study. These data will serve as the context of the related studies.

2.2 Measures

Based on the research questions in Chapter 1, the empirical chapters are divided into two parts. The first part investigates the relationship between workplace social capital and job satisfaction, and the second part examines the relationships between workplace social capital, job satisfaction and workplace performance. Both parts use workplace social capital and job satisfaction at the individual level, whilst workplace performance is measured at the higher level: workplace in the second part.

Workplace social capital Following previous studies, this thesis measures social capital by means of several aspects such as trust and social relations within the workplace (Kouvonen et al., 2006; Leana and van Buren, 1999; Lowe and Schellenberg, 2001; Requena, 2003). Furthermore, workplace social capital in this thesis is differentiated into vertical and horizontal social capital (Serageldin and Grootaert, 1999; Kouvonen et al., 2008). As workplace social capital is a variable with multiple facets, it is treated as a latent variable following Oksanen et al. (2010) in all empirical chapters, other than the chapter on Europe (Chapter 4).

In Britain, WERS2011 asked several questions on the relationships between employees and their managers, thus capturing vertical social capital only, whilst in Indonesia, questions on both vertical and horizontal social capital were asked following questions developed by Kouvonen et al. (2006). For Britain and Indonesia,

the employees answered the questions using a five-point Likert scale. For the study of Europe, there is only one question in EWCS2010 that can be used to measure workplace social capital: that of whether workers have very good friends at work. The European workers also answered using a five-point Likert scale. Therefore, in contrast to the studies of Britain and Indonesia, the workplace social capital in Europe is treated as an observed variable.

Job satisfaction As with workplace social capital, WERS2011 considered several aspects of job satisfaction, namely: the sense of achievement the employee gets from work, the scope for using one's own initiative, one's influence over the job, the training received, the amount of pay received, the opportunity for skills development, job security and the work itself. The employees responded using five-point Likert scales. This measurement of job satisfaction has been used in previous studies (Jones et al., 2009; Wood et al., 2012); however, these previous studies treated job satisfaction differently: while Jones et al. (2009) treated those aspects individually in their models, Wood et al. (2012) used job satisfaction as a latent variable. Following Wood et al. (2012), this thesis treats job satisfaction as a latent variable in both the British and Indonesian studies. Job satisfaction in the European study, though, is based on the workers' responses to a single question on satisfaction with overall working conditions in their main paid jobs. The responses were given by means of a four-point Likert scale. Previous studies have shown that a single question is sufficiently reliable to measure job satisfaction (Dolbier et al., 2005; Nagy, 2002; Wanous et al., 1997) as they have found a relatively high correlation between the results gathered using a single question and those based on with longer questionnaires on job satisfaction.

Well-being In addition to job satisfaction, the European study also measures well-being. As well-being is measured in EWCS2010, the study offers a good opportunity to examine both job satisfaction and well-being given that there are diverse domains

in a worker's life (Warr, 2007). Well-being is measured using several questions similar to those on the WHO-Five Well-being Index (WHO-5) (WHO, 2003): 'Over the last two weeks, 1) I have felt cheerful and in good spirits; 2) I have felt calm and relaxed; 3) I have felt active and vigorous; 4) I woke up feeling fresh and rested; and 5) My daily life is filled with things that interest me'. The responses are given on a Likert-scale with 0 for 'at no time' and 6 for 'all the time'. Well-being is treated as an observed variable in this study by summing all the responses following the WHO (2003).

Workplace performance The last variable in this study is workplace performance. Both the British and Indonesian studies collected those data and they include both subjective and objective performance measures. As WERS2011 is a survey for all industries in Britain, it uses general workplace performance measures. As such, in the British study (Chapter 6), the subjective workplace performance measures include productivity, financial performance and quality of product or service; absenteeism is the objective performance measure (Jones et al., 2009; de Menezes, 2012; Wood et al., 2012). These measures are taken from the answers of the managers, who were asked to compare their workplaces' performance with those of their competitors. With the exception of absenteeism, the managers answered the questions on each measure using a seven-point Likert scale to express whether their workplaces were performing better than or not as well as their competitors'.

The Indonesian questionnaires also asked about specific health performance measures such as nosocomial infection levels, however, the public hospital managers left the questions unanswered. Apparently they did not have sufficient records to answer the questions. Instead, objective performance is measured using revenue per bed, expenditure per bed, bed occupancy ratio and length of stay, all common managerial performance indicators in the hospital industry (Bergeron, 2006; Over and Watanabe, 2003) as those performance measures were also examined by the Ministry of Health (Ministry of Health, 2015). In contrast to the British study, absenteeism is

not included in workplace performance as the data on absenteeism were unavailable. Other than those measures, the managers were asked to compare their workplace performance using managerial indicators as the British study did. Unlike British workplaces, data on competitors' performance may not be available to the managers. As such, they were asked to assess their performance based on the standards issued by the Ministry of Health for subjective performance measures. This adjustment is crucial for the managers to be able to answer the questions. Similar to the British study, the managers also answered using seven-points Likert scales. The next chapter (Chapter 3) gives more detailed information on public hospitals in Indonesia.

2.3 Modelling strategy

As a reminder, this thesis is aimed to answer the following research questions:

- Does workplace social capital affect workers' well-being?
- What is the relationship of social capital, job satisfaction and workplace performance?
- How do individual characteristics differ in determining job satisfaction in developed and developing countries?
- How do the contexts of organisations in developed and developing countries differ in determining the relationship of social capital, job satisfaction and workplace performance?

To answer these questions, general latent variable model framework (Muthén and Asparouhov, 2011) is used as follows:

Structural equation modeling Based on their measurements, workplace social capital and job satisfaction are treated as latent variables. Structural equation models (SEM) are used as sets of items reflecting both workplace social capital and job

satisfaction. SEM is often used when latent variables or theoretical constructs are the focus in behavioural science analysis (Hox and Bechger, 1998). SEM consists of two parts: the measurement model and the structural part. The measurement model shows the relationships between the items or indicators and the factor or the latent variable before estimating reliability (Hair et al., 2006). This measurement model is beneficial to ensure that the indicators measure the same thing (the construct) and to account for measurement errors that may arise both from the responses in the survey and the establishment of abstract concepts (Hair et al., 2006) such as workplace social capital and job satisfaction. The structural part shows the meaningful relationships between factor or factors and the observed variables (Rabe-Hesketh et al., 2004). In other words, SEM combines a factor analysis in the measurement model and a regression analysis for the structural part (Hox and Bechger, 1998).

Multilevel analysis Several authors mention that individuals' contexts may influence workplace social capital (Brien and Smallman, 2011; Lowe and Schellenberg, 2001). Context refers to the characteristics or the opportunity structures of the location itself (Duncan et al., 1993; Macintyre et al., 2002), such as the climate within the workplace. The climate of a workplace affects workers' satisfaction, their performance, and their collegiality since they are in the same workplace. By the same logic, when a policy enacted it affects the workplace and all workers within it. Nevertheless, the workplace consists of workers with different individual characteristics such as educational background, gender, and skills, all of which are relevant to the workplace. Thus, to measure workplace outcomes, both the context and the composition of the workplace need to be considered as workers belong to a certain workplace. On a larger scale, workplaces may be affected by policies and situations in regions and countries.

The structured or nested relationships between workers, workplaces, regions and countries require multilevel regression models rather than ordinary regression models (Klein and Kozlowski, 2000; Snijders and Bosker, 2012) to capture valuable infor-

mation and understand organisational phenomena (Payne et al., 2011; Wharton et al., 2000; Zatzick and Iverson, 2011). Multilevel analysis can show the variability between individuals and workplaces (Goldstein, 2003; Snijders and Bosker, 2012). Thus, a multilevel model is applied in Chapter 4 to study relationships between workplace social capital and both of well-being and job satisfaction in Europe. A three-level model is applied with workers at level one, regions at level two and countries at the highest level (level three).

Multilevel SEM In addition to the use of appropriate regression analysis for studying workplaces, observation of the nature of relationships between the individual level or Level-One unit (micro-level) and the workplace level or Level-Two unit (macro-level) is essential (Klein and Kozlowski, 2000; Snijders and Bosker, 2012). To describe the nature of the relationship between the levels, Snijders and Bosker (2012) introduced two propositions: the Macro-micro and the micro-Macro situations. The Macro-micro situation exists when the macro-level variables influence the micro-level variables. For example, the human resource policies in a workplace affect all workers in the workplace. This situation is the more common situation in multilevel modelling (Snijders and Bosker, 2012). On the other hand, the micro-Macro situation observes the effect of micro-level variables to higher level variables at the macro level, such as the associations of job satisfaction and organisational commitment with workplace performance (Harter et al., 2002; Ostroff, 1992).

Constructing macro-level variables for the micro-Macro approach can be problematic (Croon and van Veldhoven, 2007; Lüdtke et al., 2008; van Mierlo et al., 2009). The most common method of doing so is to aggregate the individual-level variable (Croon and van Veldhoven, 2007). However, aggregation involves assigning group means of individual-level variables to a higher-level variable, which eliminates the variability in the data and thus may result in inappropriate estimates of the standard errors in the regression (Croon and van Veldhoven, 2007). To avoid this problem, Croon and van Veldhoven (2007) offered an approach that uses individual-

level variables as indicators for latent variables at a higher level. The underlying assumption is that the group mean represents the level of individual scores within a group. The estimation of latent variable parameters uses a multiple regression analysis on adjusted group means, which successfully produces unbiased estimates (Croon and van Veldhoven, 2007).

In this thesis both propositions are applied in both developed and developing countries. The Macro-micro approach affords the opportunity to observe the relationships between workplace social capital and job satisfaction in Britain and Indonesia (Chapter 5 and Chapter 6). In contrast, the micro-Macro approach is used to look into the relationships between workplace social capital, job satisfaction and workplace performance in Chapter 7 and Chapter 8. Both workplace social capital and job satisfaction are measured at the individual level, while workplace performance is measured at the workplace level. This approach uses workplace performance as the dependent variable, while both workplace social capital and job satisfaction are independent variables. As workplace social capital and job satisfaction are treated as latent variables due to their multi-dimensionality and their existence within a nested structure (Croon and van Veldhoven, 2007; Rabe-Hesketh et al., 2004; Muthén and Asparouhov, 2011), the multilevel SEM model is applied for Chapter 5 through Chapter 8 in this thesis.

2.4 Conclusion

This chapter describes the data to be used and the methods to be applied in this thesis. Using data from workers in Europe, Britain and Indonesia, this thesis attempts to investigate first: the relationship between workplace social capital and job satisfaction and second the relationships between workplace social capital, job satisfaction and workplace performance. For the first relationship the Macro-micro approach to multilevel modelling is applied, while the second relationships use the micro-Macro approach. When workplace social capital and job satisfaction are

treated as observed variables, the multilevel model is used; when both workplace and job satisfaction are latent variables, the multilevel SEM method is applied.

The next chapter will introduce the settings of each of the economies treated in this thesis, starting with the economic situations and labour markets in Europe and Britain and followed by the conditions in Indonesia.

Chapter 3

The Settings

As this work studies use workers and workplaces in different economies, this chapter introduces the settings of the research. The settings mostly cover the labour markets and/or macroeconomics condition in each country with additional explanations of healthcare systems in Britain and Indonesia.

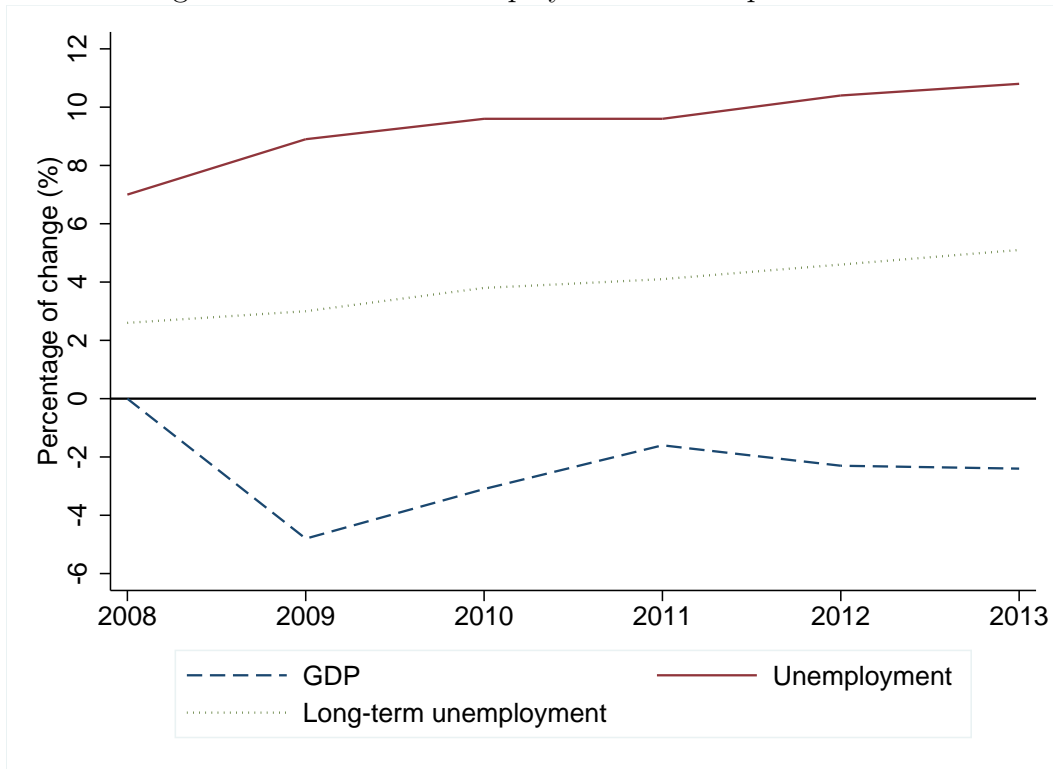
3.1 Developed countries

3.1.1 Europe

Labour market in 2008-2013 As of 2010, the European Union (EU) comprises 27 member states of which 16 countries use the euro as their currency. These 16 countries are known as the Euro area (EA). The economic crisis in Europe began with the collapsing of several European banks after Lehman Brothers, the largest investment bank in the United States, filed for bankruptcy in 2008 (European Commission, 2009). In addition, several countries in the EU fell into the debt crisis and needed financial bailout starting with Greece in 2009 and followed by Ireland in 2010 (Wearden, 2014). The economic crisis contracted the economy and drove unemployment in Europe from 2008. At the beginning of the crisis in 2008, ten out of 27 countries in the EU experienced rising unemployment rates with the highest rate in Spain, Latvia, Lithuania and Ireland (European Commission, 2009). This indicated that those countries were impacted the most by the crisis (European Commission,

2009). In 2009, Spain, Latvia, and Ireland continued to suffer high unemployment, joined by Estonia, while small increases in unemployment were experienced by Luxembourg, Finland, Poland, Sweden, Malta, Belgium, Italy and the Netherlands (European Commission, 2010). In contrast to those countries, Germany experienced a decline in unemployment (European Commission, 2010).

Figure 3.1 GDP and unemployment in Europe 2008-2013



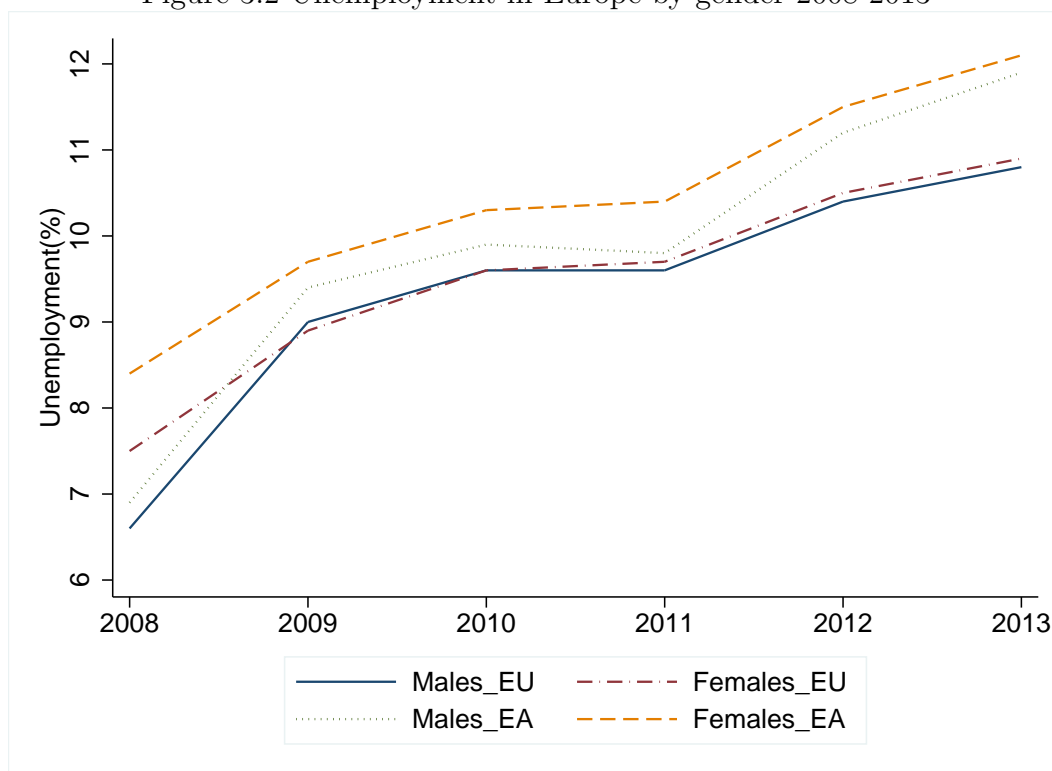
Source: Eurostat (2014b, 2015a,b)

Figure 3.1 shows a contrasting picture of unemployment, long-term unemployment and gross domestic product (GDP) across the EU from 2008 to 2013. Europe enjoyed the lowest level of unemployment in the beginning of 2008 as 16.2 million persons were without jobs; this is equivalent to a rate of 6.8% (Eurostat, 2015c). Between 2008 and 2010 the average European unemployment level rose to 9.6%. Unemployment continued to increase steadily reaching 10.9% in 2013. GDP fell drastically in 2009 and slowly recovered until 2011. However, GDP growth stopped in 2011 and slightly decreased from 2011 until 2013. As a result, at the end of 2013, the GDP in the region had not rebounded to its level at the start of the economic

crisis.

Although GDP grew from 2009 to 2011 as shown in Figure 3.1, unemployment continued to increase, which resulted in long-term unemployment in the EU. Eurostat defines long-term unemployment rate as ‘the number of people who are out of work and have been actively seeking employment for at least a year’ (Eurostat, 2014a). Several reasons existed for this increasing unemployment rate (European Commission, 2011): businesses still showed uncertainty as to the sustainability of the economic growth, which in turn discouraged them from hiring. Businesses also preferred to hire employees who had experienced relatively short period of unemployment to ensure that employees’ skills had not deteriorated during the unemployed period. Additionally, there exists the possibility of a mismatch between labour demand and the specific skills required in the recovery period.

Figure 3.2 Unemployment in Europe by gender 2008-2013



Source: Eurostat (2015b)

Figure 3.2 breaks down unemployment statistics in Europe according to gender and currency. There were significant differences in the patterns of gender unemploy-

ment in the EU overall and the EA specifically. In the EU, the female unemployment rate was higher at the start of the crisis. However, it decreased in 2009-2010 as male unemployment became more prominent. After 2010, the female unemployment level was slightly higher than the male. In the EA, the female unemployment rate was consistently higher than the male from 2008 through 2013. Overall, both female and male unemployment levels were higher in the EA than those in the EU; however, the unemployment gaps by gender between the two areas have widened since 2011.

The welfare state regimes Unemployment clearly affected the welfare of European citizens. Different countries reacted differently to remedy citizens' welfare issues when the economic crisis hit. Particular reactions may be seen as based on the role of the state in managing the economy. Esping-Andersen (1990) clustered European countries into three regimes of welfare state: the liberal, the conservative-corporatist and the social-democratic. However, his clusters are criticized and revised by several studies with an addition of southern welfare (Ferrera, 1996) and the post-communist (Fenger, 2007) that refers to countries in central and eastern Europe that had been part of the Union of Soviet Socialist Republics which are also called the transitional economies. This study classifies the countries based on the welfare state regimes used in previous studies on unemployment and working conditions in Europe (Bambra and Eikemo, 2009; Eikemo and Bambra, 2008; Holman, 2013): Anglo-Saxon (liberal type), Bismarckian (conservative/corporatist type), Scandinavian (social democratic type), Southern Europe and, lastly, Eastern Europe (post-communist/transitional economies) including the central European countries. These five welfare state regimes are used to differentiate the conditions of European countries in Chapter 4.

Each welfare state regime is different in its relationship to the labour market. The liberal welfare state regime relies on the market mechanism in providing employment and determining pay. Welfare benefits are provided for those in need, i.e. unemployed or low-income citizens (Castles, 2010). The conservative welfare state

supports the families by intervening when family resources have been exhausted, encouraging women to focus on motherhood (Palier, 2010). The provision of welfare benefits differs for different populations. The social-democratic welfare state guarantees full employment and wages; it does not rely on the market mechanism (Kautto, 2010). Workers can pursue training or education while being paid by the state and employers used this paid leave to engage in labour hoarding when the economy slowed down. In addition, this regime encourages women to work, providing benefits based on the rights of citizenship. The southern welfare state provides basic social insurance in a segmented labour market as there are regular, irregular workers and informal workers (Bambra and Eikemo, 2009; Ferrera, 2010). In addition, social assistance is weak in this welfare type due to the strong role of family, informal sector and low administrative capacities (Ferrera, 2010). Labour markets in the post-communist welfare state regime remain restrictive with depressed wages and increasing stratification of the market. Although women actively joined the workforce in the communist era, they have retreated to fulfil family responsibilities as a result of the relatively high unemployment rates found in post-communist countries. The post-communist welfare system has become 'less distributive, also more stratified and in favour to middle- and upper-income groups' (Cook, 2010, p.681).

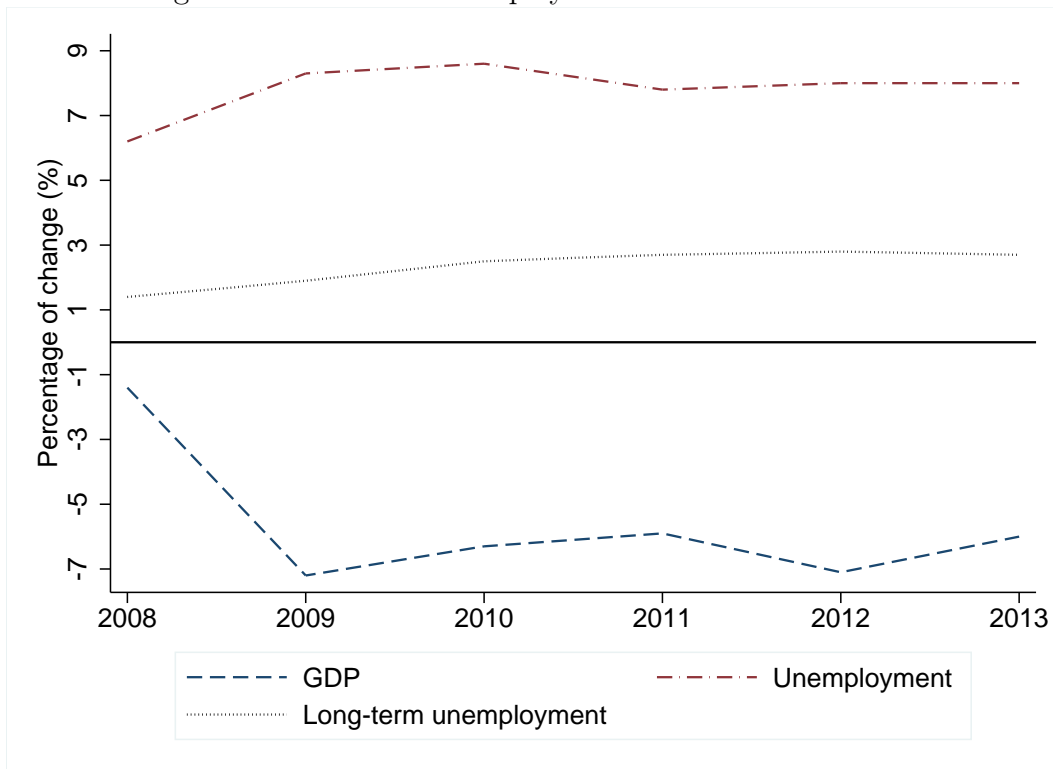
3.1.2 Britain

Labour market in 2008-2013

Britain's economic woes began with the collapse of Northern Rock bank in late 2007. In 2008, following the collapse of Lehman Brothers in the United States, several British banks were saved using taxpayers' fund in 2008 (BBC News, 2013; Wearden, 2014). Britain later involved itself in the eurozone crisis by providing financial bailout for Ireland in 2010 (BBC News, 2013; Wearden, 2014). Figure 3.3 shows GDP, unemployment and long-term unemployment in Britain during the period from 2008 to 2013. Long-term unemployment is defined as unemployment

over the immediately preceding twelve-month periods (Office of National Statistics, 2012). Similar to other countries in the EU, Britain suffered an increase in its unemployment during the period shown in Figure 3.3, although the increase was not as high as experienced in other countries (OECD, 2014b). The unemployment rate slowly decreased after peaking in 2010 and then remained stagnant, while long-term unemployment increased to approximately 2% in 2010 and remained consistent until 2013. Britain also suffered a huge contraction in its GDP (in 2008-2009); however, GDP slightly improved for a short period before falling again by the end of 2011. According to GDP statistics, Britain had not recovered from the economic crisis in 2013.

Figure 3.3 GDP and unemployment in Britain 2008-2013

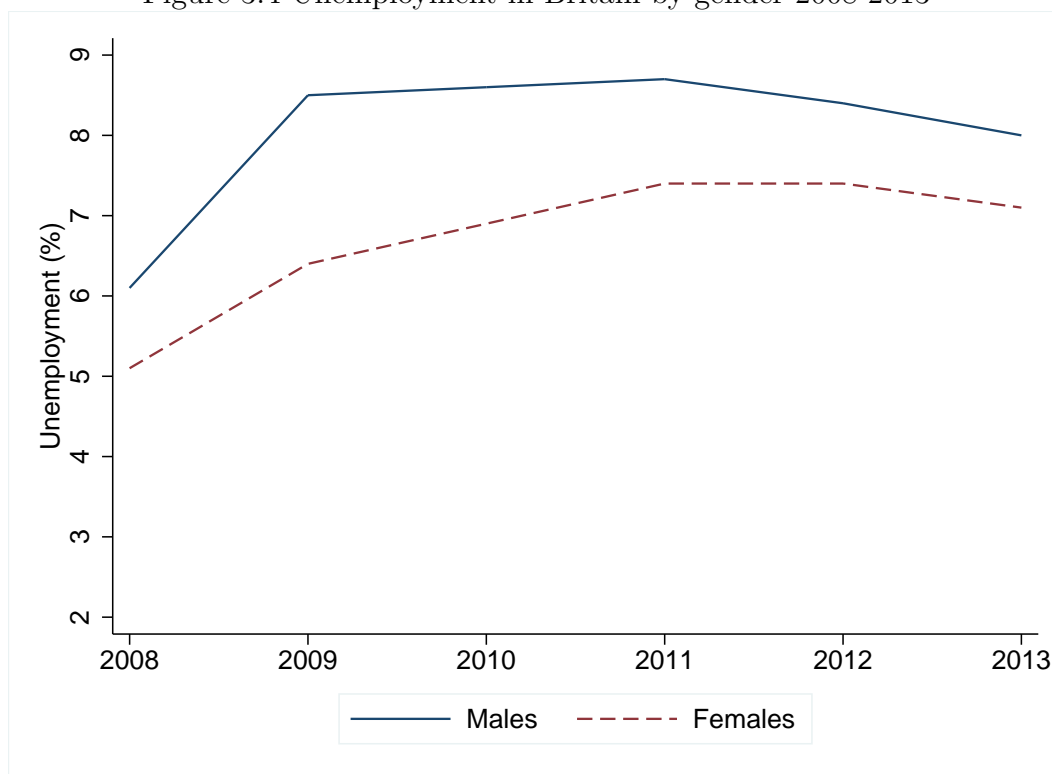


Source: Eurostat (2014b, 2015a,b)

Comparing unemployment by gender in Britain, male employees with their higher unemployment rates suffered more from the crisis than female employees. Figure 3.4 shows that, in Britain, more males than females became unemployed during six years represented. This was to be expected given that the sectors that impacted the most

by the crisis, such as construction and manufacturing, largely employ males (van Wanrooy et al., 2013). In addition, males tend to work mostly in the private sector (80%), while females generally choose the public sector (75%) (Office of National Statistics, 2015a).

Figure 3.4 Unemployment in Britain by gender 2008-2013

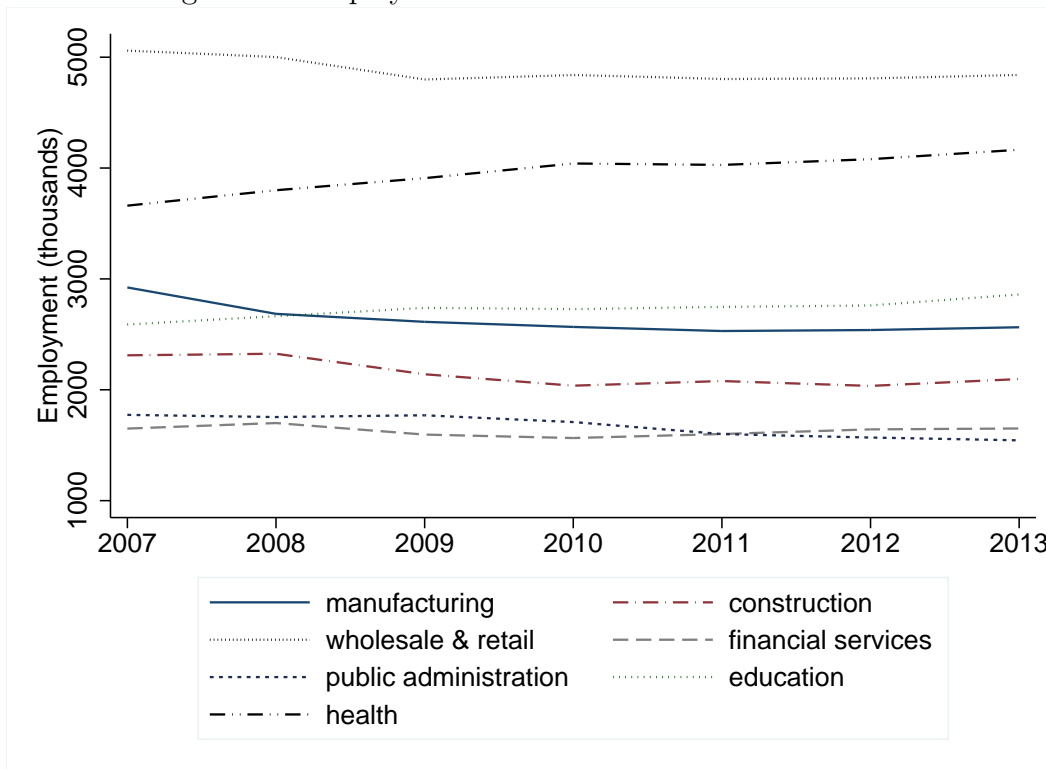


Source: Eurostat (2015b)

Figure 3.5 shows the changes of employment in selected industries across Britain during the period 2007-2013. The industries charted in the figure are based on the Standard Industrial Classification 2007 with figures seasonally adjusted (Office of National Statistics, 2015b). Most industries considered in Figure 3.5 showed a decreasing trend after 2008; both health and education, however, showed increases in employment, with health exhibiting a considerably larger increase than education. Based on Figure 3.5, employment in the health industry in Britain was not impacted by the economic crisis that began in 2008. Public administration showed only a slight decrease after 2010. Construction and financial services showed similar patterns from 2007 to 2013, while manufacturing employment declined consistently until

stabilising in 2011. The wholesale and retail industries both experienced a slight increase between 2007 and 2009, after which they remained stagnant until 2012.

Figure 3.5 Employment in selected industries 2007-2013



Source: Office of National Statistics (2015b)

The next section will focus on healthcare in Britain as this study also uses data from the healthcare industry.

Healthcare in Britain

Healthcare in Britain is provided through the National Health System (NHS) in each country within the United Kingdom: England, Wales, Scotland and Northern Ireland. The NHS is universal, free at the point of delivery, equitable and paid for by central funding (Bevan et al., 2014; Grosios et al., 2010). The central government is responsible for healthcare in England, while the governments of Wales, Scotland and Northern Ireland take responsibility for their respective countries (Bevan et al., 2014; Grosios et al., 2010). The NHS provides preventive medicine as well as primary,

secondary and tertiary care for British residents (Boyle, 2011; Grosios et al., 2010). Primary care is provided by self-employed general practitioners (GPs), community health centres, NHS walk-in centres, dentists, opticians and pharmacists (Boyle, 2011). Secondary and tertiary care are provided by specialist doctors, nurses and other health professionals who work mostly in government-owned hospitals and in a few private hospitals (Boyle, 2011; Grosios et al., 2010).

Through the NHS, most of the health expenditure in the country is public expenditure funded by taxes and national insurance contributions (Grosios et al., 2010). Table 3.1 shows GDP per capita and health expenditure in Britain. The GDP decreased in 2009 as a result of the contracted economy, as the amount of health expenditure per capita. However, the percentage of health expenditure increased due to the sinking GDP and slowly decreased beginning in 2010. Out-of-pocket health expenditure decreased slightly in line with the country's economic condition and later rebounded.

Table 3.1: GDP and health expenditure in Britain

Indicators	2008	2009	2010	2011	2012
GDP per capita (USD)	45,170.5	37,075.5	38,363.4	40,972	41,053.7
Health expenditure per capita (USD)	3,875	3,512	3,489	3,659	3,647
Total health expenditure (% GDP)	9.0	9.9	9.6	9.4	9.4
Public health expenditure (%)	81.1	82.6	83.5	82.8	82.5
Out-of-pocket health expenditure (%)	8.9	8.7	8.8	9.3	9.0

Note: USD = US Dollar

Source: OECD (2014a); World Bank (2014d)

Table 3.2 show health indicators for Britain and selected European countries. Britain and Germany has the lowest years of life expectancy compared to other countries such as France, Italy, Spain and Sweden. Britain also has the highest mortality rates for infants and children under 5 years old. Other two health indicators, maternal mortality rate and mortality rate of people aged 15 to 60 years old, show that they are among the highest. These health statistics may due to the healthcare facilities and the number of health workers in those countries.

Table 3.2: Basic demographic indicators of selected European countries (2013)

Country	Life expectancy (years)	Infant mortality rate	Under-5 mortality rate	Maternal mortality rate	Mortality of people aged 15-60 years
Britain	81	3.9	4.6	8.0	72
France	82	3.5	4.2	9.0	80
Germany	81	3.2	3.9	7.0	71
Italy	83	3.0	3.6	4.0	54
Spain	83	3.6	4.2	4.0	63
Sweden	82	2.4	3.0	4.0	56

Source: World Health Organization (2015a,b)

Table 3.3: Hospital beds and health workers density in EU, 2012

Country	Hospital beds per 1,000 population	Physicians per 1000 population	Nurses per 1000 population	Population (millions)
Britain	2.8	2.8	8.2	63.5
France	6.3	3.3	9.1	65.8
Germany	8.3	4.0	11.3	80.3
Italy	3.4	3.9	6.4	59.4
Spain	3.0	3.8	5.2	46.8
Sweden	2.6	3.9	11.1	9.5

Source: Eurostat (2014b); NHS Confederation (2015); OECD (2014a)

To compare the healthcare facilities and the number of health workers, Table 3.3 shows numbers of hospital beds and health workers density in Britain and other countries in the EU. Britain has a lower density of hospital beds compared to other countries with almost similar populations, such as France and Italy. The number of hospital beds per 1000 population in Britain is 2.8 which is slightly higher than the number provided by Sweden. Sweden's population, however, is one fifth of Britain's. The density of physicians in Britain is lower than in other countries in the EU. However, Britain does provide more nurses for its population than Italy and Spain in the EU. To certain extent, Britain's health statistics are clearly inferior to Germany's; yet, the NHS workforce has increased since 2000 (NHS Confederation, 2015) (see also Table 3.4).

Table 3.4: NHS Workforce* 2008-2013

NHS main staff groups	2008	2009	2010	2011	2012	2013
All doctors	133,662	140,897	141,326	143,836	146,075	147,807
Qualified nursing staff	368,425	375,505	375,950	372,277	369,868	371,777
Qualified scientific, therapeutic & technical staff	142,455	149,379	151,607	152,216	153,472	154,109
Qualified ambulance staff	17,451	17,922	18,450	18,687	18,645	18,734
Support to clinical staff	334,929	352,800	356,410	347,064	343,927	348,999
NHS infrastructure support	219,064	236,103	233,342	219,624	215,071	211,185
Other GP practice staff	92,436	92,333	112,985	110,593	113,832	114,223
Other	353	364	356	266	237	220

Note: * based on NHS England

Source: Health and Social Care Information Centre (2014)

Figure 3.5 previously showed that healthcare industry boasted increasing employments in spite of the economic crisis in 2008. Table 3.4 shows details of that industry using the NHS main staff groups and their workforce development from 2008 to 2013. All groups show increases in the workforce until 2010, after which several groups then exhibit a two-year decline in the workforce, before improving in 2013.

Workplaces in Britain

Guest (2004) revealed previously that British workplaces have fewer employees and the most recent WERS survey (WERS2011) showed that most workplaces in the survey had fewer than 20 employees (van Wanrooy et al., 2013). The private sector contributes 73.2% of the nation's employment, while the public sector has 26.8% (Office of National Statistics, 2015a). In addition, female employment has risen in Britain in the last twenty years (Dex and Forth, 2009) and almost half of the current workforce is made up of females (Office of National Statistics, 2015a). As more females join the workforce in the public sector, workplaces have applied equal employment and work-life balance policies, which have been increasingly been introduced in the private sector (Dex and Forth, 2009).

Observing the changes in workplaces in the country, Brown et al. (2009b) found

that workplaces in Britain have moved toward individualism and away from collectivism. Collective bargaining and union membership are less common in British workplaces as managers in workplace have not been in favour of such unions (Kersley et al., 2006; van Wanrooy et al., 2013). The significant decrease in collectivism is visible in the areas of financial services, public administration and healthcare (WERS2011). Collective bargaining is ‘a constantly changing bundle of written and unwritten agreements and understandings’ (Brown et al., 2009a, p. 23) that affect employees in a workplace. Trade unions still exist in the public sector and in large workplaces in the private sector. However, union membership is more common among employees with higher qualifications than among workers with lower skill level.

Collective bargaining and trade unions used to represent workers’ or employees interests in pay determination. With the decreasing influence of both, pay is decided by the managers of workplaces or by a higher level manager for organisations with multiple workplaces in the private sector (Dex and Forth, 2009; van Wanrooy et al., 2013). Thus, employees conduct their pay negotiations individually with representatives of their workplaces. Although there was a decentralised pay determination movement after the abolition of civil service-wide pay in 1996, central government still influences the pay setting by having independent pay reviews in the public sector (Dex and Forth, 2009).

Workplaces with fewer employees tend to create intense relationships between managers and employees (Guest, 2004). In addition, managers set the tone for employment relationships in the workplace. Managers influence the workplace environment, largely determining whether or not it is conducive to productivity (Argyle, 2001). Moreover, Sousa-Poza and Sousa-Poza (2000) found good relationships with managers and co-workers to be imperative for job satisfaction among British workers. Likewise, bad relationships in the workplace are the main sources of worker dissatisfaction. In times of crisis when unemployment is pervasive, employees need

more support from their managers.

In contrast, 'healthcare is characterised by an increasingly fragmented, specialised, professional division of labour' (Finn et al., 2010). These workplaces have commonly large workforce consisting of various professions whose conduct, employment, training and development are regulated by different professional institutions and dense unions (Buchan, 2004; Hyde et al., 2013; McBride et al., 2005). Compared to other service industries and manufacturing industries, the healthcare industry spent higher proportion of its budget on workers as it is a very labour-intensive industry (Buchan, 2004). Having specific skills and professional qualifications for the industry, these workers tend to be loyal to their professions and patients than to their employers (Buchan, 2004). Professional departments within the workplace are the source of identity for these workers, particularly when workplaces experience changes (Callan et al., 2007) as healthcare delivery has experienced different reforms since 1980 (Boyne et al., 2003) with the last reform taking place in 2000 with The NHS Plan (Department of Health, 2000). The NHS Plan is to increase the number of workers and to modernise the health services in England (Hyde et al., 2013).

Modernising health services involves more flexibility of workers to deliver patient-centred services (Hyde et al., 2005; McBride et al., 2005). Nevertheless, mutual interdependency among those numerous professions within hospitals and teamwork to deliver successful services depending on the complexity of care and type of hospitals (Baker et al., 2005; Borrill et al., 2001; Finn et al., 2010; World Health Organization, 2009). The care for patients in accident and emergency unit may be different than those in the maternity unit or a cancer unit. Teaching hospitals may require a slightly different teamwork as it is not only deliver a service for patients, but also deliver education for future workers (World Health Organization, 2009). Workers in healthcare industry are not only communicating with the patients, but also with the families and other providers in delivering the service. Lack of communication and teamwork have been found to contribute to adverse events (Weaver et al., 2014).

In contrast, team composition, work methods and workloads contribute to team effectiveness to provide better healthcare (Haward et al., 2003). Previous findings show that doctors are traditionally have higher position than nurses or other medical professions which give them more authority (Currie and Suhomlinova, 2006; Currie et al., 2010). Previous studies also found that hierarchical practice among professions within the hospital may hinder team effectiveness (Finn et al., 2010). The NHS Plan challenged this practice as the government gives new roles and more power to nurses and midwives (Department of Health, 2000) which flatten the hierarchy; yet, doctors are still considered as leaders in hospital (Currie and Suhomlinova, 2006). This hierarchical practice within professions also permeates to nurses as they treat healthcare assistants and operating department practitioners as their subordinates (Daykin and Clarke, 2000; Timmons and Tanner, 2004). As each profession has a different role in a team, social relations and negotiation may provide the oil for teamwork (Cott, 1998).

As well as having various professions, healthcare has many stakeholders, other than the government, such as regulators, researchers, patients, voluntary organisations and the public (The NHS Constitution, 2013). Those stakeholders require different performance information (Hyde et al., 2013). As the healthcare industry is highly funded by the public (see table 3.1), the government requires operational, financial and regulatory performances measures to ensure the accountability of the funding (Monitor, 2015). The operational performance measure consists of waiting times for accident and emergency, elective treatment, cancer treatment, ambulance response times and infection control; whilst the financial performance includes income and expenditure, operating expenses, cost improvement programs, and deficits among others (Monitor, 2015). The regulatory performance shows governance risk rating and continuity of services risk rating to determine suitable regulator's responses for each workplace (Monitor, 2015). Researchers in medicine may require type of diseases treated, cross-infections and process-related outcomes (e.g. outpa-

tient visits), whilst researchers in other field may look into the staffing-related outcomes (e.g. job satisfaction, absence, retention) (Buchan, 2004). Last but not least, patients and voluntary organisations may require information on the care-related outcomes such as live births, mortality rates and patient satisfaction (Buchan, 2004).

These characteristics of the healthcare industry in Britain may also present in Indonesia. However, the country's policy and its health system may affect the workplaces as I describe in the following section.

3.2 The developing country: Indonesia

Indonesia is the largest archipelagic state in the world; its archipelago extends between the Pacific and Indian oceans. The distance between the eastern and western tips of the country is equal to the distance from London in the United Kingdom to Doha in Qatar. The country is easily divided into the western and eastern parts and is commonly grouped into five big islands: Java-Bali, Sumatra, Kalimantan, Sulawesi and Eastern Indonesia (Maluku, Nusa Tenggara and Papua). Indonesia encompassed 34 provinces with 505 districts as of December 2013 (Ministry of Home Affairs, 2013); it is the fourth most populous country in the world, with a population of almost 250 million in 2013. The average population density is 134 people per km², yet the population density varies greatly across regions; as of 2010, the capital city of Jakarta (in Java) was populated with 14,469 people per km² while Papua had only nine inhabitants per km² (Statistics Indonesia, 2014b). More than half of the population live in Java, which makes it the most populous island in the world.

Indonesia's economy is the largest in Southeast Asia and ranks sixteenth in the world based on its 2013 GDP (World Bank, 2014a). Most individuals aged over 15 years work in the agricultural sector; the second largest industry in terms of providing employment opportunities is the service sector. The service sector is followed in this respect by the trading and manufacturing industries (Statistics Indonesia, 2014a). In 2013, Indonesia's GDP was 868.3 billion US dollars (USD) for a GDP

per capita of USD 3,373. The growth rate, according to World Bank (2014a), was nearly consistent at approximately 6% annually over the previous decade. However, inequality widened during the same period as the Gini coefficient has risen from 32.9 in 2002 to 41.3 in 2013 (Statistics Indonesia, 2014a).

Healthcare in Indonesia

Health expenditure in Indonesia is accounted for by a combination of public and private funding. On the one hand there are central and local government budgets, and on the other there are out-of-pocket expenditures as well as guarantees offered by commercial, corporate or other institutions. Most of Indonesia's health expenditure is used for curative services (Rokx et al., 2009b; Tandon et al., 2008), a system which consists of general physicians, specialist physicians, private outpatient clinics, *puskesmas* (health centres) and hospitals. In principle, general physicians, outpatient clinics and *puskesmas* deliver primary healthcare, while specialist physicians and hospitals deliver secondary healthcare through the curative care referral system. However, in practice, hospitals and specialists also provide primary healthcare, as patients often go to them directly. There are several reasons for this; chief among them is, that patients have more trust in specialists than general physicians; in addition, patients pay predominantly out-of-pocket. Indonesia spent approximately 3% of its GDP for health expenditure during the period from 2010 to 2012, a figure equalling USD 108 per capita in 2012. As this amount covers only approximately 40% of the country's need, the majority of health expenditure is out-of-pocket as shown in Table 3.5. With the high level of inequality that exists in Indonesia, some individuals choose not to buy medication when they fall ill; some also resort to more affordable traditional medication.

Despite Indonesia's large economy, healthcare provision remains a national challenge for the country. This challenge is illustrated in Table 3.6, which shows basic demographic indicators for countries in The Association of Southeast Asian Nations

Table 3.5: GDP and health expenditure in Indonesia

Indicators	2010	2011	2012
GDP per capita (USD)	2,947	3,470	3,551
Health expenditure per capita (USD)	86	99	108
Total health expenditure (% GDP)	2.9	2.9	3.0
Public health expenditure (%)	37.7	37.9	39.6
Out-of-pocket health expenditure (%)	75.8	76.3	75.1

Source: World Bank (2014d)

Table 3.6: Basic demographic indicators of ASEAN member states

Country	Life expectancy (years)	Infant mortality rate	Under-5 mortality rate	Maternal mortality rate (2008)	Mortality of people aged 15-60 years
Indonesia*	68	30	37	229	173
Malaysia*	72	5	5	42	118
Phillipines*	71	21	29	84	170
Singapore*	81	2	3	16	67
Thailand*	70	9	9	47	150
Brunei	76	6	8	37	104
Cambodia	61	50	60	266	243
Laos	61	49	68	339	216
Myanmar	56	42	55	219	219
Vietnam	72	11	13	64	141

Note: * founding members

Source: Chongsuvivatwong et al. (2011)

(ASEAN), created in 1967 with Indonesia, Malaysia, the Philippines, Singapore and Thailand as the founding members. The table shows that Indonesia is still lagging in many indicators compared to other founding members of ASEAN; Indonesia's health status is obviously closer to that seen in new members and smaller economies such as Laos, Cambodia and Myanmar. The life expectancy of Indonesians is 68 years which is lower than that of Vietnam and other large ASEAN countries such as Thailand and the Philippines. The infant mortality rate in Indonesia is threefold that of Thailand and Vietnam. With regard to maternal mortality rates, Indonesian mothers have a risk almost fivefold that of Thai mothers. The mortality rate of adult Indonesians is higher than that in the Philippines and only lower than the rates of Cambodia, Laos and Myanmar.

One of the reasons for Indonesian's lagging health status is the lack of suffi-

Table 3.7: Hospital beds and health workers density in ASEAN

Country	Hospital beds per 1,000 population	Physicians per 1000 population	Nurses & midwives per 1000 population	Dentists per 1000 population
Indonesia	0.6	0.204	1.383	0.099
Malaysia	1.8	1.198	3.276	0.363
Phillipines	1.0	1.153	6.000	0.564
Singapore	2.0	1.921	6.392	0.328
Thailand	2.1	0.393	2.077	0.258
Brunei	2.8	1.498	7.730	0.234
Cambodia	0.8	0.227	0.786	0.017
Laos	0.7	0.182	0.876	0.035
Myanmar	NA	0.612	1.003	0.069
Vietnam	2.0	1.159	1.137	NA

Note: latest data available for each country. NA: not available.

Source: World Bank (2014c); World Health Organization (2014)

cient numbers of health workers to serve the population. Compared to its fellow ASEAN members, as shown in Table 3.7, Indonesia is in a position similar to those of Cambodia, Laos and Myanmar with respect to the number of health workers. The availability of Indonesian physicians is only half of that in Thailand and Indonesia's physician density is only slightly better than Laos'. Nurses and midwives are more available to Indonesians than physicians, but their density is only two-thirds that of Thai nurses. The number of dentists available to the Indonesian population is particularly poor at only one-third of that in Thailand. Table 3.7 also shows that Indonesia has the smallest number of hospital beds per 1,000 population of any nation in ASEAN. The challenge for Indonesia is not only to increase the number of health workers, but also to ensure their distribution nationwide to provide healthcare for the entire population. The unequal distribution of health workers found in Indonesia is not unique; rather, it is a problem experienced in many other developing countries (Kolstad, 2011; Kruk et al., 2010; Lori et al., 2012; Mangham and Hanson, 2008; Raha et al., 2009a,b).

As of 2013, there were 295,508 nurses, 136,606 midwives and 46,336 pharmacists in Indonesia (Ministry of Health, 2014c). As to the availability of doctors in 2013, there were 38,866 specialists, 42,265 physicians and 13,092 dentists (Ministry of

Health, 2014c), compared to 5,515 specialists, 14,761 physicians and 4,079 dentists in 1992 (Gani, 1996). Thus, the numbers of physicians and dentists has increased threefold in the past two decades while the number of specialists has increased sixfold. These increases have resulted from thriving public health education, medical schools and nursing schools following decentralisation (Rokx et al., 2010; Thabrany, 2006; Yavuz et al., 2008). However, the qualifications of those health workers may not be standardised due to the weak accreditation process in Indonesia (Heywood and Choi, 2010; Rokx et al., 2009a). Unsurprisingly, the distribution of these health workers is unequal across Indonesia.

Until shortly before the time of this writing, the National Body of Accreditation for Higher Education was responsible for the accreditation of health education. However, this institution focused more on the administrative aspects of the education than on the clinical aspects (Rokx et al., 2009a). Table 3.8 describes selective schools in health education with their degrees and accreditation in Indonesia. All accredited schools are at the diploma level, other than medical and dentistry which are at the bachelor's level (WHO SEARO, 2011). The table shows that only 46 of 71 medical schools and approximately half of the dentistry schools had been accredited as of 2009. The length of medical education in Indonesia is similar to that in Thailand; it consists of three years of pre-clinic and three years of clinical learning (Kittrakulrat et al., 2014). However, the clinical stage for future physicians in Indonesia is not always conducted in the teaching hospitals: in fact, only half of the hospitals used are accredited as teaching hospitals (Rokx et al., 2009a). To be accredited as teaching hospitals, hospitals must meet the academic criteria set by the Ministry of National Education, not the Ministry of Health (Rokx et al., 2009a). As for other health education, as shown by Table 3.8, fewer than one in three diploma-level schools have accreditation.

Despite having the largest number of medical schools among ASEAN members (Kittrakulrat et al., 2014), the small number of accredited nursing and midwifery

Table 3.8: Health education and their degrees as of 2010

Schools	Diploma	Bachelor	Master	Doctoral	Professional	Specialist	Accredited
Medical	n.a	71	22	11	35	212	46
Dentistry	8	25	6	2	12	10	14
Nursing	288	308	3	1	0	1	50
Midwifery	748	2	1	0	0	0	214
Pharmacy	52	51	8	2	22	0	4

Note: n.a: not applicable

Source: WHO SEARO (2011)

schools in Indonesia may reflect both government neglect and confusion over the accreditation process as there are two ministries involved. The Ministry of Health gives accreditation to public nursing and midwifery schools at the diploma level, while private schools and higher-level public schools are accredited by the National Body of Accreditation for Higher Education (Rokx et al., 2009a; World Bank, 2009). Unlike medical schools, nursing and midwifery schools have no legal institutions to certify their graduates (Rokx et al., 2009a; World Bank, 2009). Nurses and midwives need only their school certificates to register at the provincial health office and to receive a license to practice World Bank (2009). Moreover, it is not mandatory for nurses and midwives to register in their professional or occupational associations. This situation is likely to improve: accreditation for health education is now covered by the Indonesian Accreditation Agency for Higher Education in Health as decreed by of the current Minister of Education in March 2015 (Indonesian Accreditation Agency for Higher Education in Health, 2015).

The weak accreditation process in Indonesian health education has compromised the quality of the country's medical graduates. Table 3.9 shows the ability of health providers to correctly diagnose illness using vignettes from the Indonesia Family Life Survey in 1997 and 2007 (Rokx et al., 2010). The vignettes are related to the conditions in three types of care: prenatal, child curative and adult curative. All scores in Table 3.9 are below 100 (the highest and expected score). Generally, health providers nationwide have a greater ability to treat children than to treat adults and prenatal conditions. Child curative care also showed the most significant

Table 3.9: Quality of public health services in 1997 & 2007

Service	National		Java & Bali		Sumatra		Others	
	1997	2007	1997	2007	1997	2007	1997	2007
<i>Prenatal care</i>								
Public	42	46	45	47	35	39	38	49
Private	40	44	43	46	34	37	39	46
<i>Child curative care</i>								
Public	56	64	58	66	48	56	55	65
Private*	55	59	57	62	50	52	54	60
<i>Adult curative care</i>								
Public	49	56	52	59	43	48	44	53
Private	46	53	48	56	40	51	44	51

Notes: All changes are significant at $p < 0.01$ or $p < 0.05$, except for *;

* insignificant in Sumatra.

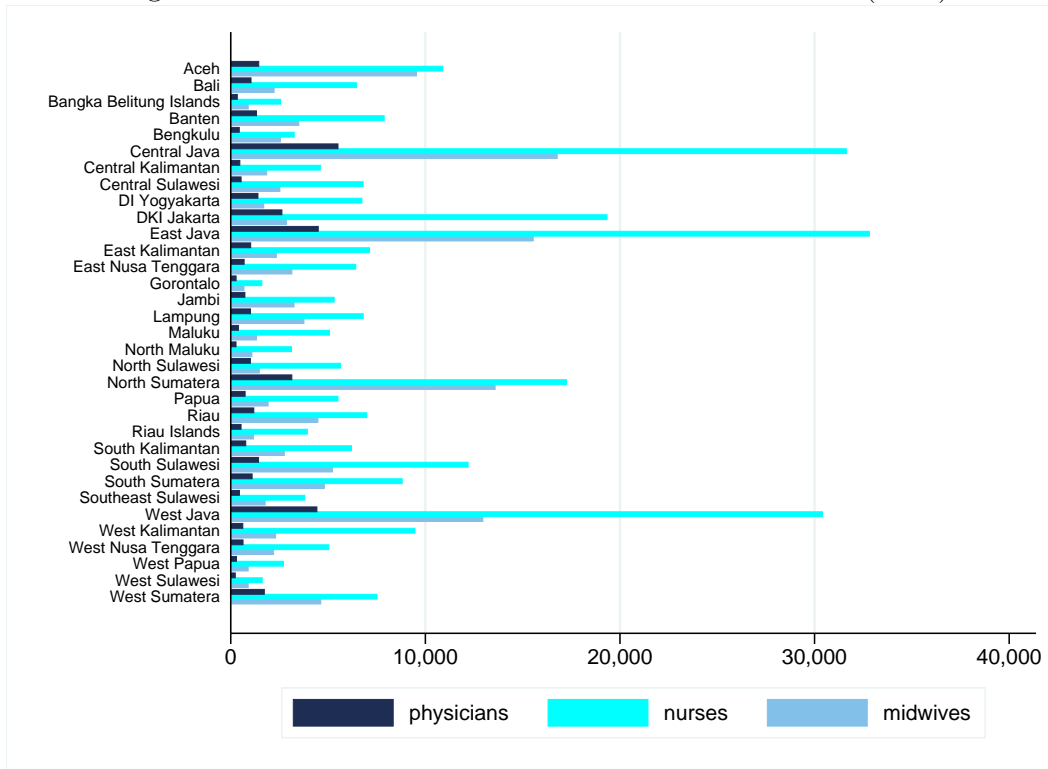
Source: Rokx et al. (2009a)

improvement between 1997 and 2007. At both the beginning and end of that period, public health providers demonstrated more ability than private providers. Health providers in Java and Bali are stronger than those in other provinces in terms of diagnosing the need of prenatal and adult curative care. In order to practice, Indonesian medical graduates must pass a medical licensing examination, as is true in most other countries in ASEAN (Kittrakulrat et al., 2014). The examination is held by the Indonesian Medical Council (Government of Indonesia, 2004b). Medical graduates need to pass the national examination to receive their certification. However, upon the first standardised competency examination for physicians in Indonesia, which took place in 2007, only 50% graduates reached the passing score of 45 out of 100 (World Bank, 2009); this result confirmed the variability of medical graduates' quality in Indonesia.

Figure 3.6 shows the distribution of health workers (physicians, nurses and midwives) among Indonesia's provinces. Since most hospitals are in Java, the largest numbers of those health workers are concentrated in several provinces of the island: Central Java, DKI Jakarta, East Java and West Java. The smallest number of health workers is found in the province of West Sulawesi, which was the newest province as of 2013. Health workers data from the 34th province, North Kalimantan, are still reported as part of East Kalimantan in this figure. Comparing the numbers of

health workers in each province, there are generally more nurses than other health workers. However, it is insufficient to consider only the number of health workers available in each province as both the professional quality and the placement within provinces of those health workers play a crucial role in healthcare provision.

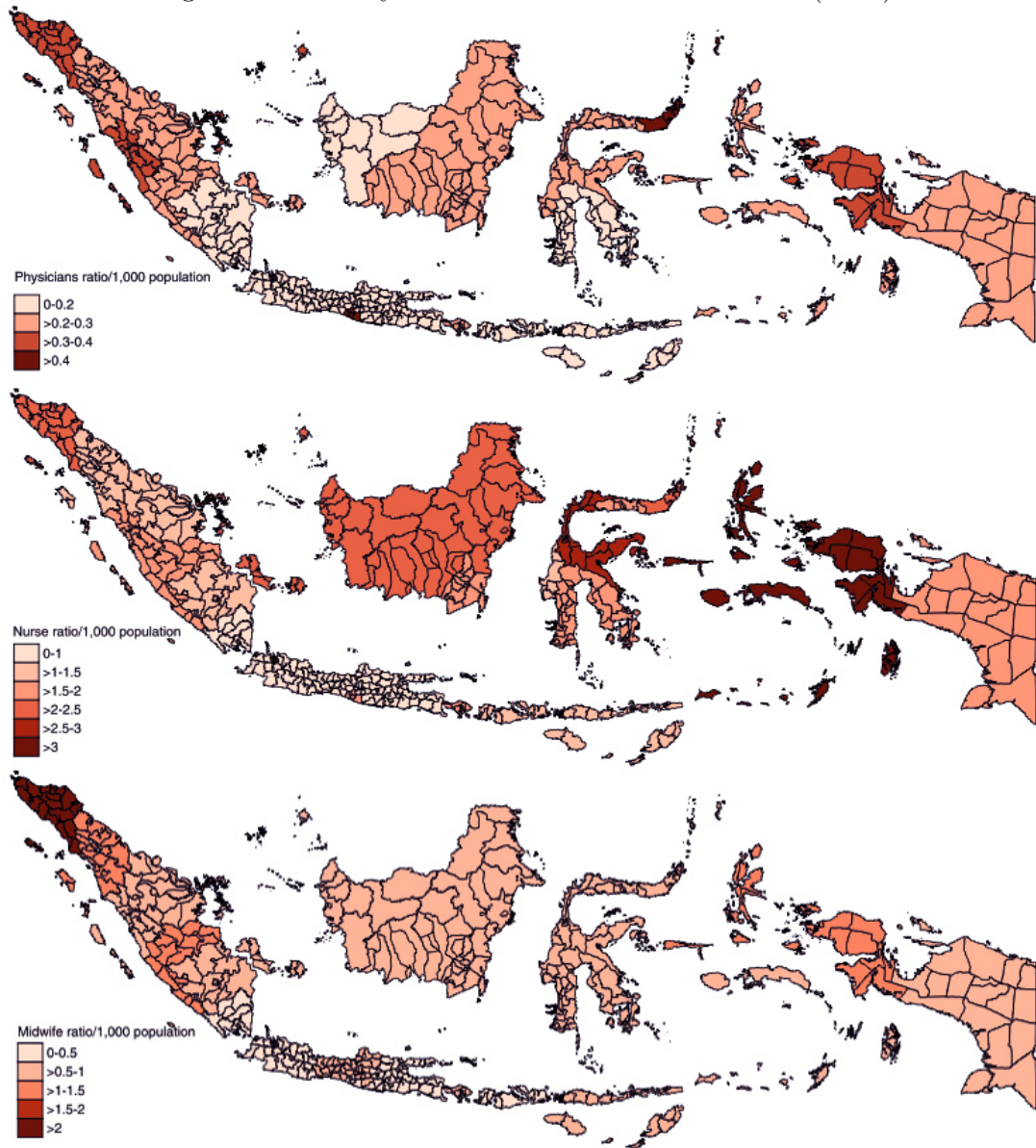
Figure 3.6 Distribution of health workers in Indonesia (2014)



Source: Ministry of Health (2014a)

Figure 3.7 consists of three maps depicting the density of physicians, nurses and midwives in Indonesia in 2014 (Ministry of Health, 2014c). The density is measured by the number of physicians, nurses and midwives per 1,000 inhabitants according to the World Health Organization (2014). The maps show regions within provinces in Indonesia. Darker regions indicate areas with higher densities of physicians, nurses and midwives.

Figure 3.7 Density of health workers in Indonesia (2014)



Source: Ministry of Health (2014a)

With respect to physicians density, DKI Jakarta and DI Yogyakarta in Java, Riau Islands in the east of Sumatera and North Sulawesi show darker regions than the rest of Indonesia, followed by Aceh, West Sumatera and West Papua. Riau Islands, DKI Jakarta, North Maluku, Maluku and West Papua have the highest densities of nurses in the country, while the highest densities of midwives are shown in Aceh and Riau Islands. The high rank of Aceh in health workers density is possibly a result of the tsunami that struck the region in 2004. After the tsunami,

the government of Indonesia was supported by many international agencies to help the population and to rebuild the impacted areas. The health infrastructure was heavily damaged by the tsunami as many health centres were washed away; the loss of many health workers was also devastating (Suwandono et al., 2005). Due to the importance of the health infrastructure, it was among the first to be revived with an influx of health workers to the province using foreign financial aid (Trisnantoro and Handono, 2008).

Although the western part of Indonesia is considered more developed than its eastern counterpart, and though the west enjoys more sufficiency in terms of facilities, one province in Sumatera is clearly lacking in physicians, nurses and midwives. Lampung shows considerably lighter regions compared to other regions in provinces in Sumatera. This is even more striking given that Lampung is the closest Sumatran province to Java; Lampung is not a remote area. Working in remote areas may discourage health workers in developing countries as remote assignments are considered unattractive (Kolstad, 2011; Kruk et al., 2010; Lori et al., 2012). However, lighter regions are also present in West Java, the closest province in Java to Lampung. Despite the large numbers of health workers in Java, imbalances clearly exist between provinces in Java as Central Java, DKI Jakarta and DI Yogyakarta show darker regions for physicians. These imbalances permeate Indonesia in its entirety as shown in the maps. A later section on East Java will clarify the issue of imbalances within provinces.

Healthcare in Indonesia is provided by both public and private institutions. Private involvement in health provision is encouraged by government's decision to limit the number of public hospitals in 1990 (Gani, 1996). This policy resulted from a limited government budget for health expenditure. The composition of public and private hospitals in 2012 is 44:56 (based on Table 3.10). Previously, in 2008, Indonesia had 1,320 hospitals providing 143,000 beds (1 bed:1,580 inhabitants) (Ministry of Health, 2010b). In the six years that followed, the number of hospitals increased

to 2,228 providing 291,899 beds (1 bed:857 inhabitants) (Ministry of Health, 2014c). Although this ratio is beginning to approach to that recommended by the WHO (1 bed: 500 inhabitants), it indicates that Indonesia still needs 200,000 additional beds to meet the ideal ratio. Furthermore, these beds are not equally distributed along the archipelago. The most populous island in the country, Java, has 1,162 hospitals (52% of Indonesia's hospitals). In contrast, the Maluku Islands have the fewest hospitals (35 hospitals, or 1.5% of Indonesia's hospitals) (Ministry of Health, 2014c). This unequal distribution also yields a discrepancy in the ratio of inhabitants per bed, but it can be misleading: Java has one bed for every 946 inhabitants while Maluku can provide one bed for every 685 inhabitants; Maluku's ratio is close to that recommended by the WHO.

Indonesian hospitals are categorised into four classes (A, B, C and D) according to the medical specialty, technological competencies, and number of beds (Ministry of Health, 2014b, 2010a). Class A hospitals are highly specialised referral centres and have 34 specialty and sub-specialty departments and have a minimum of 400 beds, while Class B hospitals usually operate a minimum of 18 specialty and sub-specialty departments have a minimum of 200 beds. Class C hospitals are general hospitals, designed to provide a minimum of four basic specialist services: surgery, internal medicine, obstetrics and gynaecology, and paediatrics, as well as four supporting medical specialist departments: anaesthesiology, radiology, medical rehabilitation and clinical pathology. Class C hospitals must offer a minimum of 100 beds. Class D is the lowest level, providing general services and designed to provide, at a minimum, any two of the four basic specialist services. Class D hospitals offer a minimum of 50 beds. The majority of both Class C and D hospitals are in rural areas and are owned by district governments (Ministry of Health, 2010a). In addition to their classes, Indonesian hospitals are differentiated based on their types. General hospitals provide all healthcare services for the population and treat all diseases, while specific hospitals provide certain healthcare services according to medical specialty

or treat certain diseases, organs or age groups. Table 3.10 shows the number of hospitals in Indonesia in 2012 according to category (public or private), ownership, types (general or specific) and classes. Although 56% of the hospitals are private-owned, but they only provide 41% of the available hospitals beds as there are more class A and B public hospitals in the country.

Table 3.10: Hospital in Indonesia in 2012

Category	Owner	Type		Class					Total	Number of beds
		General	Specific	A	B	C	D	NC		
Public hospital	Ministry of Health	14	18	21	8	1	0	2	32	13,678
	Province	47	38	15	41	18	2	9	85	19,183
	District/City	472	25	4	105	243	131	14	497	54,559
	Other ministries	3	0	0	1	0	0	2	3	244
	Military/police	132	2	0	1	0	0	31	134	12,307
Private hospital	Non-profit organisations	458	196	0	32	123	70	429	654	47,060
	State-owned companies	70	7	2	4	9	5	57	77	8,305
	Others*	175	62	1	26	53	41	116	237	15,241
Total		1,371	348						1,719	170,577

Note: *Others include companies or individuals. NC = non-class.

Source: Ministry of Health (2014c)

Indonesia has applied several policies in the last four decades to distribute health workers more equally throughout the country. In the late 1970s, the government deployed physicians and other health workers to different areas in Indonesia accompanying the national programme to build health centres in rural areas (President of Republic of Indonesia, 1977). This deployment focused on newly graduated physicians and other health workers. Those physicians and health workers became civil servants with the obligation to serve two to five years at the health centre or *puskemas* in both remote and urban areas (Ministry of Health, 2013; President of Republic of Indonesia, 1991; Rokx et al., 2010). The length of the service varied: those serving in the urbanised areas served the longest five years, while those serving in rural health centres had three-years contracts. The shortest service period was for placements in remote areas. These civil servants were required to serve for two

years before requesting to be moved to other areas. The central government was unable to maintain the deployment policy as a result of the financial crisis that struck in the late 1980s (Gani, 1996). The central government decided to stop recruiting civil servants due to the contracted budget; inevitably, this policy applied to every sector including health. This zero-growth civil service policy impacted the supply of physicians to needy areas all over the country.

To remedy the situation, the central government introduced a new policy starting in 1992, contracting newly graduated physicians and midwives as temporary employees or *pegawai tidak tetap* (PTT) (Ministry of Health, 2013; President of Republic of Indonesia, 1994, 1991). The contracts offered were for three years in a designated health centre in an area selected by the government. At the end of the contract period, the physicians and midwives (nurses were not required to join the PTT programme) were given the choice to keep working with the government by becoming civil servants, to pursue their careers in the private sectors or to continue their education. However, the PTT program was short-lived in its original form as the public sector could only absorb 40% of the physicians and midwives who completed the PTT programme. In the early 2000s the number of medical graduates recruited for civil service began to fall. However, despite the common belief outside Indonesia that the PTT programme was officially abolished in 2007 (Rokx et al., 2010), the PTT programme does continue to exist albeit with several adjustments. For example, the central government began to recruit medical graduates for an even shorter contract period of six months which could be extended for another six months if the physicians or midwives wished. To attract medical graduates to this programme, the government offered attractive salary packages. With the latest modification in 2013, the Ministry of Health stated that PTT physicians and midwives are being offered one-year contracts with the option to renew (Ministry of Health, 2013).

In Indonesia, as in many other developing countries, health workers' salaries are

paid by central government (McPake et al., 2014). All health workers working in public hospitals are either civil servants or temporary employees. The temporary employees may have the opportunity to become civil servants when there are openings to apply. A civil servant salary is determined and evaluated by the central government and adjusted accordingly. There are no bonuses at the end of the year, but every civil servant receives the equivalent of one month's salary to cover his or her expenses for the annual religious celebration. Usually individuals receive this additional payment in the month of Eid Mubarak regardless of religion since most of the population is Moslem.

Although civil servants are paid by the government, their salaries may not be sufficient for them to make a living. For example, a new physician receives a salary of 2.4 million rupiahs (USD 240) per month which is considerably lower than even the minimum wage of 2.7 million rupiahs per month in Surabaya (the capital city of East Java) (Government of East Java, 2014). Consequently, almost all health workers, especially physicians, nurses and midwives, also practice outside the public hospitals - either in private hospitals or in their own practices, as is also common in other developing countries (McPake et al., 2014). These dual practices are allowed by the Ministry of Health, but the maximum number of outside practices for a physician is limited to two (Ministry of Health, 2007). Physicians, nurses and midwives can only work at their outside practices after their hours in public hospitals finish for the day. Midwives and nurses are also allowed to open their own practices with licenses granted by the local government (Ministry of Health, 2010c,d). Another source of income is also available to physicians: the so-called medical service fee received by physicians in hospitals. The amount or the share of the medical service depends on each hospital's policy (Maharani et al., 2014; Suwandono et al., 2001).

When Indonesia underwent decentralisation in 2001, the responsibility of providing district healthcare fell on the shoulders of the local governments. Local governments authorise licenses for the private health centres or hospitals and em-

employs a medical officer; these tasks were formerly completed by central government (Thabrany, 2006). PTT physicians and midwives can be recruited by central government or local government (Ministry of Health, 2013). However, each local government has its own fiscal capacity for financing public health and hiring public health professionals; this results in an even more unbalanced distribution of health workers. In addition, local governments may lack understanding and awareness of the benefits of public health services, which may in turn be reflected in their emphasis on curative approaches rather than promotion of preventive health policies (Thabrany, 2006). It is obvious that healthcare provision at the local levels, including policies on health workers and public health measures, depends on the leadership and capacity of elected officials.

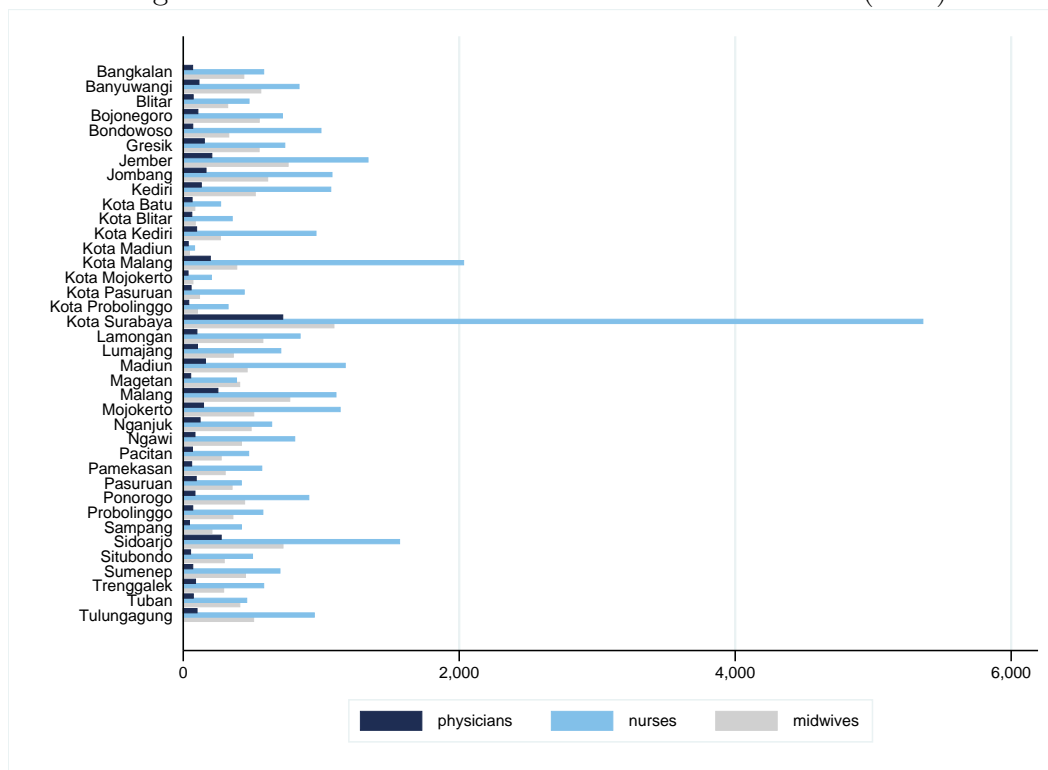
As local governments are responsible for the healthcare provision, I collected data from public district hospitals in one province, East Java, which the next subsection describes.

3.2.1 East Java

East Java is the second most populous province in Indonesia after the capital city (Statistics Indonesia, 2014b) with the population density of 784 people per km² in 2010. It has 47,800 km² of land area spread between the eastern part of Java and Madura Island, separated by the Madura Strait. Overall, the province of East Java consists of 29 districts and nine cities. Due to its position as the second largest port in the country and to its unique location, East Java has become a hub for the distribution of goods and services to the eastern part of Indonesia. With regard to business climate, the unemployment rate was 4.1% in 2012, considerably lower than the national unemployment rate of approximately 6% (Statistics Indonesia, 2014a). East Java is also the province with the largest number of districts and cities among the top 20 in good local governance in Indonesia, according to *Komite Pemantauan Pelaksanaan Otonomi Daerah* (KPPOD or Regional Autonomy Watch)

(KPPOD and The Asia Foundation, 2011). Despite this mark of distinction, East Java experiences economic imbalances within its borders, and some of its districts are classified as disadvantaged regions (Bappenas, 2013).

Figure 3.8 Distribution of healthworkers in East Java (2014)



Source: Ministry of Health (2014a)

Figure 3.8 shows the distribution of health workers in East Java. Like Indonesia itself, East Java’s distribution of health workers is unbalanced. Most health workers are concentrated in its capital city, Surabaya. There were 55 public hospitals in East Java, with four in the capital city, when I collected data in summer 2013. Table 3.11 shows the hospitals in East Java with the number of beds as of 2012. That number of beds corresponds to a ratio of 1.8 beds for every 1,000 population, which is equal to the hospital bed density in Malaysia and three times higher than Indonesia’s overall hospital bed ratio (see Table 3.7).

Table 3.11: Hospital in East Java in 2012

Category	Owner	General	Specific	Total	Number of beds
Public hospital	Ministry of Health	0	1	1	273
	Province	5	7	12	2,968
	District/City	45	0	45	6,788
	Other ministries	1	0	1	20
	Military/police	20	1	21	1,687
Private hospital	Non-profit organisations	58	24	82	6,289
	State-owned companies	13	2	15	1,551
	Others*	9	1	10	802
Total		151	36	187	20,378

Note: *Others include companies or individuals.

Source: *Data Rumah Sakit Online, Kementrian Kesehatan RI* (2014)

Public hospitals in East Java, like others in the country, follow a certain organisational structure according to the law (Republic of Indonesia, 2010). A public hospital has one director who has a medical degree and hospital management expertise. The hospital must offer several basic resource including medical service, nursing, medical support, a medical committee, an internal auditor and administration and finance. However, the number of departments in each of these functions depends on the hospital class. Hospital class also determines the number of employees needed, which is tied to the number of beds and the services provided. The hospital director is responsible to set the number of employees. Fifty per cent of the medical and nursing staffs must be full-time employees (Direktorat Jenderal Bina Pelayanan Medik, 2008). Based on the data collected in East Java, approximately 84% of public hospitals have 150-999 employees with another 10% have over than 1,000 employees; the remaining hospitals have fewer than 149 employees on their payrolls.

As government institutions, public hospitals have a hierarchical structure. The hospital director may have more than one vice director at the top of the hierarchy, followed by the next layer of management which consists of heads of functions and heads of departments. The lower management may consist of heads of sections of departments and supervisors, and employees are found on the bottom rung. In addition to departments, the public hospitals have groups of medical staffs (SMF).

These groups are based on professional skills or qualifications to improve the quality and skills of the staffs. For example, there are SMF for mental health, physicians, and the like. As in any government institution, hospital communication may often flow from top to bottom (Setiadi, 2007) and employees may interact more with their immediate superiors than with higher hospital management.

This study focuses on Indonesian's public hospitals as they have faced major challenges in recent decades. First, they are competing with increasing numbers of private hospitals serving the same population due to the institution of the 1991 government policy. Second, there is an increasing demand for quality health services to support the 2014 implementation of universal healthcare coverage (President of Republic Indonesia, 2013; Republic of Indonesia, 2011). Third, public hospitals operate under a rigid bureaucracy, especially in managing finances, human resources, and procurement; this leads to inefficiency in many ways.

3.3 Conclusion

This chapter introduces the settings of both developed and developing countries considered in the present study. The developed countries were in economic crisis when the data used in this thesis were collected; they were suffering from contracting GDPs and rising unemployment rates. The unemployment rates showed the severity of the impact of the crisis for both the EU in general and for the EA. In this economic crisis, construction, manufacturing and financial services were the industries most affected.

In Britain, the GDP plunged in 2009 although the unemployment rate did not reach that of certain European countries. Britain's recovery began in 2011. During the crisis, the healthcare industry was protected and even boasted a growing workforce. Healthcare in Britain is provided mostly by the public sector through NHS.

The study's developing country, Indonesia, is the largest economy in ASEAN and

has experienced an economy stagnation in the past ten years. Health provision and health workers distribution remain challenges for the government. Unlike healthcare in Britain, Indonesian healthcare is offered by a combination of public and private providers with the private sector providing a considerably bigger share. However, this thesis only uses data collected from public hospitals in the province of East Java.

With the settings having been established in this chapter, the next five chapters focus on the empirical data. They show the results in Europe, Britain and Indonesia. The first three chapters consider job satisfaction, while the last two chapters examine the workplace performance.

Chapter 4

Workplace social capital and well-being of workers across Europe

4.1 Introduction

Work is important as the majority of adults spend much of their life in paid employment (Layard, 2011; Warr, 2007). While pay, conditions of work, skills used, meaningfulness of task and autonomy determines the desirability of the work (Argyle, 2001; Layard, 2011), one's social relationships determines the timing to enter the labour market and one's likelihood to find a job (Verhaeghe et al., 2015). Most people enjoyed and satisfied with their work because they can earn money for their families, achieve their goals in life, have satisfaction from the work itself and makes new social relationships (Argyle, 2001; Layard, 2011). Thus, workplace is a place where not only performance matters but also a place where social relationship, such as friendship, develops between individuals (Helliwell and Putnam, 2004) as a large fraction of one's waking hours is spent in the workplace.

Friendships at workplace as any relationships between individuals may potentially develop social capital. According to Kouvonen et al. (2006), workplace social capital is the structure and context of individuals' networks and density of interaction. Workplace social capital has been found to improve both general well-being and job satisfaction as a specific-domain well-being (Helliwell et al., 2009b; Helliwell

and Huang, 2010). Despite the findings, these relationships have lesser evidence in times of crisis. Rodríguez-Pose and von Berlepsch (2014) and Helliwell et al. (2014) have looked into the relationships of social capital and well-being in Europe and the United States using samples from general public. They found that social capital has a robust and positive association with Europeans' happiness (Rodríguez-Pose and von Berlepsch, 2014) and, similarly, social capital among Americans improved their well-being in time of crisis (Helliwell et al., 2014). However, both studies only use happiness or well-being as the dependent variable.

In addition, studies investigating the relationships between social capital and workers' well-being mostly do that in isolation. They use the workplace domain and its characteristics to control the relationships without including other variables from other domain of the workers' life. Nevertheless, workers have more than one domain in their life, which possibly contribute to their general well-being and specific-domain well-being such as job satisfaction. In other domains of life, workers have activities outside work that affect both general well-being and job satisfaction, such as spending time with family, household activities and leisure, which had been reviewed in Chapter 1.

This chapter will first investigate the association between workplace social capital and well-being of European workers in general and in workplace. As the data were collected during economic crisis (see Chapter 3) as Europe experienced an unemployment rate of 9.6% or approximately 23 million persons were without work between January and June 2010 (Eurostat, 2015b), the effect of such crisis may be observed in this study. Thus, this study will address the following research questions:

1. Does workplace social capital improve well-being and job satisfaction of workers?
2. Do activities outside work improve well-being and job satisfaction of workers?
3. Do regions and countries have effect on well-being and job satisfaction in Europe?

The study begins with the descriptive analysis, followed by the results for workers' well-being and job satisfaction. After the results, a discussion section is presented before the conclusion of this chapter.

4.2 Data and method

As explained in Chapter 2 (see page 73), this study relies on EWCS2010 data on the well-being and job satisfaction of workers aged 15 and over at the time of survey in regions of 34 countries in Europe: 27 member of European Union and seven other countries: Norway, the Former Yugoslav Republic of Macedonia (FYROM), Croatia, Turkey, Albania, Kosovo and Montenegro (Eurofound, 2010). The number of countries included is larger than those in Rodríguez-Pose and von Berlepsch (2014) (23 countries) and Helliwell et al. (2014) (one country). As workers reside within regions and countries, the situations and conditions in regions and in countries may influence workers. In considering the nested structure of workers within regions and countries, multilevel models are used to investigate the relationships.

As the data were collected during the economic crisis, I include the unemployment and growth rates for regions to take into account the labour market situation. I also include Gini coefficients and the typology of welfare-state regimes (Bambra and Eikemo, 2009; Eikemo and Bambra, 2008; Holman, 2013) to capture the differences between countries. A Gini coefficient measures equality of income distribution in a country, with zero is a perfect equality and 100 is perfect inequality (World Bank, 2013); while, the typology of welfare-state regimes is to acknowledge different employment policies and social protection in European countries (Bambra and Eikemo, 2009; Holman, 2013). The Scandinavian regime consists of Denmark, Finland, Norway, Sweden; the Bismarckian regime includes Austria, Belgium, Germany, France, Luxembourg, Netherlands; the Anglo-Saxon regime has Ireland and United Kingdom; the Southern Europe consists of Greece, Italy, Portugal, Spain, Malta and Turkey (Buğra and Keyder, 2006; Gough, 1996); the Eastern Europe includes the

rest of the countries including FYROM, Croatia, Albania, Kosovo and Montenegro.

The dependent variables To explore the relationship between workplace social capital and general well-being, well-being is used as the dependent variable. Respondents reported their status by indicating their feelings over the two weeks before the survey according to five statements. The five statements, similar to those used in the WHO index of well-being (WHO, 2003), are: ‘I have felt cheerful and in good spirits’, ‘I have felt calm and relaxed’, ‘I have felt active and vigorous’, ‘I woke up feeling fresh and rested’ and ‘My daily life has been filled with things that interest me’. The scale of response is one to six in the survey and is reclassified into zero to five with five as the highest occurrence following WHO (2003). A well-being index is built then by summing the responses (WHO, 2003).

To predict well-being in workplace, self-reported overall job satisfaction is the dependent variable in this analysis. In the survey, respondents answer the question: ‘On the whole, are you very satisfied, satisfied, not very satisfied or not at all satisfied with working conditions in your main paid job?’. The scale of this response is from one to four. Previous studies have confirmed the reliability of a single question for overall job satisfaction (Dolbier et al., 2005; Nagy, 2002; Wanous et al., 1997).

The independent variables The first independent variable is workplace social capital measured by friendships at work, which uses the responses to the statement ‘I have very good friends at work’. Respondents show their agreement or disagreement on a scale of one to five ranging from ‘strongly disagree’ to ‘strongly agree’. The second set of independent variable concerns activities outside work. Here respondents answered the question: ‘In general, how often are you involved in any of the following activities outside work?’ The list of activities available included voluntary or charitable activity, political or trade union activity, caring for and educating children or grandchildren, cooking and housework, caring for elderly or disabled relatives, taking a training or education course, sport, a cultural or leisure activity, gardening

and repairs. The scale of the answers ranged from one (for ‘never’) to six (‘everyday for one hour or more’). Respondents could answer each question according to their involvement in the stated activity.

As this study focuses on workers, their individual and job characteristics are included. Individual characteristics included are age, gender (with female as the reference), health, education measured with years of education, being married or in a partnership and income in quintiles (with the lowest quintile as the reference), whether respondents were the main earner in their household or not and whether their work schedules suit their families’ needs. The job aspects included are pay received for their work, career advancement opportunities, motivation to give their best at work, feeling at home in the organisation, the possibility of losing their job in the next six months, and ease of finding a new job with similar salary if they lose the current one. Types of employment contracts are also incorporated with those having no employment contracts as the reference and the work sector. Work sectors are differentiated as ‘public’, ‘joint’ for mixed public and private, ‘nonprofit’ for non-for-profit, ‘other’ for an occupation not falling into any other categories, and ‘private’ as a reference.

Multilevel approach The EWCS2010 data were collected following multistage stratified sample as each country is divided into regions (Gallup Europe, 2010). The sample then allocated to the regions proportionately to the number of individuals in employment. Random sampling methods then applied to select households to be surveyed. In each household, the interviewer sought to speak with the individuals who were in employment. To capitalise on the nested structure of the data, a multilevel model is applied: specifically, a three-level modelling as the number of regions and countries guarantee the sufficiency of the sample at level three (country)(Hox, 1998) and level two (region)(Maas and Hox, 2005) with workers at level one. Some missing data exist in the sample, ranging from less than 1% for health to approximately 15% for income. As missing data may alter the results of the analysis,

multilevel multiple imputation using REALCOM Impute (Bartlett, 2011; Carpenter et al., 2011) was applied. The imputed data set is used for the analysis, while the results using unimputed data set are included in Appendix D of this thesis.

Regional maps on well-being and job satisfaction EWCS2010 uses geographic codes to identify where the workers live. Those codes were matched with digital boundary codes in the EuroBoundaryMap 5.0 (Eurographics, 2008) which consist of latitudes and longitudes of areas in Europe. Using the `spmap` program in STATA, the combined matched codes and values of well-being and job satisfaction from the survey create maps of well-being and job satisfaction on Figure 4.1 and 4.2 in this chapter. However, not all of the regions were sampled in EWCS2010 which resulting in no data appearance (yellow areas) on the maps.

4.3 Results

Descriptive analysis Table 4.1 shows the sample characteristics and bivariate analysis in this study. The average well-being of workers was slightly over one half on the WHO scale, whilst both job satisfaction and workplace social capital approached the highest points available in the survey. As for the characteristics, the respondents were almost evenly split between males (52.2%) and females (47.8%) with an average age of 41 years. The majority of the respondents were married or in a partnership, and they tended to have either a child or a relative living with them as the average household size was three people. Although more than half of the respondents were the main earners in their households, approximately 81% indicated that their work schedules were highly suited to the needs of their families. Most of the respondents were in good health and the average number of years of schooling was 13.6. Approximately a quarter of workers are in the lowest quintile of income (less than €4,800), while the top quintile of income (above €21,000) is occupied by one-sixth of workers. When asked about their jobs, most workers agree that their

jobs are well-paid, make them feel at home at the workplace and motivate them to do their best. However, they disagree that their jobs offer career advancement and it is easy to find jobs once they lose their current jobs. Most of them disagree that they will lose their jobs in the next six months.

Turning to the contextual factors, the average growth in regions is 2.1% with the average unemployment rate is 11.4% and the average Gini index is 30.6. Most workers live in Eastern Europe (36.5%) and the least workers live in Anglo-Saxon countries (6.0%).

The survey lists several activities in which respondents may engage when they are not working. Table 4.2 provides a clearer picture of the frequency of the listed activities outside work. Only very few respondents take part in political or trade union activities and for this reason this activity has been excluded from the analyses. The two most frequent activities for respondents were cooking and caring for children/grandchildren which conforms to their average household size of three people (see Table 4.1). One-fifth of the respondents engaged in sporting/cultural activity and gardening and repairs weekly outside work. The same activities were also undertaken monthly for one-sixth of the respondents. Taking training (signing up for training) and becoming involved in volunteering activity was generally an annual activity for respondents. The bivariate analysis are explained after the description of the variables.

Bivariate analysis The analyses begin with the bivariate relationships of well-being with key covariates in Table 4.1. Workplace social capital is significantly associated with higher well-being. However, the associations of activities outside work with well-being show mixed results as three activities are significantly associated with lower well-being: caring for children/grandchildren, cooking and caring for the elderly, while the rest of the activities are associated with higher well-being. Selected individual characteristics i.e. being male, married and healthy have positive associations with well-being. Similarly, higher education and higher income are

Table 4.1: Sample characteristics and bivariate relationships (40,533 workers in 400 regions of 34 countries)

	Mean/Modes/%	SD	Missing(%)	Well-being*	Job satisfaction*
Well-being	16.309	5.268	1.76	16.309(0.026)‡	
Job satisfaction	2.987	0.738	9.79		2.986(0.004)‡
Social capital	3.901	0.940	6.82	1.303(0.028)‡	0.180(0.004)‡
<i>Activities outside work:</i>					
Voluntary activity	Never		1.17	0.372(0.026)‡	0.051(0.004)‡
Caring for children★	Never		0.84	-0.024(0.011)†	0.003(0.002)†
Cooking	1 hour/day		0.72	-0.038(0.014)‡	0.035(0.002)‡
Caring for the elderly	Never		0.82	-0.096(0.017)‡	-0.027(0.002)‡
Taking a training	Never		1.19	0.389(0.027)‡	0.055(0.004)‡
Sporting/cultural activity	Never		0.79	0.500(0.016)‡	0.058(0.002)‡
Gardening and repairs	Never		0.98	0.121(0.016)‡	0.001(0.002)
<i>Individual characteristics:</i>					
Age	41.2	11.3	0	-0.035(0.002)‡	0.001(0.000)‡
Male	52.2%		0	0.663(0.053)‡	-0.046(0.007)‡
Health	Good		0.18	3.526(0.050)‡	0.406(0.008)‡
Years of education	13.6	3.99	1.45	0.134(0.007)‡	0.032(0.001)‡
Having a spouse/partner	61.8%		13.01	0.242(0.063)‡	0.100(0.008)‡
Being a main earner	65.5%		0.61	-0.037(0.049)	0.010(0.007)
Work schedule fits with family	81.1%		0.65	-2.358(0.065)‡	-0.487(0.009)‡
Size of household	3.1	1.45	0.04	-0.015(0.018)	-0.037(0.003)‡
Income < €4800	25.3%		14.58**	ref	ref
Income €4801 - €7200	19.1%			0.265(0.086)‡	0.200(0.012)‡
Income €7201 - €12000	17.8%			1.052(0.087)‡	0.311(0.010)‡
Income €12001 - €21000	22.4%			1.671(0.082)‡	0.390(0.011)‡
Income €21001 - €48000	15.4%			2.186(0.091)‡	0.584(0.011)‡
<i>Job aspects:</i>					
Well-paid job	38.8%		1.68	1.288(0.023)‡	0.275(0.003)‡
Career advancement	31.7%		4.76	1.114(0.022)‡	0.194(0.003)‡
Feel at home	69.3%		2.85	1.589(0.024)‡	0.304(0.003)‡
Motivated to do the best	61.1%		7.15	1.472(0.024)‡	0.268(0.003)‡
Possibility to lose job	19.4%		7.93	-0.794(0.022)‡	-0.174(0.003)‡
Easy to find similar job	29.7%		7.35	0.524(0.021)‡	0.048(0.003)‡
<i>Regional factors:</i>					
Growth	2.1%	2.3		-0.070(0.011)‡	-0.018(0.002)‡
Unemployment rate	11.4%	7.5		0.019(0.004)‡	-0.015(0.000)‡
<i>Country factors:</i>					
Gini index	30.6	4.4		-0.114(0.006)‡	-0.030(0.001)‡
Bismarckian	27.9%			-0.774(0.098)‡	-0.143(0.013)‡
Anglo-Saxon	6.0%			-0.271(0.136)†	0.022(0.0.19)
Scandinavian countries	9.4%			ref	ref
Southern Europe	20.2%			-1.710(0.102)‡	-0.349(0.014)‡
Eastern Europe	36.5%			-2.169(0.095)‡	-0.441(0.013)‡

Notes:* reported in coefficients (standard errors). **for all quintiles of income. Sig. 1%‡; 5%†

Notes:★ including grandchildren

Table 4.2: Activities outside work for workers (40,533 workers in 400 regions of 34 countries)

	Never	Annually	Monthly	Weekly	Daily	1 hour daily
<i>Activities outside work:</i>						
Voluntary activity	72.1	13.5	7.4	4.9	1.0	1.1
Political/trade union activity	91.3	4.2	2.7	1.1	0.3	0.4
Caring for children★	43.8	1.7	4.7	8.1	7.5	34.3
Cooking	19.1	2	4.7	12.5	13.8	48
Caring for elderly	75.6	3.5	5.4	6.9	3.2	5.5
Taking a training	71.5	17.6	4.7	3.8	0.9	1.5
Sporting/cultural activity	38.7	6.5	16.3	26.5	7.2	4.9
Gardening and repairs	42.3	8.4	16.1	20.1	6.8	5.7

Note:★ including grandchildren

also associated with higher levels of well-being. However, being older has a negative association with well-being. Surprisingly, work schedules that fit workers' family needs are associated with lower levels of well-being and being the main earner is not significantly associated with well-being. All of the job aspects explored are associated positively with well-being, except for the possibility of losing one's job. As with the higher level factors, regional growth is significantly negatively associated with well-being. On the contrary, regional unemployment has a positive and significant association with well-being. Both country factors (Gini index and welfare state regimes) have negative associations with well-being. These contrasting results on higher level factors and their associations with well-being can not be explained in isolation. Hence, the models including all individual and work-related covariates with higher level factors are logical to be built.

When job satisfaction is considered as the dependent variable, workplace social capital also shows a positive association with job satisfaction. As distinct from the associations with well-being, only caring for the elderly is significantly negatively associated with job satisfaction, while gardening and repairs are not significantly associated with job satisfaction. The rest of the activities considered have significant positive associations. Turning to individual characteristics, two results are in contrast with those obtained from the examination of well-being. Being older is positively associated with job satisfaction, while being male is negatively associated

with job satisfaction. Similar to the results of well-being, all job aspects except for the possibility of losing one's job, are significantly and positively associated with job satisfaction. The effect of higher level factors also shows different results from those obtained with well-being as the dependent variable: both regional growth and unemployment rates are negatively associated with job satisfaction and there is no significant association between Anglo-Saxon states and job satisfaction.

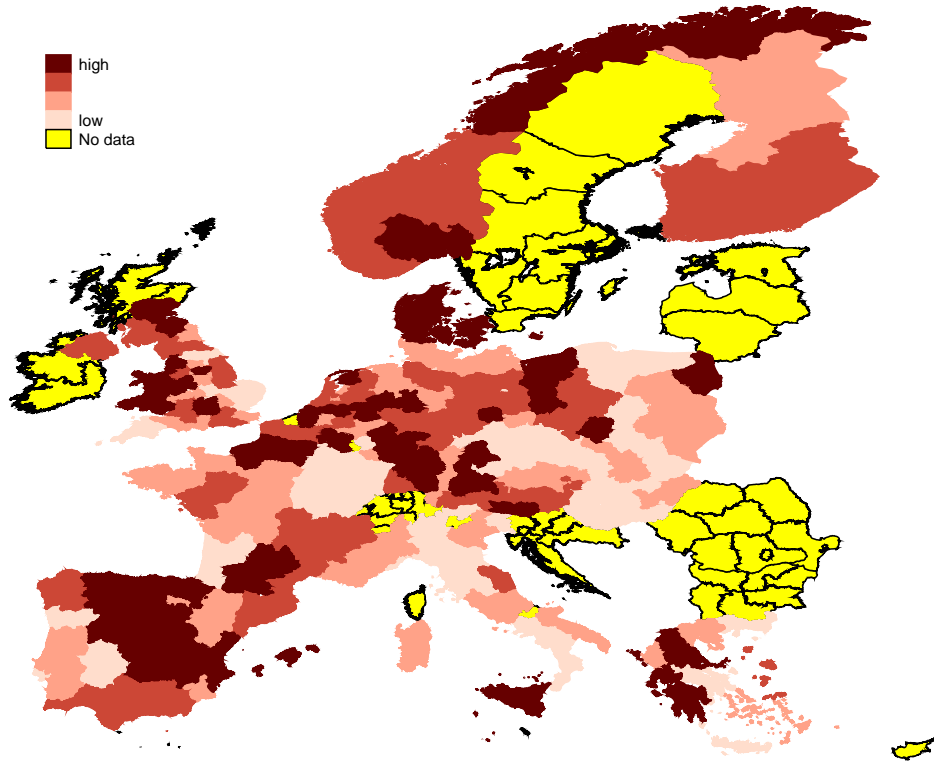
Multilevel models Results on the bivariate analyses show the expected positive relationships between workplace social capital and both well-being and job satisfaction and partially confirm previous studies (Bjørnskov, 2003; Rodríguez-Pose and von Berlepsch, 2014). However, these relationships assume that individuals are independent, which are unlikely as workers in a region tend to resemble each other. Moreover, the condition of regions may vary in countries as shown by the higher level factors. All of these factors are then considered in multilevel models using a three-level modelling.

4.3.1 The relationship between workplace social capital and well-being

Figure 4.1 shows workers' well-being across regions in Europe. At the time of the survey, some countries in Europe were suffering disproportionately from the recent financial crisis (Gerstberger and Yaneva, 2013; Troitiño, 2013), including Italy, Spain, Portugal and Greece. However, some regions in those suffering countries still show high levels of well-being which equal to some regions in less effected countries such as Great Britain. Nevertheless, most of the Scandinavian countries show higher levels of well-being than others, in particular regions in Denmark and Finland show higher levels of well-being among the Scandinavian countries. Although the contrasting results with regard to well-being between regions in Europe are to be expected as regions in suffering countries are more likely to show lower levels of well-being than

regions in countries suffering to a lesser degree, this map shows that the expectation may not be all true.

Figure 4.1 Well-being of workers across regions (NUTS 2) in Europe



Source: EWCS2010 values mapped into EuroBoundaryMap (Eurographics, 2008)

Table 4.3 shows all multilevel models for well-being. Model 1 is the baseline model. Model 2 incorporates workplace social capital, while Model 3 incorporates individual and work-related covariates. Model 4 shows the effect of regional factors. Model 5 is the complete model for well-being inclusive of both regional and country factors with all covariates. In every model, workplace social capital shows a significantly positive association with well-being, but it attenuates as more covariates are added to the models. The effect of workplace social capital on well-being decreases drastically when individual and work-related factors are introduced in Model 3. When regional effects are introduced in Model 4, the coefficients of workplace social capital remains constant. Similar coefficients of workplace social capital also exist when the country factors are included in the last model, Model 5. This re-

Table 4.3: Multilevel models predicting well-being of workers in Europe - complete results

	Model 1	Model 2	Model 3	Model 4	Model 5
Constant	16.266(0.220)‡	11.997(0.233)‡	4.462(0.399)‡	4.198(0.458)‡	5.166(0.903)‡
Social capital		1.089(0.027)‡	0.427(0.027)‡	0.427(0.027)‡	0.427(0.027)‡
<i>Activities outside work:</i>					
Voluntary activity			0.097(0.024)†	0.098(0.024)†	0.097(0.024)†
Caring for children*			0.003(0.011)	0.003(0.011)	0.002(0.011)
Cooking			-0.037(0.016)†	-0.036(0.016)†	-0.037(0.016)†
Caring for elderly			-0.045(0.016)‡	-0.046(0.016)‡	-0.046(0.016)‡
Taking a training			0.023(0.025)	0.023(0.025)	0.023(0.025)
Sporting/cultural activity			0.151(0.016)‡	0.152(0.016)‡	0.151(0.016)‡
Gardening and repairs			0.092(0.016)‡	0.092(0.016)‡	0.092(0.016)‡
<i>Individual characteristics:</i>					
Age			-0.140(0.016)‡	-0.141(0.016)‡	-0.139(0.016)‡
Age-squared			0.002(0.000)‡	0.002(0.000)‡	0.002(0.000)‡
Male			0.450(0.058)‡	0.449(0.058)‡	0.450(0.058)‡
Health			2.382(0.049)‡	2.382(0.049)‡	2.380(0.049)‡
Education			-0.008(0.007)	-0.008(0.007)	-0.008(0.007)
Having a spouse/partner			0.194(0.055)‡	0.196(0.055)‡	0.193(0.055)‡
Being a main earner			-0.165(0.044)‡	-0.167(0.044)‡	-0.163(0.044)‡
Work schedule fits with family			1.095(0.059)‡	1.097(0.059)‡	1.097(0.059)‡
Income €4801 - €7200			-0.140(0.076)	-0.133(0.076)	-0.137(0.076)
Income €7201 - €12000			-0.167(0.085)	-0.155(0.085)	-0.174(0.085)†
Income €12001 - €21000			-0.213(0.089)†	-0.196(0.088)†	-0.226(0.088)†
Income €21001 - €48000			-0.413(0.100)‡	-0.394(0.100)‡	-0.429(0.101)‡
<i>Job aspects:</i>					
Well-paid job			0.421(0.024)‡	0.421(0.024)‡	0.421(0.024)‡
Career advancement			0.212(0.022)‡	0.211(0.022)‡	0.213(0.022)‡
Feel at home			0.502(0.028)‡	0.501(0.028)‡	0.499(0.028)‡
Ease to find other job			0.172(0.019)‡	0.173(0.019)‡	0.172(0.019)‡
Motivated to do the best			0.405(0.026)‡	0.405(0.026)‡	0.405(0.026)‡
Possibility to lose job			-0.220(0.020)‡	-0.221(0.020)‡	-0.219(0.020)‡
<i>Employment contract:</i>					
Temporary/apprenticeship			0.123(0.190)	0.123(0.190)	0.119(0.190)
Fixed contract			0.170(0.110)	0.168(0.110)	0.170(0.110)
Indefinite contract			0.142(0.091)	0.140(0.091)	0.144(0.091)
<i>Work sectors:</i>					
Public			-0.007(0.055)	-0.008(0.055)	-0.006(0.055)
Joint			0.090(0.120)	0.092(0.120)	0.093(0.120)
Non-profit			0.046(0.210)	0.050(0.210)	0.045(0.210)
Other			-0.378(0.199)	-0.377(0.199)	-0.376(0.199)
<i>Regional factors:</i>					
Growth				-0.111(0.057)†	-0.146(0.044)‡
Unemployment rate				0.026(0.016)	0.063(0.016)‡
<i>Country factors:</i>					
Gini index					-0.018(0.031)
Bismarckian					-0.180(0.407)
Anglo-Saxon					-0.464(0.566)
Southern Europe					-0.628(0.467)
Eastern Europe					-1.360(0.436)‡
Between-country variance	1.193(0.167)	1.121(0.158)	0.698(0.111)	0.633(0.107)	0.424(0.095)
Between-region variance	1.266(0.062)	1.253(0.061)	1.133(0.055)	1.135(0.055)	1.132(0.054)
Between-individual variance	5.030(0.018)	4.930(0.017)	4.480(0.016)	4.487(0.016)	4.487(0.016)
ρ country	0.159	0.153	0.113	0.101	0.070
ρ region	0.201	0.203	0.202	0.202	0.201
Individuals	40533	40533	40533	40533	40533
Regions	400	400	400	400	400
Countries	34	34	34	34	34

Sig. 1%‡; 5%†

Notes: reported in coefficients (standard errors). * including grandchildren

sult corroborates previous findings that social capital improves well-being (Helliwell et al., 2009a, 2014; Rodríguez-Pose and von Berlepsch, 2014).

Examining the activities outside work in this analysis, the results show that some activities have different associations with well-being and the coefficients remain relatively constant after the introduction of regional and country factors in Model 4 and Model 5. Model 5 shows that voluntary activity ($\beta=0.097$, $p<0.05$), sporting/cultural activity ($\beta=0.151$, $p<0.01$) and gardening and repairs ($\beta=0.092$, $p<0.01$) are activities that have significant associations with higher well-being. In contrast, cooking ($\beta=-0.037$, $p<0.05$) and caring for elderly ($\beta=0.045$, $p<0.01$) are significantly associated with lower well-being. Whilst another two activities: caring for children/grandchildren and signing-up for training are not statistically significant for well-being.

Similarly, the results of other covariates do not vary in Model 3, 4 and 5. Focusing on the results of the individual characteristics in the complete model (Model 5), age shows a non-linear association with well-being ($\beta=-0.139$, $p<0.01$), as older workers are associated with higher well-being ($\beta=0.002$, $p<0.01$) confirming the finding of Clark et al. (1996). As well as age, having good health contributes to higher well-being ($\beta=2.380$, $p<0.01$) (Clark, 1997; Dolan et al., 2008; Gerdtham and Johannesson, 2001). Education has a non-significant association with well-being. Male workers have significantly higher well-being than their female colleagues ($\beta=0.450$, $p<0.01$), and having a spouse or partner is also positively associated with well-being ($\beta=0.193$, $p<0.01$), which confirms previous findings of Alesina et al. (2004), Dolan et al. (2008), and Helliwell (2003). Those who have work schedules that fit with their family needs also tend to have higher well-being ($\beta=1.097$, $p<0.01$) as previous research found that most fathers tend to find job that fit with their families (Hobson and Fahlen, 2009). However, being the main earner in the household is significantly associated with lower well-being ($\beta=-0.163$, $p<0.01$) contrasting previous results (Georgellis and Lange, 2012). Spending more years in education is not significantly

associated with well-being, while higher income is associated with lower well-being, particularly significant for those in the top quintiles of income ($\beta=-0.226$, $p<0.05$ and $\beta=-0.429$, $p<0.01$). This result corroborates the finding of Easterlin (1974) that higher income does not bring happiness.

Turning to the job-related aspects, all variables (such as well-paid job and opportunities for career advancement) are significantly positively associated with well-being, other than fear of losing one's job ($\beta=-0.219$, $p<0.01$), which confirms previous studies (Clark et al., 1996; Oesch and Lipps, 2012; Warr, 2007). Although having an employment contract is positively associated with well-being as compared to having no contracts, however, these associations are not significant. Similarly, workers in any other working sector are not significantly associated with well-being compared to those in the private sector.

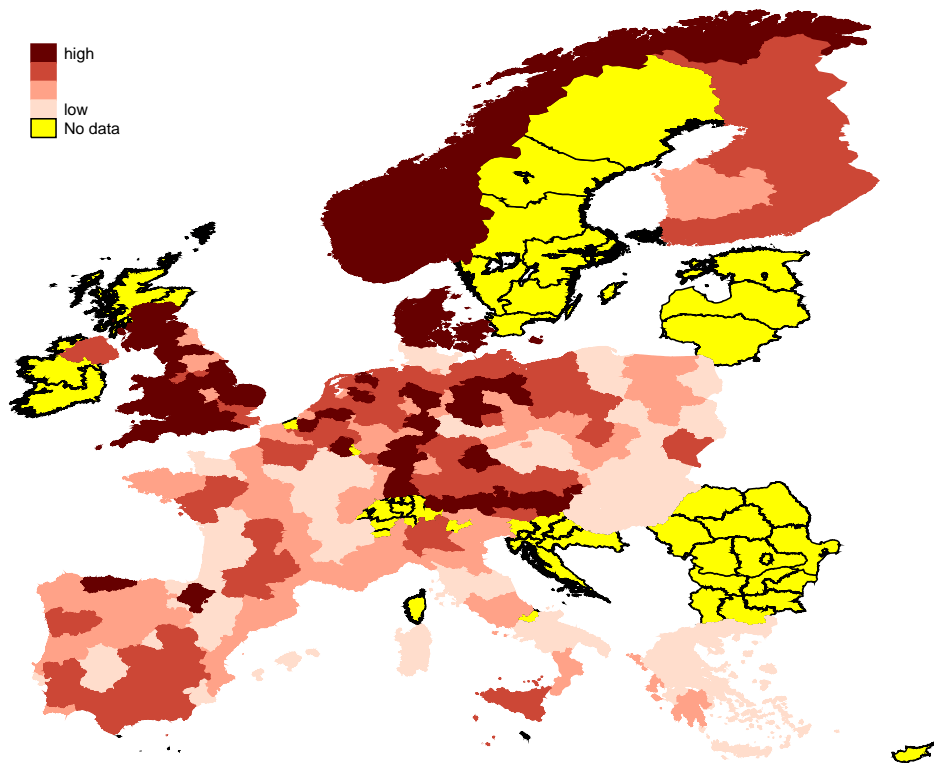
As far as higher level factors are concerned, the regional factors such as growth and unemployment rates affect workers' well-being differently. A low growth rate is associated with lower well-being ($\beta=-0.146$, $p<0.01$), while the high unemployment rate is associated with higher well-being ($\beta=0.063$, $p<0.01$). Examining the influence of higher level factors, the regional intra-class correlation for well-being is 20.1%, while the country intra-class correlation is 7.0%. Thus, well-being is more likely to be influenced by the regional variations than by country variations (Aslam and Corrado, 2012; Pierewan and Tampubolon, 2014). Nevertheless, these results indicate that well-being is more attributable to individual variations than to regional or country variations. Following these results, similar analysis is conducted for job satisfaction in the next subsection.

4.3.2 The relationship of workplace social capital and job satisfaction

Figure 4.2 shows workers' job satisfaction in Europe. Again concentrating on countries suffering the most during the crisis, there are disparities within those countries.

Most regions in Italy, Portugal, Spain and Greece show lower job satisfaction than the rest of Europe. Similar to the analysis of well-being, all regions in Denmark, Finland and Norway experience high job satisfaction. However, this map shows mostly light-coloured areas. Compared to Figure 4.1, this figure shows an early indication that job satisfaction is more affected when the countries are suffering from the crisis.

Figure 4.2 Job satisfaction of workers across regions (NUTS 2) in Europe



Source: EWCS2010 values mapped into EuroBoundaryMap (Eurographics, 2008)

Multilevel models Table 4.4 shows progressive multilevel models for job satisfaction. Model 1 is the baseline model and Model 2 includes workplace social capital and activities outside work with individual and work-related covariates. Model 3 introduces individual and work-related covariates. Model 4 is inclusive of regional factors and lastly, country covariates are included in Model 5 together with all covariates. As with well-being, each model for job satisfaction shows that workplace

Table 4.4: Multilevel models predicting job satisfaction in Europe - complete results

	Model 1	Model 2	Model 3	Model 4	Model 5
Constant	2.967(0.039)‡	2.353(0.041)‡	1.073(0.054)‡	1.211(0.062)‡	1.235(0.144)‡
Social capital		0.157(0.004)‡	0.015(0.003)†	0.015(0.003)†	0.015(0.003)†
<i>Activities outside work:</i>					
Voluntary activity			0.007(0.003)†	0.007(0.003)†	0.007(0.003)†
Caring for children*			0.003(0.001)†	0.003(0.001)†	0.003(0.001)†
Cooking			-0.001(0.002)	-0.001(0.002)	-0.001(0.002)
Caring for elderly			-0.004(0.002)‡	-0.004(0.002)†	-0.004(0.002)†
Taking a training			0.011(0.003)‡	0.011(0.003)‡	0.011(0.003)‡
Sporting/cultural activity			0.005(0.002)†	0.005(0.002)‡	0.005(0.002)†
Gardening and repairs			-0.011(0.002)‡	-0.011(0.002)‡	-0.011(0.002)‡
<i>Personal characteristics:</i>					
Age			-0.006(0.002)‡	-0.006(0.002)‡	-0.006(0.002)‡
Male			-0.028(0.007)‡	-0.028(0.007)‡	-0.028(0.007)‡
Health			0.174(0.006)‡	0.174(0.006)‡	0.174(0.006)‡
Education			0.006(0.001)‡	0.006(0.001)‡	0.006(0.001)‡
Having a spouse/partner			0.001(0.007)	0.001(0.007)	0.001(0.007)
Being a main earner			0.001(0.006)	0.001(0.006)	0.001(0.006)
Work schedule fits with family			0.218(0.008)‡	0.218(0.008)‡	0.218(0.008)‡
Income €4801 - €7200			0.015(0.010)	0.015(0.010)	0.015(0.010)
Income €7201 - €12000			0.007(0.011)	0.006(0.011)	0.006(0.011)
Income €12001 - €21000			-0.026(0.011)†	-0.029(0.011)†	0.003(0.019)†
Income €21001 - €48000			-0.021(0.013)	-0.022(0.013)	-0.024(0.013)
<i>Job aspects:</i>					
Well-paid job			0.129(0.003)‡	0.129(0.003)‡	0.129(0.003)‡
Career advancement			0.048(0.003)‡	0.048(0.003)‡	0.048(0.003)‡
Feel at home			0.130(0.004)‡	0.130(0.004)‡	0.130(0.004)‡
Ease to find job			-0.003(0.002)	-0.003(0.002)	-0.003(0.002)
Motivated to do the best			0.090(0.003)‡	0.089(0.003)‡	0.089(0.003)‡
Possibility to lose job			-0.060(0.003)‡	-0.060(0.003)‡	-0.060(0.003)‡
<i>Employment contract:</i>					
Temporary/apprenticeship			0.011(0.025)	0.011(0.025)	0.011(0.025)
Fixed contract			0.034(0.014)†	0.034(0.014)†	0.034(0.014)‡
Indefinite contract			0.003(0.012)	0.003(0.011)	0.003(0.012)
<i>Work sectors:</i>					
Public			0.014(0.007)	0.014(0.007)	0.014(0.007)
Joint			-0.006(0.015)	-0.007(0.015)	-0.007(0.015)
Non-profit			-0.010(0.027)	-0.010(0.027)	-0.010(0.027)
Other			-0.048(0.026)	-0.047(0.026)	0.048(0.026)
<i>Regional factors:</i>					
Growth				-0.009(0.009)	-0.010(0.008)
Unemployment rate				-0.010(0.002)‡	-0.008(0.003)‡
<i>Country factors:</i>					
Gini index					0.001(0.005)
Bismarckian					-0.033(0.069)
Anglo-Saxon					0.077(0.099)
Southern Europe					-0.103(0.077)
Eastern Europe					-0.112(0.072)
Between-country variance	0.221(0.028)	0.214(0.027)	0.139(0.018)	0.110(0.014)	0.097(0.013)
Between-region variance	0.125(0.007)	0.127(0.007)	0.089(0.006)	0.088(0.006)	0.088(0.006)
Between-individual variance	0.698(0.002)	0.683(0.002)	0.578(0.002)	0.578(0.002)	0.578(0.002)
ρ country	0.212	0.210	0.172	0.141	0.127
ρ region	0.152	0.157	0.132	0.132	0.132
Individuals	40533	40533	40533	40533	40533
Regions	400	400	400	400	400
Countries	34	34	34	34	34

Sig. 1%‡; 5%†

Notes: reported in coefficients (standard errors). * including grandchildren

social capital has a significantly positive association with job satisfaction. Similarly, workplace social capital attenuates as more covariates are introduced to the models. As the model progresses, the coefficients of the covariates remain mostly constant. After introducing activities outside work in Model 3, all activities outside work have significant associations with job satisfaction, other than cooking. Model 5 (the full model) shows contrasting results to those of well-being as caring for children/grandchildren has a statistically significant association with higher job satisfaction ($\beta = 0.003$, $p < 0.05$) and gardening and repairs show significant association with lower job satisfaction ($\beta = -0.011$, $p < 0.01$).

As with individual characteristics, Model 5 shows that age ($\beta = -0.006$, $p < 0.01$) and being males ($\beta = -0.028$, $p < 0.01$) have significant negative associations with job satisfaction. These results corroborates previous findings (Clark et al., 1996; Clark, 1997). In contrast, health has a significant positive association with job satisfaction ($\beta = 0.174$, $p < 0.01$) and so does education ($\beta = 0.006$, $p < 0.01$). The result on education is against those of previous studies (Clark et al., 1996; Clark, 1997; Frey and Stutzer, 2001; Jones et al., 2009). Contrasting the effects on well-being and previous findings (Dolan et al., 2008), having a spouse/partner and being the main earner in the households are both non-significantly associated with job satisfaction. However, having a work schedule that fits with family needs is associated with higher job satisfaction ($\beta = 0.218$, $p < 0.01$) supporting earlier studies (Byron, 2005; Costa et al., 2006; McNall et al., 2010).

A closer look into the associations of work-related factors with job satisfaction shows that there are similarities with the results for well-being. For example, fear of losing one's job is also significantly associated negatively with job satisfaction ($\beta = -0.060$, $p < 0.01$) as found by Ferrie et al. (1995) and Oesch and Lipps (2012), whereas other job aspects show significantly positive associations with job satisfaction. However, ease of finding a job has no significant association with job satisfaction. Although any type of employment contract has a positive association with

job satisfaction as opposed to not having any employment contract, having a fixed contract is significantly associated with higher job satisfaction ($\beta=0.034$, $p<0.05$) confirming previous results (De Cuyper and De Witte, 2007; De Witte and Näswall, 2003; Mauno et al., 2005). Similar to the result on well-being, working in any other sector classified is not significantly associated with job satisfaction compared to the private sector.

Turning to contextual effects, a higher unemployment rate has a significant and negative association with job satisfaction ($\beta=-0.008$, $p<0.01$), which represents the reverse of its effect on well-being. Compared to Scandinavian countries, most regimes in Europe have negative associations with job satisfaction; however, the associations are not significant. Moreover, the inequality in a country represented by the Gini coefficient has no significant association with job satisfaction. Similar to the effects of contextual factors on well-being, the regional intra-class correlation for job satisfaction is 13.2%, while the country intra-class correlation is 12.7%. Thus, job satisfaction is slightly more attributable to regional variations than to country variations, although individual variations have a larger contribution to job satisfaction.

4.4 Discussion

Does workplace social capital improve well-being and job satisfaction of workers? This study shows that workplace social capital is significantly associated with both higher well-being and job satisfaction. This finding supports previous studies that social capital in general improve well-being (Helliwell et al., 2009a, 2014; Rodríguez-Pose and von Berlepsch, 2014) and job satisfaction (Helliwell et al., 2009b; Helliwell and Huang, 2010; van der Horst and Coffe, 2012; Yamaguchi, 2013). Helliwell et al. (2014) emphasised that humans feel happier when they can interact to each other in a trusting environment.

As workplace social capital is measured with friendships at work in this study, friendships at work, as well as those outside the workplace, may provide support

and networks which provide life satisfaction, especially close friends (Argyle, 2001). Moreover, workplace is a specific domain which may contain workers with similar values or attitudes, van der Horst and Coffe (2012) found that having homogenous friends are better for well-being and job satisfaction. Homogenous friends share interests and most likely similar attitudes by being open to each other which may raise the self-esteem of the parties involved in the relationships and, in turn, leads to higher life satisfaction. In addition, opening to each other build more trust among the workers. More trust means more happiness as human as social beings inherently like to trust each other (Layard, 2011).

Working in the same workplace creates more opportunities for workers to have face to face interaction with their friends which are important for the relationships (Argyle, 2001; van der Horst and Coffe, 2012). This interaction may well nurture their relationships and strengthen the support they gain from the relationships to perform well in their jobs. It is plausible also that workplace social capital may alleviate the tension of the need keeping the job in the shadow of the unemployment during hardship as workers receive emotional support from outside groups beyond family to endure such a challenging time (Helliwell et al., 2014) as companionship is the value of friendship (Argyle, 2001). These supports then lead to higher job satisfaction as workers feel attached to their friends and jobs.

Do activities outside work improve well-being and job satisfaction of workers? The results show that different activities outside work have different effect on well-being and job satisfaction. Sporting, cultural activities and gardening (and repairs) significantly improve the workers' well-being which support previous studies (van der Berg et al., 2010; Dolan et al., 2008; Ferrer-i-Carbonell and Gowdy, 2007; Hawkins et al., 2011). The improvement in well-being is a result of being healthy by engaging in physical activities, such as sports and gardening. Thus, it is the health that improves the well-being. On the contrary, gardening is negatively associated with job satisfaction. Gardening may take up some of workers' time which

then decrease the possibility of earning. Else, gardening itself may need more resources such as money to indulge the hobby. Both time and money are particularly scarce in this time of study.

Other activity such as signing-up for training is only significantly positive for job satisfaction. This is understandable since joining a training may add more knowledge and even provide contacts and opportunity to find a better job. In this study, I also find support for previous findings that voluntary work is significantly positive to both well-being and job satisfaction (Argyle, 2001; Mojza et al., 2011). Voluntary work gives an opportunity for workers to disengage themselves from their jobs and to fulfill their needs for competence and relatedness by helping others (Mojza et al., 2011). As ‘helping others is a source of joy’ (Argyle, 2001, p.123), people who volunteers will volunteer more to accumulate the joy (Meier and Stutzer, 2008). In contrast, caring for children/grandchildren is only associated with higher job satisfaction in this study. Although having children is found to improve parents’ well-being (Angeles, 2010), children bear financial costs for the parents (Pollman-Schult, 2014) which indicate that having jobs is essential to support the children. Being able to provide for the children may become the motivation to keep the jobs, thus, satisfaction of being employed when the high unemployment prevails (such the time in this study) may lead to higher job satisfaction.

Other activities outside work are significantly negatively associated with well-being and job satisfaction. Caring for the elderly reduced both well-being and job satisfaction as this may relate to the time and efforts needed to carry out the associated tasks, which reduces the time available for paid work or for leisure activities. Other plausible cause is put forward by Marks et al. (2002) that taking care of elder relatives causes stress and depression to individuals, especially for men (Marks, 1997), which then lead to not only lower well-being but also reduced job satisfaction.

Do regions and countries have effect on well-being and job satisfaction in Europe? I include growth and unemployment rates in the regions and Gini coef-

ficient and welfare-state regimes of the countries in the analysis. I find that regional unemployment is significantly related to both well-being and job satisfaction. The regional unemployment rate improves the well-being of individuals and this finding contradicts previous findings (Clark, 2003; Hooghe and Vanhoutte, 2011). Clark (2003) found that the unemployment rate of an individual's immediate surrounding or in the community is significantly negatively associated with the well-being of employed respondents. Hooghe and Vanhoutte (2011) also found that unemployment rate in the community is negatively related to well-being of respondents. Workers in this study have regions as their immediate surrounding and the unemployment rates are high during data collection of this study. This inevitable condition may make the workers compare themselves to those who become unemployed and they may feel grateful, relieved and probably proud that they still keep their jobs to provide for the families. Buunk and Gibbons (2007) mention this comparison as downward social comparison which commonly happens in bad situation. Those positive feelings may be stronger particularly in this study since more than half of the respondents are reported being the main earners in their households.

On the contrary, a regional unemployment rate is significantly negatively associated with job satisfaction. The prolonged unemployment due to the crisis reduces career opportunities and one's expectation of getting a new job. This unfavourable condition consequently force workers to keep their current jobs in order to earn a living whether they like the jobs or not. These workers may become more 'job-oriented' since they only work in terms of the tangible benefits such as salary (Diener and Biswar-Diener, 2008). Before the crisis happens, they can be more 'career-oriented' as they work to gain respect or social status or even more they may tend to be 'calling-oriented' as their jobs contribute to the community (Diener and Biswar-Diener, 2008). The loss of these latter orientation of work may reduce hope and increase job dissatisfaction of workers. Other plausible explanation is the existence of survivor effect (Appelbaum et al., 1997; Baruch, 1999). These workers are those

who survive the dramatic change in organisation, probably downsizing or redundancy. Changes in organisations may cause uneasiness for them as they may feel they do not have any job security or they lose the opportunity to work with the colleagues experiencing the redundancy or being laid off. These surviving workers then may experience demotivation which then shows as lower job satisfaction. Organisations tend to prepare those who will be dismissed, but they tend to ignore those who will stay in the organisations after the organisational change. Previous studies emphasise the need of management to take care both workers who are leaving and workers who are staying within organisations after such organisational changes (Appelbaum et al., 1997; Baruch, 1999).

This contradictory results may shed light on the difference between well-being and job satisfaction of workers in Europe previously shown in Figure 4.1 and 4.2. Well-being is darker, hence higher, than job satisfaction for certain countries. Those workers in the most suffered countries such as Greece, Spain and Italy are the survivors who have higher level of well-being since they are in better position than the rest of the unemployed in their regions, hence their status and self-esteem are intact, although they may suffer in their jobs because of the downsizing of the workplaces.

On the country level, the inequality within a country has insignificant positive associations with well-being and job satisfaction. Workers in any other welfare states have lower well-being compared to those in the social democrat welfare regimes. Significantly, the workers in Eastern Europe suffer in their well-being, but not in their job satisfaction. This finding not only underlines the position of Scandinavian countries who have the social democrat regimes as the happiest countries in Europe, but it also echoes the result of previous study that people reside in countries like Denmark, Sweden and Finland have higher well-being in Europe, while those living in Eastern Europe mostly have lower well-being (Aslam and Corrado, 2012).

4.5 Conclusion

My research begins by studying the relationships between workplace social capital and both of workers' well-being and job satisfaction in developed countries. This study examines the relationships by incorporating other covariates i.e. activities outside work, individual and job characteristics accounting for contextual determinants at regional and country levels in 34 countries in Europe. This study finds that workplace social capital is significantly associated with both higher well-being and job satisfaction.

Notwithstanding the findings, there are several limitations in this study. First, workplace social capital measured by friendships at work is used to predict well-being, but the reverse may happen. Happy workers may attract more friends either in or outside the workplace and feel content in the workplace. This signifies a possibility that friendships at work may be endogeneous to both well-being and job satisfaction due to unobserved confounding factors such as positive personality trait of the workers. As the information on the personality trait of the workers in the survey are unavailable, it is necessary to use the results of this study cautiously. In addition, more elaborate information on the friends at work such as gender, their position at work or the intensity of interaction within or outside the workplace may clarify the effect of having friendships at work. Second, the recall bias on the frequency of activities outside work may affect the results of the study. The respondents were only asked on how often they do the activities without further evidence of membership (for voluntary work or sporting activities) for example. Third, as data collected using house address in the regions instead of workplaces, workers are nested within regions rather than workplaces. This fact limits the exploration of workplace characteristics in this study. Finally, this study has separate models for well-being and job satisfaction using similar covariates which limit the interpretation to each domain.

Despite the limitations, this study has highlighted several contribution to the

literature and policy makers. This study gives evidence that workplace social capital contributes to well-being and job satisfaction by combining two domains of workers' lives: work and non-work in a study. This combination provides more empirical evidence on the associations and the interaction of the domains in workers' lives. As not all aspects and activities in both domains have similar relationships to well-being and job satisfaction, this study apparently adds another differentiation between general and domain specific well-being. Some examples of the aspects and activities: ease of finding a job is only associated positively to well-being, but not job satisfaction; gardening and repairs associate positively to well-being in contrast to its negative association with job satisfaction. Whist signing-up for training and caring for children (grandchildren) are only associated with higher job satisfaction, both sporting activities and voluntary work are associated with higher well-being and job satisfaction.

This study also gives more evidence on the existence of survivor effect after examining the associations of both well-being and job satisfaction to regional unemployment. Being employed significantly improve workers' well-being in this time of crisis as they compare themselves to the unemployed, yet staying in the organisations lower their job satisfaction since they may have more workloads and lose their colleagues. This evidence is not only important for the literature but also for decision makers as they need to be aware of this condition to ensure they have policies in place for the dismissed as well as the survivors.

As workplace social capital significantly improve both well being and job satisfaction, but job aspects such as career advancement, being able to do the best and having a well-paid job relatively contribute more to workers' job satisfaction. This study also indicates the interaction between work and non-work domains in workers' lives as the fit between working schedule with family responsibility shows significant positive association to both well-being and job satisfaction. These findings may give insights to the policy makers in the organisations to put more attention not

only on the working schedule arrangement but also on the maintenance of job aspects attractiveness in their organisations. In addition, activities such as taking care of elder relatives is detrimental for both well-being and job satisfaction. Decision makers in the companies may use these findings to improve the working conditions for the workers, especially in this time of crisis, such as allowing flexible working arrangement to help those who take care of their elders.

The findings on this study may lead to two directions: future data collection and research. Future data collection may attempt to use workplace addresses in regions as the basis for getting respondents. To have a thorough understanding of workplace social capital, the survey shall include questions on personality trait of the workers and more information on the friends at work such as gender, position at work and the intensity of interaction both at the workplace and outside the workplace. In addition to the frequencies of the activities outside work, questions on the membership of those activities may help to lessen respondents' recall bias. These data will enable future research to elucidate more on the association between workplace social capital and job satisfaction. Further, future research shall jointly look into both well-being and job satisfaction in one model and possibly include the confounding factors to have more solid results. Future research may also include specific workplace characteristics such as size of workplace to investigate the association between workplace social capital and job satisfaction.

This European investigation has provided evidence on the relationships between workplace social capital and both well-being and job satisfaction across Europe. The next chapter will examine the association between workplace social capital and job satisfaction in a single country based on research on workers in Britain.

Chapter 5

Workplace social capital and job satisfaction in Britain

5.1 Introduction

Job satisfaction is one of the most researched topics in organisations (Harter et al., 2002; Rice et al., 1991); a quick search on the Web of Science produced approximately 12,000 articles since 1900. Job satisfaction has been used to predict both worker performance and workplace performance (Barling et al., 2003; de Menezes, 2012; Shields and Ward, 2001; Wood et al., 2012; Wright and Cropanzano, 2000; Wright and Bonett, 2007). Similarly, workplace social capital has been discussed as an element with the potential to improve workplace performance (Bandiera et al., 2008; Nahapiet and Ghoshal, 1998; Sako, 1998). Social capital in the workplace is ‘a resource reflecting the character of social relations within the firm, realised through members’ level of associability and shared trust’ (Leana and van Buren, 1999, p.540) which has two dimensions: vertical social capital and horizontal social capital (Oksanen et al., 2010). Vertical social capital refers to norms and trusting relationships across formal hierarchy within the workplace, whilst horizontal social capital refers to relations between individual at the same hierarchical level (Oksanen et al., 2010; Szreter and Woolcock, 2004). However, lesser attention is given to the relationship between social capital and job satisfaction as only Flap and Völker (2001) and Agneessens and Wittek (2008) investigate the associations. Flap and Völker (2001)

found that relationships with both coworkers and managers were associated with satisfaction at work, whilst workers will adjust their job satisfaction according to those of their network relationships in the workplace (Agneessens and Wittek, 2008); yet, both studies ignore that workers are nested within their workplaces.

In addition, most studies on job satisfaction and its relation to social capital use data from normal economic condition. Britain experienced the financial crisis in 2007-2008 which impacted the country's labour market for the following years as Britain suffers from the highest unemployment since 1996 (BBC News, 2013) with 2.62 million people unemployed (8.3% of the working population) in October 2011 (Office of National Statistics, 2011a). Long-term unemployment persists at approximately 3% in 2011-2013 (Eurostat, 2015a). Workers fear not only the current employment, but also the future employment as explained in Chapter 1 and workers may perceive a considerable threat for losing their jobs if the economy does not recover in the near future. This changing economic condition may influence the relationship between social capital and job satisfaction and gives an opportunity to examine the relationship in such a time.

Acknowledging the gaps in the literature i.e. lesser attention on the relationship of workplace social capital and job satisfaction, the nested structure of workers in workplaces and the rarity of job satisfaction studies in difficult economic condition such as a recession, this study is an attempt to fill those gaps. First, using the nested data gained from employees and workplaces, this study will investigate the relationship between social capital and job satisfaction using multilevel analysis. Second, this study is among the few using data relevant to job satisfaction that has been collected during a period following the financial crisis; it is precisely data gathered at such time that enables the investigation of job satisfaction in such a rare condition. Third, this study explores the relationships between social capital and job satisfaction using large data coming from many industries in a single country: Great Britain. Fourth, this study then makes further investigation of the relationships in

a single industry: the healthcare industry which recently becomes the focus of social capital studies in other countries (Driller et al., 2011; Ommen et al., 2009).

Using data collected in times following the financial crisis in Britain (2011-2012), this chapter attempts to test the following hypotheses:

1. H1 Workplace social capital has associations with job satisfaction in a developed country.
2. H2 Individual characteristics affects job satisfaction in a developed country.
3. H3 Workplace characteristics affects job satisfaction in a developed country.

The chapter is structured as follows. The next section describes the data, variables and the model applied for this specific chapter. Section 3 reports the results of the estimation, followed by the discussion in Section 4 before reaching the conclusion in Section 5.

5.2 Data and method

I use WERS2011 data in this analysis. WERS2011 is the most current data set exploring Britain's working condition and it was conducted when Britain was still in recession after the onset of financial crisis in 2008 (van Wanrooy et al., 2013) (see Figure 3.3 in Chapter 3). The data set include 21,981 employees in 2,680 workplaces in Britain; it captured responses from the perspectives of employees, managers and employee representatives. For this study I link the responses from the employees and the managers only resulting in 21,981 employees in 1,923 workplaces as the sample.

Table 5.1 shows individual and workplace characteristics for the analytic sample. The majority of the respondents were females (56%). They were mostly married and in good health. More than half of the respondents had tenure of more than five years in the current workplace and less than half of them claimed that they had matched or higher skills than required for their jobs. However, approximately 70% of them

Table 5.1: Analytic sample

Covariates	No/Mean/%	SD	Missing(%)	Job satisfaction*
Vertical social capital	3.716	0.777	0.98	0.465(0.004)‡
Female	56.2		1.22	0.101(0.011)‡
Married	69.8		1.53	0.056(0.009)‡
Health	Good		1.36	0.267(0.018)‡
Tenure: 5 years or more	54.9		0.95*	-0.033(0.011)‡
With matched skill for the job	44.3		1.29*	0.238(0.011)‡
With higher skill for the job	4.0			-0.264(0.027)‡
Received training this year	70.4		1.41	0.240(0.011)‡
Being a supervisor	32.9		2.41	0.250(0.011)
Education:				
GCSE D-G or NVQ level 1	6.1		3.46*	
GCSE A-C or NVQ level 2	6.7			-0.098(0.030)†
A levels or NVQ level 3	17.9			-0.130(0.024)‡
Certificates of higher education	32.8			-0.083(0.023)‡
Diplomas of higher education, NVQ level 4	3.7			0.001(0.034)
Bachelor degree, NVQ level 5	22.6			-0.076(0.023)†
Master, doctoral degrees	10.2			0.040(0.026)
Income:				
Income < £13,520 per year	28.4		5.0*	ref
Income £13,521 - £22,360 per year	30.3			-0.170(0.012)‡
Income £22,361 - £33,800 per year	22.4			-0.008(0.013)
Income > £33,801 per year	18.9			0.193(0.014)‡
<i>Workplace characteristics</i>				
Public organisations	37.9		0.65*	-0.081(0.011)‡
Private organisations	62.1			
Size of organisation:				
≥250 employees	30.3		0.65*	-0.045(0.003)‡
Having a performance-based pay	41.6		0.76	-0.046(0.011)‡
Experiencing impact of recession	75		0.81	-0.057(0.012)‡
Redundancy in organisation	1.89		4.69	-0.001(0.001)
Dismissal in organisation	0.97		6.19	-0.000(0.002)

Note: Reported in standardised coefficients (standard errors). Sig: 1%‡;5%†

Note: * for all categories in the variable

had received a training opportunity in the previous year. Only one third of them is in the supervisory position. Most of them had been educated to A level or beyond with more than half were in the highest two quartiles of income. Turning to the workplace characteristics, workplaces involved in this survey were mostly private organisations categorised as small-medium enterprises as only one third of them had more than 250 employees (Ward and Rhodes, 2014). Approximately 42% of the workplaces applied performance-based pay system for their employees. Most of the workplaces were experiencing the impact of recession and they had redundancy and dismissals in the previous year.

5.2.1 Dependent variable

The dependent variable in this study is job satisfaction based on employees' responses using the available answers from strongly disagree to strongly agree in five-points Likert scale. In WERS2011 job satisfaction is measured through eight aspects of employees' satisfaction. These include achievement, initiative, influence over job, skill development, training received, pay received, job security and work itself. Using the aspects to measure job satisfaction, it follows the practice of determining job satisfaction is a directly dimensionally measured variable (Price and Mueller, 1986).

Most studies use factorial analysis to determine job satisfaction (Spector, 1997). A previous study using WERS2004 data had shown that there is a high possibility that employees who satisfy with one aspect may also be satisfied in other dimension which may cause high collinearity among those aspects (Jones et al., 2009). To solve this problem, Jones et al. (2009) used principal component analysis which can combine aspects that are collinear and reduce the data set to a manageable size. I use confirmatory factor analysis (CFA) to determine job satisfaction (Currivan, 1999; Rich, 1997).

5.2.2 Independent variable

The independent variable in this study is social capital. Following Oksanen et al. (2010), social capital is measured by means of the quality of the perceived relationships between employees and their superiors in WERS2011. There are six statements in the employee questionnaire to be answered reflecting perceived trust, honesty, sincerity, fairness, considerateness and tolerance of the superior with the answers available from strongly disagree to strongly agree in five-point Likert scale. Those statements are: ‘Now thinking about the managers in this workplace, to what extent do you agree or disagree with the following? Managers here.....a) can be relied upon to keep their promises; b) are sincere in attempting to understanding employees’ views; c) deal with employees honestly; d) understand about employees having to meet responsibilities outside work; e) encourage people to develop their skills; f) treat employees fairly’. However, I only use only four statements (a,b, c and f) which are similar with the statements of vertical social capital used by Oksanen et al. (2010) (see Table 1.2 in Chapter 1). To construct the social capital score, instead of summing the responses as in Kouvonen et al. (2006), I use factorial analysis (Oksanen et al., 2010).

As control variables, I include some individual and workplace characteristics in the model. The individual characteristics included are gender (with male as the reference), health, highest education/qualification and being married as previously used in other studies (Belfield and Harris, 2002; Clark et al., 1996; Clark, 1997; Groot and van den Brink, 1999; Oshagbemi, 2000). I also some characteristics regarding their jobs i.e workers’ matched skills for their jobs with lower skill as the reference, tenure (with tenure under 5 years as the reference), the opportunity to receive training other than health safety in the past one year (with those having none as the reference), having a supervisory position, and income (Haile, 2009; Lévy-Garboua and Montmarquette, 2004; Nguyen et al., 2003; Oshagbemi, 2000, 2003; Sousa-Poza and Sousa-Poza, 2000). I divide income into quartiles with the lowest

quartile serving as the reference.

As for workplace characteristics, I use a log of organisation size (judging by the number of employees) following Gazioğlu and Tansel (2002). I also include the formal status of the workplace e.g. private and public organisations with private as the reference. I use a dummy variable for the existence of a performance-based pay system in the workplace. As the workplace may be impacted by the economic condition during the time of survey, I include several covariates. I use both dismissal and redundancy percentages within organisations in the last 12 months and a dummy variable representing companies disproportionately impacted by economic recession. This is based on the answers of the managers on a specific question in the survey: ‘Looking at this card, can you tell me to what extent your workplace has been adversely affected by the recent recession?’ The responses are: ‘no adverse affect’, ‘just a little’, ‘moderate amount’, ‘quite a lot’ and ‘a great deal’. I divide the responses into two: 0 for those who answers less than moderate amount and 1 for moderate amount and above. Lastly, I include average unemployment rates by industry during the survey period according to Office of National Statistics (2012).

5.2.3 Method

I apply a multilevel SEM model (Hox and Bechger, 1998; Iacobucci, 2009; Muthén and Asparouhov, 2011) to predict job satisfaction using Stata 12 and Mplus 5.0 as both job satisfaction and social capital are latent variables and employees are nested within workplaces. The multilevel SEM model is to observe the relationships between two latent variables while accounting for other observed variables such as individual and workplace characteristics. The multilevel SEM model is first applied to the general industry, then to a specific industry: healthcare industry, as it is the most represented workplaces in WERS2011, other than education, with approximately 17% of the survey observations (van Wanrooy et al., 2013).

Table 5.2: Factor analysis of the variables with rotated factor loadings

Codes	Variables	Factor 1
	<i>Social capital</i>	
TRUST	Managers can be relied upon to keep to their promises	0.862
SINCERE	Managers are sincere in attempting to understand employees' views	0.894
HONEST	Managers deal with employees honestly	0.903
FAIR	Managers treat employees fairly	0.833
	<i>Job satisfaction</i>	
ACH	The sense of achievement you get from your work	0.723
INIT	The scope of using your own initiative	0.775
INFL	The amount of influence you have over your job	0.723
TRAIN	The training you receive*	0.272
SKILL	The opportunity to develop your skills in your job	0.415
PAY	The amount of pay you receive*	0.247
SECURE	Your job security*	0.294
WORKC	The work itself	0.642

Note: *excluded from further analysis.

Before building the model, the exploratory factor analysis (EFA) is conducted for both job satisfaction and social capital. Although all eight aspects of job satisfaction asked to the employees comprise a factor, only five aspects i.e. satisfaction with achievement (ACH), initiative (INIT), influence over job (INFL), skill (SKILL) and work itself (WORKC) have rotated loading factors above 0.40. The remaining three aspects with loading factors below 0.40 are not included in further analysis (Guadagnoli and Velicer, 1988; Hair et al., 2006). As mentioned earlier, only four statements on the perceived quality of the superiors are similar with the statements of vertical social capital used by Oksanen et al. (2010). These four aspects are perceived trustworthiness (TRUST), honesty (HONEST), sincerity (SINCERE) and fairness (FAIR) of the superiors. The results are in Table 5.2.

After the EFA, the CFA is conducted at the single and two-levels. Table 5.3 shows the results with all loading factors are at above 0.40 which make good factors (Hair et al., 2006). The single level CFA for both job satisfaction and social capital shows a convincing goodness of fit as all fit indices are in accordance with conventional cut-off (Hooper et al., 2008; Iacobucci, 2009). The two-level CFA shows all indicators as latent as described by Hox (2010).

Table 5.3: CFA results

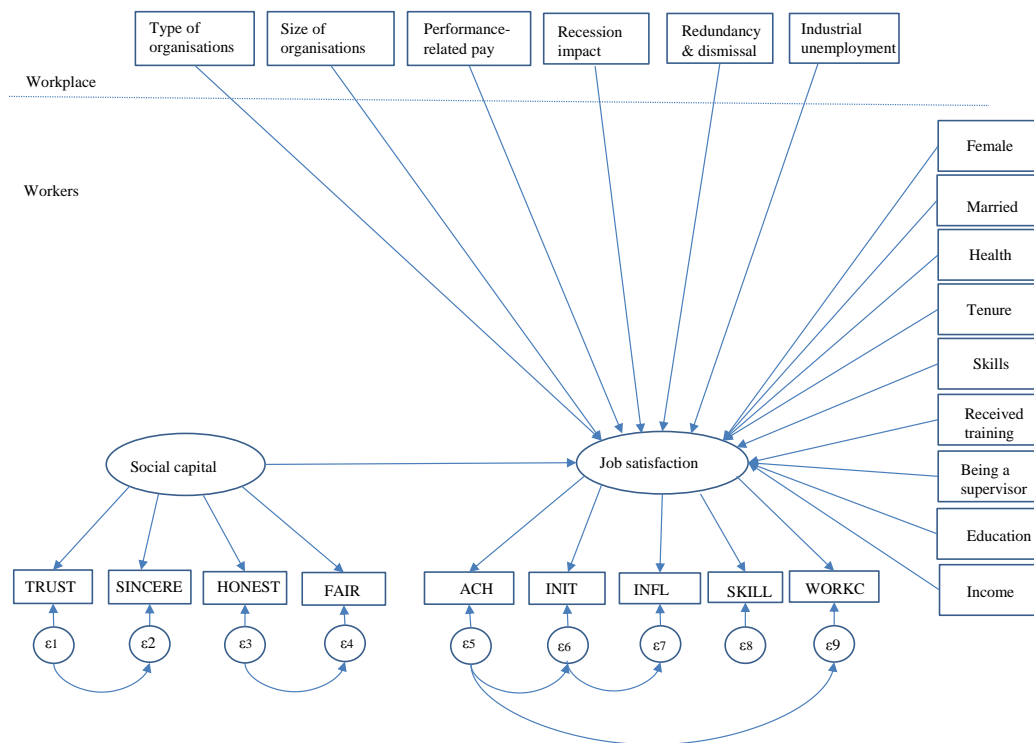
Indicators	Single-level		Two-level	
	Job satisfaction	Social capital	Job satisfaction	Social capital
<i>Within level</i>				
ACH	0.733(0.004)‡		0.713(0.006)‡	
INIT	0.765(0.005)‡		0.733(0.006)‡	
INFL	0.778(0.004)‡		0.768(0.005)‡	
SKILL	0.731(0.004)‡		0.705(0.006)‡	
WORKC	0.688(0.004)‡		0.663(0.006)‡	
TRUST		0.867(0.003)‡		0.846(0.004)‡
HONEST		0.907(0.003)‡		0.890(0.004)‡
SINCERE		0.904(0.003)‡		0.894(0.004)‡
FAIR		0.831(0.003)‡		0.809(0.004)‡
<i>Between level</i>				
ACH			0.994(0.001)‡	
INIT			0.993(0.001)‡	
INFL			0.994(0.001)‡	
SKILL			0.981(0.002)‡	
WORKC			0.995(0.001)‡	
TRUST				0.997(0.001)‡
HONEST				0.999(0.000)‡
SINCERE				0.997(0.000)‡
FAIR				0.831(0.001)‡
α	0.87	0.93		
RMSEA	0.046		0.055	
CFI	0.993		0.969	
TLI	0.988		0.954	
SRMR (within)	0.022		0.027	
SRMR (between)			0.187	
AIC	416800.504		416572.249	
BIC	417072.390		416972.082	

Note: Reported in standardised coefficients (standard errors). Sig:1%‡

Figure 5.1 shows the multilevel structural equation modelling (SEM) used in this analysis. However, this figure does not show the correlated measurement errors within the latent variables at workers level. Vertical social capital has correlated measurement errors between TRUST and SINCERE and HONEST and FAIR. It is suggested that managers with certain quality of political skills may develop both feeling of trustworthiness and sincerity in their followers (Perrewè et al., 2000). In addition, Ashton and Lee (2007) found that sincerity and fairness are facets of honesty in individual personality. Moreover, honesty and fairness coexist to enhance communication in interpersonal relationships (López-Pérez, 2012). Job satisfaction has more correlated measurement errors as ACH is related to INIT, INIT is with INFL and lastly, ACH with WORKC. Frese et al. (1997) found that need of

achievement has positively associated with initiative using McClelland's theory of motivation. McClelland proposed that need of achievement is the antecedent of initiative (Frese et al., 1997). Therefore, it is justified that satisfaction with achievement is correlated with satisfaction of having initiative at work in this study. In a similar vein, initiative at work may produce one's influence over one's job as one would seek information and knowledge to take control of one's job (Wrzesniewski and Dutton, 2001; Lyons, 2008). Lastly, satisfaction with achievement comes from having achievements at work which gives evidence of one's capability to perform a job which lead to satisfaction with work itself (Bandura, 1997).

Figure 5.1 Multilevel SEM model for job satisfaction in Britain

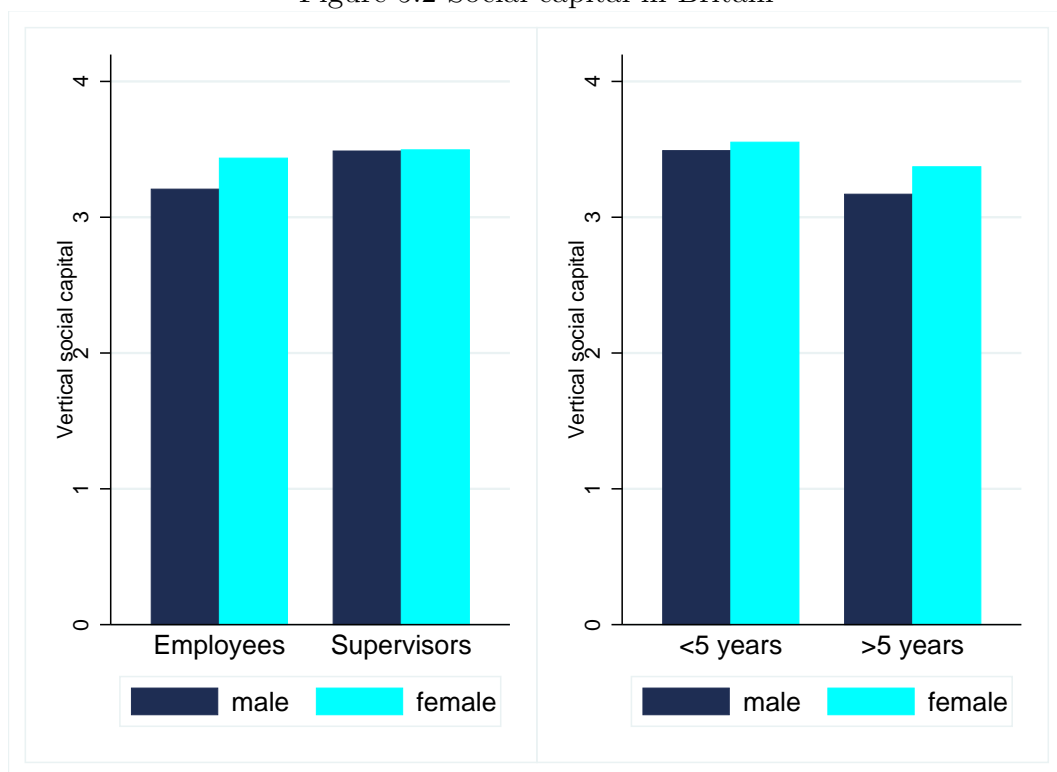


5.3 Results

Descriptive analysis Before testing the hypotheses, I present the levels of social capital and job satisfaction in Britain using their mean scores. Figure 5.2 shows

the social capital between gender for employees. In general, those with supervisory positions have higher level of social capital with female supervisors have the highest. There is only a slight difference in social capital between gender for supervisors. In contrast, male employees have the lowest level of social capital in Britain and there is a significant difference among gender for employees. Turning to tenure, those working under five years in the workplace have higher level of social capital compared to those with longer working years. Similar trend appears between gender regardless of the tenure, that is males has lower social capital than females. However, males with tenure over five years have the lowest level of social capital. The significant difference of social capital level happens between gender for those working over five years.

Figure 5.2 Social capital in Britain

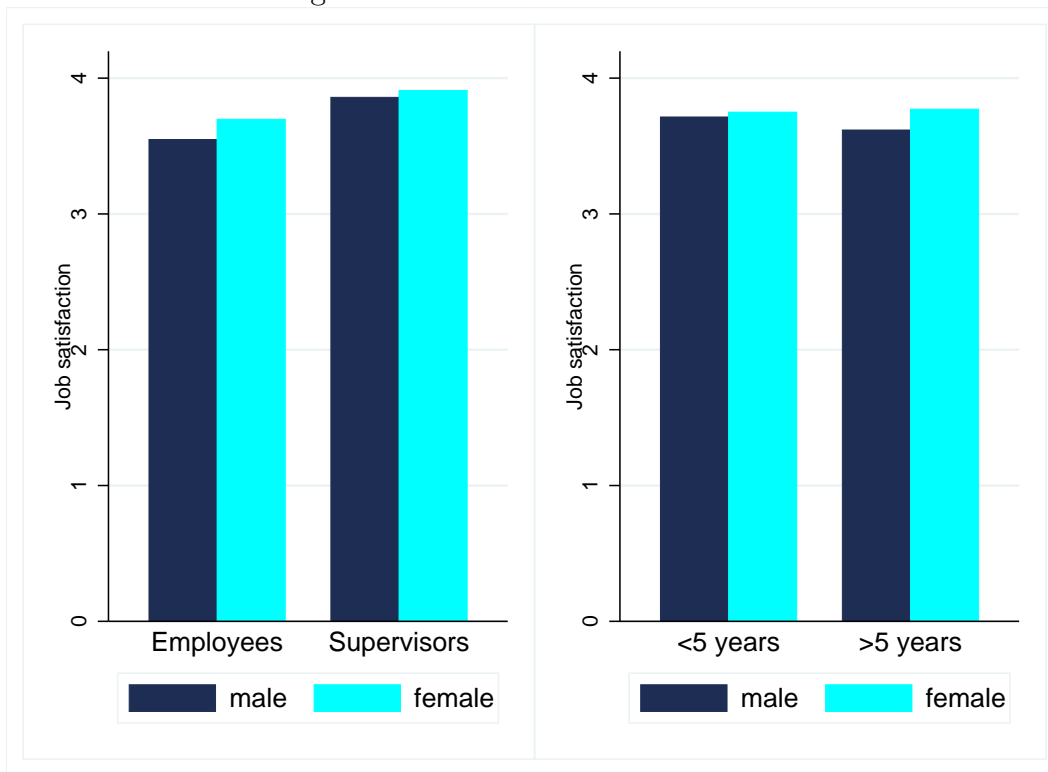


Source: author's calculation based on WERS2011 (the scale is 1 to 5).

Turning to job satisfaction, Figure 5.3 shows it according to job positions and tenure. Male employees experience the lowest level of job satisfaction, while female supervisors experience the highest level. There is a significant gender differential

in job satisfaction for employees compared to supervisors. In contrast, female have higher job satisfaction than male regardless of their tenure. Job satisfaction is higher for those working less than five years, but the highest job satisfaction belongs to female working over five years.

Figure 5.3 Job satisfaction in Britain



Source: author's calculation based on WERS2011 (the scale is 1 to 5).

Bivariate analysis Table 5.1 also shows the correlations between job satisfaction and those characteristics in Britain. Vertical social capital has a positive association with job satisfaction. Female employees have higher job satisfaction compared to their male co-workers. In addition, being healthy and married also are also positively associated with job satisfaction. Having longer tenure or higher skill are negatively related with job satisfaction. Similarly, having higher education has negative association with job satisfaction. Having skills required by their job and a training opportunity contribute to higher job satisfaction. Although having a supervisory position is positively related to job satisfaction, but the association is insignificant.

Unexpectedly, having higher income is negatively associated with job satisfaction, unless they have the highest income.

Turning to the workplace characteristics, most of them are significantly associated with lower job satisfaction. Working in a public organisation or larger organisation (with more than 250 employees) has negatively associated with job satisfaction, likewise in workplace impacted by recession and those applying performance-related pay system.

Multilevel SEM model Based on the model in Figure 5.1, there are five models in Table 5.4. Model 1 is the baseline model, Model 2 includes individual covariates, and Model 3 integrates both individual and workplace characteristics using SEM. Model 4 uses clustered covariance-variance matrix for robustness, while model 5 uses multilevel SEM model. If I look closely, there are slight differences between the results of a clustered SEM model (Model 4) and a multilevel SEM model (Model 5). Both clustered and multilevel models recognise the nested structure of employees in workplaces; the clustered SEM model adjusts for the standard errors whereas the multilevel model estimates workplaces' random intercepts (Snijders and Bosker, 2012). However, the multilevel model is superior to the clustered model (Primo et al., 2007) since it can separate an individual predictor and its contextual effect (Gelman, 2006).

All models show good fit indices since the values of CFI and TLI are above 0.96, except for Model 5. Nevertheless, Model 5 still shows good fit indices with both CFI and TLI above 0.90 which is previously recognised as the cut-off point, RMSEA is below 0.06 (the cut-off point) and the SRMR_(within) is 0.028 which is below the conventional cut-off point of 0.08 (Hooper et al., 2008; Hsu, 2009; Hu and Bentler, 1999). Since I am interested in learning about the contextual effect on the relationship of social capital and job satisfaction, I prefer to accept the results of the multilevel model (Model 5) and to relax the assumption on its goodness of fit.

Table 5.4: Job satisfaction in Britain - complete results

	Model 1	Model 2	Model 3	Model 4	Model 5
Social capital	0.673(0.005)‡	0.641(0.005)‡	0.639(0.005)‡	0.637(0.007)‡	0.594(0.008)‡
Individual characteristics:					
Female		0.029(0.006)‡	0.029(0.007)‡	0.029(0.008)‡	0.006(0.009)
Married		0.035(0.006)‡	0.037(0.007)‡	0.037(0.007)‡	0.039(0.007)‡
Health		0.048(0.006)‡	0.047(0.007)‡	0.047(0.006)‡	0.050(0.008)‡
Tenure ≥ 5 years		0.031(0.007)‡	0.034(0.007)‡	0.034(0.007)‡	0.040(0.008)‡
Match skill with the job		0.070(0.007)‡	0.068(0.007)‡	0.067(0.006)‡	0.072(0.007)‡
Higher skill for the job		-0.056(0.006)‡	-0.053(0.007)‡	-0.053(0.007)‡	-0.055(0.008)‡
Received training this year		0.067(0.007)‡	0.069(0.007)‡	0.069(0.008)‡	0.072(0.009)‡
Being a supervisor		0.094(0.007)‡	0.097(0.007)‡	0.096(0.007)‡	0.099(0.008)‡
Education:					
GCSE A-C or NVQ level 2		-0.025(0.008)‡	-0.026(0.008)‡	-0.026(0.008)‡	-0.033(0.009)‡
A levels or NVQ level 3		-0.069(0.011)‡	-0.069(0.011)‡	-0.069(0.011)‡	-0.087(0.012)‡
Certificates of higher education		-0.086(0.014)‡	-0.087(0.014)‡	-0.087(0.013)‡	-0.118(0.015)‡
Diplomas of higher education, NVQ level 4		-0.019(0.008)‡	-0.019(0.008)‡	-0.019(0.008)‡	-0.036(0.009)‡
Bachelor degree		-0.121(0.012)‡	-0.119(0.012)‡	-0.119(0.013)‡	-0.163(0.014)‡
Master, doctoral degrees, NVQ level 5		-0.065(0.011)‡	-0.065(0.011)‡	-0.065(0.011)‡	-0.101(0.012)‡
Income:					
Income £13,521 - £22,360 per year		-0.010(0.008)	-0.005(0.008)	-0.005(0.008)	0.032(0.010)‡
Income £22,361 - £33,800 per year		0.043(0.008)‡	0.045(0.009)‡	0.045(0.010)	0.088(0.011)‡
Income > £33,800 per year		0.063(0.010)‡	0.063(0.010)‡	0.063(0.011)‡	0.105(0.012)‡
Workplace characteristics:					
Public organisations			-0.038(0.007)‡	-0.038(0.010)‡	-0.047(0.011)‡
Size of organisation			-0.004(0.007)	-0.004(0.008)	-0.120(0.010)‡
Existence of performance-based system			-0.022(0.007)‡	-0.022(0.009)‡	-0.011(0.010)
Having a recession impact			-0.010(0.006)	-0.011(0.008)	-0.013(0.010)
Redundancy in organisation			0.009(0.006)	0.009(0.009)	-0.022(0.008)‡
Dismissal in organisation			0.019(0.006)	0.010(0.008)	0.008(0.010)
Industrial unemployment			-0.025(0.007)‡	-0.025(0.009)‡	-0.051(0.013)‡
CFI	0.993	0.983	0.981		0.949
TLI	0.987	0.978	0.975		0.940
RMSEA	0.048	0.027	0.025		0.034
SRMR _(within)	0.023	0.013	0.011	0.011	0.029
SRMR _(between)					0.071
Individuals	20495	18718	17606	17606	18637
Workplaces				1802	1805

Note: Reported in standardised coefficients (standard errors). Sig: 1%‡;5%†

Table 5.5: Job satisfaction in British healthcare industry - complete results

	Model 1	Model 2	Model 3	Model 4	Model 5
Social capital	0.660(0.013)‡	0.646(0.014)‡	0.638(0.015)‡	0.638(0.016)‡	0.608(0.017)‡
Individual characteristics:					
Female		0.025(0.017)	0.027(0.017)	0.027(0.019)	0.021(0.020)
Married		0.009(0.016)	0.018(0.017)	0.018(0.015)	0.025(0.016)
Health		0.054(0.016)‡	0.050(0.017)‡	0.050(0.019)‡	0.055(0.019)‡
Tenure ≥5 years		0.038(0.025)‡	0.042(0.018)‡	0.042(0.019)‡	0.034(0.019)
Match skill with the job		0.059(0.017)‡	0.065(0.017)‡	0.065(0.018)‡	0.076(0.019)‡
Higher skill for the job		-0.043(0.016)‡	-0.043(0.007)‡	-0.043(0.018)‡	-0.049(0.020)‡
Received training this year		0.073(0.017)‡	0.073(0.017)‡	0.073(0.019)‡	0.079(0.020)‡
Being a supervisor		0.076(0.019)‡	0.068(0.020)‡	0.068(0.021)‡	0.079(0.021)‡
Education:					
GCSE A-C or NVQ level 2		-0.007(0.022)	-0.008(0.023)	-0.008(0.023)	-0.006(0.024)
A levels or NVQ level 3		-0.035(0.034)	-0.035(0.036)	-0.035(0.033)	-0.029(0.032)
Certificates of higher education		-0.042(0.041)	-0.043(0.043)	-0.043(0.041)	-0.043(0.041)
Diplomas of higher education, NVQ level 4		-0.003(0.024)	-0.001(0.025)	-0.001(0.023)	-0.003(0.024)
Bachelor degree		-0.137(0.037)‡	-0.137(0.038)‡	-0.137(0.038)‡	-0.141(0.038)‡
Master, doctoral degrees, NVQ level 5		-0.078(0.028)‡	-0.079(0.029)‡	-0.079(0.029)‡	-0.080(0.029)‡
Income:					
Income £13,521 - £22,360 per year		-0.007(0.019)	-0.025(0.020)	-0.025(0.022)	0.032(0.010)
Income £22,361 - £33,800 per year		0.032(0.021)	0.058(0.022)‡	0.058(0.024)‡	0.088(0.011)‡
Income > £33,800 per year		0.040(0.022)	0.072(0.024)‡	0.072(0.027)‡	0.105(0.012)‡
Workplace characteristics:					
Public organisations			-0.080(0.021)‡	-0.080(0.020)‡	-0.286(0.085)‡
Size of organisation			0.021(0.021)	-0.021(0.024)	-0.308(0.089)‡
Existence of performance-based system			0.020(0.017)	-0.020(0.018)	-0.079(0.059)
Having a recession impact			0.015(0.018)	-0.015(0.018)	-0.050(0.076)
Redundancy in organisation			0.013(0.017)	0.013(0.021)	-0.081(0.087)
Dismissal in organisation			0.028(0.017)	0.028(0.024)	0.072(0.063)
CFI	0.992	0.986	0.986		0.977
TLI	0.985	0.981	0.981		0.973
RMSEA	0.050	0.025	0.023		0.024
SRMR _(within)	0.023	0.013	0.011	0.011	0.022
SRMR _(between)					0.039
Individuals	3373	3035	2811	2811	3002
Workplaces				289	290

Note: Reported in standardised coefficients (standard errors). Sig: 1%‡;5%†

Regarding the results, all models show that social capital has a positive and significant relationship with the job satisfaction of employees in Britain. The magnitude of the relationship attenuates somewhat as more covariates are included in the model, but the effect remains positive. As social capital in this study represents the perceived quality of relationships between employees and their superiors, having a superior that can be trusted may evoke a pleasant feeling for the employees as such a relationship enhance the working climate (Flap and Völker, 2001). Previous studies also found that having a good relationships with one's superiors may be beneficial for the employees (e.g. Bandiera et al., 2008; Lowe and Schellenberg, 2001)

From individual characteristics, it shows that being married ($\beta=0.039$, $p<0.01$) and being healthy ($\beta=0.050$, $p<0.01$) have consistently significant associations with higher job satisfaction; this confirms the results of previous studies (Clark, 1997; Clark et al., 1996). However, being female loses its significance in the multilevel model (Model 5). Contrasting results are found in relations to education and income. Employees with any level of education higher than GCSE D-G have significantly lower levels of job satisfaction in this survey, while employees with any level of income placing them above the lowest quartile have significantly higher levels of job satisfaction.

Several job-related characteristics have a significant influence on job satisfaction. Employees who have a tenure of more than five years are more satisfied ($\beta=0.040$, $p<0.01$) than those with fewer working years which confirms previous findings (Oshagbemi, 2003, 2000). Unsurprisingly, employees who have jobs that match with their skills are more satisfied ($\beta=0.072$, $p<0.01$) compared to those whose jobs need lower skills, while those who have higher skills for the job are less satisfied ($\beta=-0.055$, $p<0.01$). Being trained in the last 12 months is significantly associated with higher job satisfaction ($\beta=0.072$, $p<0.01$) as also has been found by Jones et al. (2009) and Gazioglu and Tansel (2002). Lastly, as suggested by Oshagbemi (2000),

having a higher rank such as that of supervisor is also significantly associated with higher job satisfaction ($\beta=0.099$, $p<0.01$).

Turning to the workplace characteristics, working in the public sector is significantly harmful for job satisfaction ($\beta=-0.022$, $p<0.01$) and being an employee in a large workplace is significantly associated with lower job satisfaction ($\beta=-0.051$, $p<0.01$). The impact of recession, as measured in terms of perception of having recession impact, redundancy, dismissal and industrial unemployment, has a negative association with job satisfaction. However, only redundancy in organisation ($\beta=-0.022$, $p<0.01$) and industrial unemployment ($\beta=-0.051$, $p<0.01$) have significant associations with job satisfaction.

Turning to the results in healthcare industry, Table 5.5 shows similar results with the general industry: workplace social capital is positively significantly associated with job satisfaction ($\beta=0.608$, $p<0.01$), thus corroborating previous findings (Omnen et al., 2009). Nevertheless, there are some differences regarding both individual and workplace characteristics and their associations with job satisfaction than those in general industry. Using similar characteristics as in the general industry in the models, individual characteristics such as: being married, being healthy, having skill matched with jobs, having education lower than bachelor degree and having income lower than £22,361 annually do not have significant association with job satisfaction. As for the workplace characteristics, only working in the public sector ($\beta=-0.286$, $p<0.01$) and larger workplaces ($\beta=-0.308$, $p<0.01$) are associated significantly with lower job satisfaction.

Table 5.6 shows the intraclass correlations coefficient (ICC) for indicators in both industries. In the general industry, the ICCs are ranging from 0.072 to 0.126 which mean that approximately 7% of the total variance in job satisfaction is accounted for by the differences of workplaces. Similarly, approximately 12% of the total variance in social capital is due to the workplaces' differences. Similar ICCs for job satisfaction and social capital also exist in healthcare industry. Those ICCs of

the variables show that job satisfaction and social capital are influenced more by individual differences within a workplace.

Table 5.6: ICC for individual items

General industry				Healthcare industry			
Job satisfaction		Social capital		Job satisfaction		Social capital	
Indicators	ICC	Indicators	ICC	Indicators	ICC	Indicators	ICC
ACH	0.077	TRUST	0.125	ACH	0.063	TRUST	0.115
INIT	0.081	SINCERE	0.120	INIT	0.044	SINCERE	0.116
INFL	0.079	HONEST	0.126	INFL	0.059	HONEST	0.121
SKILL	0.072	FAIR	0.106	SKILL	0.081	FAIR	0.102
WORKC	0.073			WORKC	0.053		
Mean	0.076		0.119		0.060		0.114

ICC = Intraclass correlations

5.4 Discussion

This study aims to investigate the relationship between social capital and job satisfaction in Britain using multilevel analysis. The main result shows that social capital is significantly associated with higher job satisfaction, both in general and healthcare industries. This finding confirms the first hypothesis, H1, and corroborates previous studies (Flap and Völker, 2001; Lowe and Schellenberg, 2001; Ommen et al., 2009; Requena, 2003). Argyle (2001) has suggested that European workers value good relationships with co-workers and superiors highly and those relationships was found to enhance the social aspect of the work (Flap and Völker, 2001); Sousa-Poza and Sousa-Poza (2000) have found that good relationships with management contributed to British workers' job satisfaction.

Some plausible explanations are available for this result. First, subordinates trust superiors who show sincere behaviour and provide positive examples (Paswan et al., 2005; Rich, 1997); this may encourage better communication and interaction between subordinates and superiors, thus leading to better understanding of their jobs. Employees who understand their jobs may then adjust their expectations of the jobs and the workplace since the discrepancy between what is desired and what is expected may result in dissatisfaction depending on the importance of the aspect

under consideration (Locke, 1969, 1976). When employees desire good and trusted relationships with their superiors and they experience that the relationships exist, the gap is lessened or even eliminated. Second, superiors have the power to create a conducive working atmosphere, hence, the pleasant atmosphere and positive feeling then become a source of job satisfaction for employees (Argyle, 2001). Trusted superiors may have more possibility to also grow the feeling of supported for employees, particularly in times of organisational changes (Armstrong-Stassen, 1994). Such relationships may also open more opportunity to the employees as superiors may empower employees by giving more freedom for the employees as they do their jobs (Grönroos, 2000; Lowe and Schellenberg, 2001).

Other than having more freedom, having opportunities for advancement is considered important by employees which corroborates previous findings (Gazıoğlu and Tansel, 2002; Oshagbemi, 2000). Having the chance to receive training is considered a common pathway for advancement. Employees receive training opportunities as a signal that the organisation cares about the employees' continuing careers. It is not uncommon in organisations for superiors to become involved in decisions regarding trainings for employees which then may further reinforce employees' trust toward their superiors as they gain benefits from the relationships. This situation may reflect fulfillment of a psychological contract that involves reciprocal exchange between parties for future benefits (Rousseau, 1995). Employees trust their superiors as they believe that the trust will bring future benefits. This relational trust or social capital grows as employees receive promotions and perhaps become supervisors themselves. Having a higher job position is associated with greater job satisfaction as it implies more rewarding benefits to the promoted employees such as higher pay, higher initiative, more influence and higher skills attainment. In addition to those tangible benefits, having higher position may be seen as a signal of increased trust and recognition from superiors, which may improve employees' self-esteem and in turn lead to greater satisfaction. These findings support the second hypothesis of

this study (H2).

Turning to workplace characteristics, the results show that working in a large organisation is associated with lower job satisfaction. This finding supports H3 and confirms previous results in the US (Idson, 1990), Britain (Gazioğlu and Tansel, 2002), Germany and Switzerland (Benz and Frey, 2008). Idson (1990) suggest that the lower degree of work freedom in a large organisation causes this lower job satisfaction, an assertion that is supported by evidence that people who are self-employed are more satisfied because they have complete freedom over the ways in which they do their work (Benz and Frey, 2008). Another plausible reason for lower levels of satisfaction is that the structure of a large organisation may hinder frequent interaction between manager and employees, which leads to poor relationships and lower levels of job satisfaction (Gazioğlu and Tansel, 2002).

Regarding organisation type, results show that working in the public sector is associated with lesser job satisfaction; this confirms the findings of a previous study by Solomon (1986). She discussed bureaucracy structure, lack of merit systems and goal ambiguity as possible contributors to the lower job satisfaction experienced by public sector employees as compared to those working in private organisations. It may also be the case that lower job satisfaction in the public sector is related to the comparatively heavy impact of recession on the public sector in Britain.

When hit by the financial crisis, the government did what it thought necessary to stabilise the country². By the end of 2011, there were 4.4% decrease of employment or 276,000 job loss in UK public sector (Office of National Statistics, 2011b) including the National Health Service (NHS)³. For example, in the health care industry, it was forecasted an annual cut in government spending of 2.3% or more depending on the government protection of the NHS funding (Appleby et al., 2009). According to Wanless et al. (2007, p.92), 'Health care is labour intensive, and staff

²It should be noted that the government strategy to address the crisis was highly controversial and continues to be challenged, for example, by the opposition political parties.

³see Table 3.3 on NHS Workforce in Chapter 3

pay accounts for around two-thirds of the total NHS budget'. As most of the budget will be used to pay for the salary, however, 75% of the workplaces in this study were being impacted to some degree by the financial crisis and the most common actions they took was to have compulsory redundancies and to freeze wages. Frozen wage and/or redundancy then become imminent, and redundancy within the organisation is associated with lower job satisfaction. Nevertheless, lower job satisfaction for public sector employees is also found under normal condition in Britain (Gazioğlu and Tansel, 2002) which may mean that budget cuts do not provide the only explanation. Rather, it appears that the job satisfaction of public employees may already be low and that the impact of the financial crisis only diminishes it.

However, there is another plausible explanation. Lower job satisfaction suggests the existence of survivor effect, which may be experienced by those who survive changes in organisation (Baruch, 1999; Appelbaum et al., 1997). Previous studies have found that employees who remain in a workplace after downsizing experience adverse effects (Brockner, 1992; Luthans and Sommer, 1999). Paulsen et al. (2005) found that the job satisfaction of surviving employees decreases during the pre-downsizing stage of a workplace, but that it improves during the implementation period and for 18 months thereafter.

Redundancies in organisations may cause uneasiness for employees as they may feel they lack of job security; they also lose the opportunity to with colleagues being made redundant or being dismissed (Amundson et al., 2004). These surviving workers then may experience demotivation and work overload (Amundson et al., 2004), both of which results in lower job satisfaction. Snorradóttir et al. (2013) found that employees experiencing major organisational changes such as downsizing were most likely to experience psychological distress, with a particularly strong effect on those losing their colleagues or being transferred to a different department. Similarly, Markovits et al. (2014) found that economic crisis is associated with significantly lower job satisfaction, particularly with respect to the job security. Clark (1997)

argued that people compares themselves to others in evaluating their job satisfaction and that they may use downward social comparison (Buunk and Gibbons, 2007) to adapt to the situation and feel grateful for keeping their jobs, however, their feelings of gratitude are overcome by the fear of job insecurity when unemployment persists for some time as it happened in Britain.

The last finding shows that industrial employment is associated with lower job satisfaction, which may corroborate the negative effect of redundancy of job satisfaction. Clark et al. (2010) argued that the insecurity of the labour market or industry determines employees' satisfaction. Those who are employed may feel threatened by industrial unemployment as it diminishes the possibility of good job opportunities for an unknown period of time. Baruch (1999) and Appelbaum et al. (1997) emphasised the need to take care not only for departing employees, but also of those who remain after major organisational changes. Travaglione and Cross (2006) and Sahdev (2004) suggested that employers may be able to assist employees to avoid experiencing the survivor effect with thorough preparation, good communication and proper management support for those remaining employees.

As results in healthcare industry show similarities with those in the general industry, healthcare industry is a perfect representative of the general industry which confirms the use of this industry in many studies investigating social capital recently as mentioned in Chapter 1.

5.5 Conclusion

This study aims to investigate the relationship of social capital and job satisfaction in Britain using data collected in the period following the crisis. The main finding shows that vertical social capital is significantly associated with job satisfaction both in general industry and a specific industry like the healthcare industry which supports previous studies. This empirical evidence supports the framework of the whole research. In addition, individual characteristics such as being healthy, having

tenure more than five years, skill-match with jobs, training opportunities, being in a supervisory position, education and income are significantly associated with job satisfaction even in time of high unemployment in Britain. Whilst workplace characteristics i.e. working in a public sector, larger workplaces, redundancy in the organisation and industrial unemployment are associated with lower job satisfaction.

Admittedly, there are some limitations to this study. In analysing the relationship of social capital to job satisfaction, I treat both variables as continuous variables instead of categorical variables as they were collected. Future research should explore the advantage of using categorical variables to ensure more robust findings. In addition, I only include vertical social capital measured by the perceived quality of relationships with superiors. Future study should include horizontal capital i.e. the relationship with co-workers and its influence on job satisfaction to have a more rounded perspective, provided that the future WERS collect the data. Another limitation is the nature of the study as this is a cross-section study. To ensure robustness of the result, further investigation should use datasets from the normal condition by including data from WERS2004 in the analysis to compare the relationship of social capital and job satisfaction before and after a financial crisis.

Despite the limitations, this study shares several findings and unfolds implications for the decision makers. Firstly, the significant and positive relationship between social capital and job satisfaction shows that trusting relationships with superiors affects the well-being of employees. This may need to be considered when designing a work unit or hierarchy in public or large organisations. It is imperative that the hierarchy or organisational structure enables the development of trusting relationship. In addition, more freedom and empowerment may enhance the job satisfaction. Secondly, trusting relationships can only be cultivated by trusted superiors, which make superior's attitude is key for an organisation. The evidence found in this study encourages organisations to invest in social capital as suggested by Cohen and Prusak (2001) and Ellinger et al. (2013), particularly to enable superiors to

maintain such trusting relationship and to retain the good superiors. Thirdly, this study shows that employees value advancement opportunities in their workplaces, a finding which may justify the provision of training opportunities at least, even in times of crisis, in a way that is beneficial for both employees and organisations. Fourthly, although redundancy may compulsory for an organisation, it may need good communication and preparation for both departing and remaining employees as major changes in the workplace have the potential to impair the well-being of all workers. Fifthly, healthcare industry is a good representation of general industry in Britain as both show similar results. It may be justified to have healthcare industry for parsimony in this study. Lastly, the future wave of WERS may also ask the quality of co-workers relationships within the workplace.

Chapter 6

Workplace social capital and job satisfaction in Indonesia

6.1 Introduction

Social capital in Indonesia has been investigated in a number of studies related to health outcomes, small businesses and industrialisation. However, those studies have focused on social capital within the community. Geertz (1962) found that social capital in the Javanese community is used to prevent default by the members of local credit association. Studies have also found that village social capital, such as arising from participating in village water service projects or joining various community groups, is positively associated with good health in the community (Isham and Kahkonen, 1999; Miller et al., 2006) and improved mental health (Tampubolon and Hanandita, 2014), while studies focusing on women observed that a mother's social capital improves her children's health (Sujarwoto and Tampubolon, 2013) and a woman's social capital provides better access to healthcare (Alawiyah, 2013). Turner (2007) found that small businesses in Makassar depend on their bonding social capital, but less so on their bridging or linking social capital. Observing industrialisation in the country, social capital increases in districts with rapid industrialisation, while less industrialised neighbouring districts experience decreasing levels of social capital due to out-migration (Miguel et al., 2005, 2006).

It is very rare for scholars to investigate large workplaces in Indonesia with

respect to social capital and job satisfaction. I found one study exploring job satisfaction in a construction industry and found that relationships with superiors and co-workers had a significantly correlation with job satisfaction (Marzuki et al., 2012). No additional research on social capital has been identified in other sectors in Indonesia.

The healthcare industry is a significant sector to be investigated as Indonesia is still struggling to serve its population despite the reforms that the healthcare industry has undergone in the past two decades. In addition, the relationship of workplace social capital and job satisfaction in Indonesia may be of particular interest due to the changes in its government system that came with decentralisation in 2001, resulting in devolution of a great deal of responsibility - including healthcare provision - from the central government to local governments (Rokx et al., 2010; Government of Indonesia, 2004a). Local governments are responsible for healthcare provision in their districts/cities, although the salaries of health workers in public hospitals are paid by the central government (Rokx et al., 2010). This change has inevitably influenced public hospitals in the country and eventually health workers in addition to the systemic changes that have already been put in place with regards to the health system.

As a workplace, there are two types of social capital likely to exist within the public hospitals: vertical social capital showing relationships between workers and their leaders and horizontal social capital in reference to relationships among workers (Serageldin and Grootaert, 1999; Kouvonen et al., 2008; Szreter and Woolcock, 2004). Although the concept of workplace social capital for health workers, especially nurses, is still considered novel (Read, 2014), several studies have examined the relationship of social capital as embodied trust within the workplace and attitudinal performance of health workers in developed countries (Ansmann et al., 2014; Driller et al., 2011; Ommen et al., 2009). Meanwhile, only Gilson et al. (2005) have explored the association of trust and health workers' experiences of their workplaces

in a developing country. They found that, in South Africa, health workers trusted their co-workers more than their leaders. However, the researchers suggested that trust in leaders is more influential than trust in co-workers in developing workplace trust. In addition, they found that hospitals with higher workplace social capital were associated with greater trust on the part of their patients.

Using data collected throughout public hospitals in East Java in 2013, this chapter tests the following hypotheses:

1. H1. Vertical social capital has associations with job satisfaction in healthcare industry in a developing country.
2. H2. Horizontal social capital has associations with job satisfaction in health-care industry in a developing country.

This chapter begins with a description of the data and of the method used where I specify the measures of social capital and job satisfaction in this study. I then report the results and discuss the findings with their implications. The chapter ends with conclusion.

6.2 Data and method

6.2.1 Data

The data were collected during summer 2013 in East Java, a province in Indonesia. Fifty-four public hospitals with 1,282 employees participating in the survey. Most of these were corporatized hospitals (46 out of 54 hospitals) as a result of the government reforms previously explained in Chapter 3. As corporatized hospitals, they can recruit their own human resources, but those employees are not civil servants (Government of Indonesia, 2014). Therefore, public hospital employees consist of civil servants and contract government employees (*pegawai pemerintah dengan perjanjian kerja*) with the majority still remaining as civil servants. Before analysing

the data, I describe the sample of this study.

Table 6.1: Analytic sample

Covariates	Mean/%	SD	Missing(%)	Job satisfaction
<i>Employee characteristics:</i>				
Job satisfaction	3.647	0.697		
Vertical social capital	3.687	0.751	0.23	0.280(0.025)‡
Horizontal social capital	3.878	0.663	0.23	0.272(0.028)‡
Female	62.7%			-0.074(0.041)
Age:			0.39	
(≤30 years)	16.6%			ref
31-40 years	34.4%			0.027(0.058)
41-50 years	40.6%			0.200(0.056)‡
≥51 years	8.4%			0.188(0.082)†
Married	89.8%			0.023(0.065)
Good health	99.3%			0.241(0.233)
With a bachelor degree	51.2%			-0.012(0.040)
5 years of tenure (or more)	74.7%			0.112(0.045)†
<i>Skills suitability with current job:</i>				
Underskilled	9.5%		0.23	ref
Matched skill	54.6%			0.288(0.068)‡
Over-skilled	35.9%			0.301(0.071)‡
Received training in the last one year	70.7%			-0.028(0.062)
<i>Type of job:</i>				
Doctors	10%		0.31	-0.135(0.070)
Nurses and midwives	56.3%			-0.051(0.042)
Others	33.7%			ref
<i>Hospital characteristic:</i>				
Hospital class (A & B)	46.2%			0.090(0.039)†
Hospital class (C & D)	53.8%			ref

Sig: 1%‡;5%†

Table 6.1 shows that the means of job satisfaction and vertical social capital are almost identical and tend to be high. Horizontal social capital among employees is higher than vertical social capital in this sample. Most of the respondents were females between the ages of 31 and 50 years. Most of them were married and in good health; approximately half of them had earned a degree. The majority of the respondents had already been working in hospitals for more than five years.

Regarding their skills, more than half of the employees claimed that their skills matched those needed for their current jobs. Approximately one third of the respondents were confident that their skills were at a higher level than that required by their jobs. In addition, around 70% of respondents had received training opportunities in the year previous to the survey. Looking at their job positions, half of the respondents were nurses and midwives, approximately one tenth were doctors

(including specialists) and one third were others including administrative staffs.

6.2.2 Method

The dependent variable This part of research examines job satisfaction as the dependent variable. Although there are eight indicators in the survey as shown in Table 6.2, job satisfaction is measured by means of three indicators: satisfaction with achievement, satisfaction with initiative and satisfaction with influence. Other indicators, with asterisks, show factor loadings below 0.40, and they have thus been eliminated as indicators of job satisfaction (Guadagnoli and Velicer, 1988; Hair et al., 2006). Inclusion of lower standardised loading estimate indicators (e.g. below 0.40) in a factor will increase unrelated error variance which reduces both the amount of possible common variance and the ability to relate to other indicators in the factor (Hair et al., 2006).

The independent variable Workplace social capital is measured using vertical social capital and horizontal social capital following Oksanen et al. (2010). Vertical social capital measures the perceived relationships between employees and their superiors, while the horizontal social capital measures the quality of the relationships among the employees. Vertical social capital includes kindness, concern and trustworthiness as indicators, while the five indicators of horizontal social capital are feeling accepted, having an attitude of togetherness, keep each other informed on work-related issues, building ideas for the best outcome and develop new ideas. However, for my purpose in Indonesia, horizontal social capital includes only four indicators. Keeping each other informed on work-related issues has been removed as a result of the EFA as shown in Table 6.2. I selected only indicators with factor loadings above 0.40 as recommended (Guadagnoli and Velicer, 1988; Hair et al., 2006).

After the EFA, I conducted a single- and two-level CFA for the latent variables.

Table 6.3 shows that all indicators have loading factors above 0.40, confirming that all latent variables are valid in the CFA; in addition, the fit indices show values above 0.95, reflecting a good model (Hu and Bentler, 1999). Cronbach's α coefficient was computed and each latent variable shows an α of at least 0.70 as suggested for reliability and internal consistency (Hair et al., 2006). Concentrating on the loading factors, the loading factor for CONCERN is the highest for vertical social capital, which is similar to the results arrived at by Oksanen et al. (2010), while the highest loading factor for horizontal social capital is DEVELOP in contrast to TOGETHER as found by Oksanen et al. (2010). There is a correlation between the measurements of error of two indicators in horizontal social capital: DEVELOP and TOGETHER. A feeling of togetherness is a sign of a cohesive group and studies have shown that cohesive groups may have open communication that accommodates the development of ideas, leading to the achievement of higher performance (Behfar et al., 2008; Chun and Choi, 2014; Jehn, 1995; Murnighan and Conlon, 1991; Tekleab et al., 2009). Nevertheless, the correlation of measurement of errors in CFA is typical.

Both of individual and organisational factors are suggested to influence job satisfaction among nurses in developing countries (Franco et al., 2002, 2004; Lu et al., 2005). The individual factors that influence job satisfaction are gender, education background, tenure and skills. In analysing Indonesian job satisfaction, I use gender (treated as a binary variable with female coded as 1 and male coded as 0), highest education (with those having a degree coded 1 and others as 0), and skills (with under-skilled workers coded as 1, matched-skill workers coded as 2 and over-skilled workers coded as 3).

Organisational factors affecting job satisfaction include rewards and workplace characteristics. Job satisfaction among health workers is found to be influenced by both financial and non financial factors. In addition to salary and housing packages, opportunities for continuing education and career development are considered important for job satisfaction in developing countries (Bonenberger et al., 2014;

Table 6.2: Factor analysis of the variables with rotated factor loadings

Codes	Variables	Factor 2	Uniqueness
	<i>Vertical social capital</i>		
KIND	Our supervisor treats us with kindness and consideration	0.5696	0.3388
CONCERN	Our supervisor shows concern for our rights as employees	0.6107	0.2914
TRUST	We can trust our supervisor	0.6098	0.3365
	<i>Horizontal social capital</i>		
ACCEPT	People feel understood and accepted by each other	0.5414	0.3929
TOGETHER	We have a 'we are together' attitude	0.7133	0.3442
INFORM	People keep each other informed about work-related issues in the work unit*	0.3208	0.6978
BEST	Do members of the work unit build on each other's ideas in order to achieve the best possible outcome?	0.8609	0.2087
DEVELOP	People in the work unit cooperate in order to help develop and apply new ideas	0.7716	0.2447
	<i>Job satisfaction</i>		
ACH	The sense of achievement you get from your work	0.6215	0.4631
INIT	The scope of using your own initiative	0.6452	0.4557
INFL	The amount of influence you have over your job	0.6064	0.4705
TRAIN	The training you receive*	0.1708	0.3337
SKILL	The opportunity to develop your skills in your job*	0.1910	0.2611
PAY	The amount of pay you receive*	0.2081	0.6467
SECURE	Your job security*	0.1197	0.6683
WORKC	The work itself*	0.3347	0.6412

Note: *excluded from further analysis.

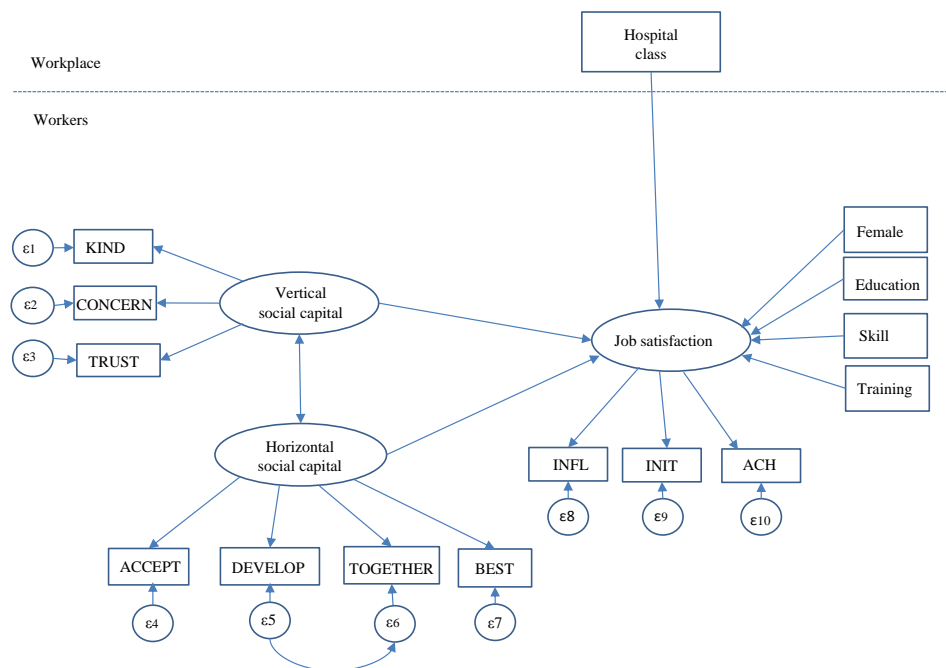
Table 6.3: CFA of job satisfaction and social capital in Indonesia

	Single-level		Two-level	
	Vertical social capital	Horizontal social capital	Vertical social capital	Horizontal social capital
<i>Within level</i>				
KIND	0.814(0.013)†		0.810(0.023)†	
CONCERN	0.835(0.012)†		0.831(0.021)†	
TRUST	0.819(0.013)†		0.812(0.024)†	
ACCEPT		0.709(0.016)†		0.710(0.034)†
TOGETHER		0.820(0.013)†		0.875(0.018)†
BEST		0.843(0.011)†		0.844(0.017)†
DEVELOP		0.876(0.011)†		0.822(0.022)†
ACH				0.611(0.034)†
INIT				0.732(0.032)†
INFL				0.637(0.035)†
<i>Between level</i>				
KIND			1.000(0.008)†	
CONCERN			0.997(0.005)†	
TRUST			1.000(0.009)†	
ACCEPT				0.926(0.357)†
TOGETHER				0.994(0.0026)
BEST				0.969(0.106)†
DEVELOP				0.878(0.771)†
ACH				0.984(0.011)†
INIT				1.000(0.017)†
INFL				0.992(0.020)†
α	0.86	0.88	0.70	0.952
CPI			0.993	0.935
TLI			0.990	0.053
RMSEA			0.032	0.022
SRMR (within)			0.020	0.589
SRMR (between)			25319.706	25446.338
AIC			25495.016	25719.616
BIC				

Note: Reported in standardised coefficient (standard error). Sig. 1%†; 5%†

Dieleman et al., 2003; Halepota and Shah, 2011). To measure this, I coded those who had received training in the previous year as 1 and those who had not as 0, while the hospital class represents the size and the resources of workplace as treated by Peng and Luo (2000) and Acquah (2007) in other industries. Hospital class is also treated as a binary variable: Class A or B = 1, Class C or D = 0.

Figure 6.1. Multilevel SEM model for job satisfaction in Indonesia



Considering that workers labour within a workplace with both social capital and job satisfaction as latent variables, I use multilevel structural equation modelling (SEM) in this study. Figure 6.1 shows the model that I use in this study. The multilevel SEM model uses three latent variables (job satisfaction, vertical and horizontal social capital) and other individual characteristics at the worker level, with hospital class as the workplace characteristics, at the higher level (workplace) or at Level Two. I analyse the relationships using a clustered model before I moving on to the multilevel model. I use both models to compare the results as Primo

et al. (2007) posited that adjusting standard errors for clustering when the data are nested is easier than using a multilevel model. The clustered standard errors and multilevel approaches has been encouraged when dealing with nested data (Primo et al., 2007; Harden, 2009). I use Stata 12 for the clustered model and Mplus 5.0 for the multilevel model.

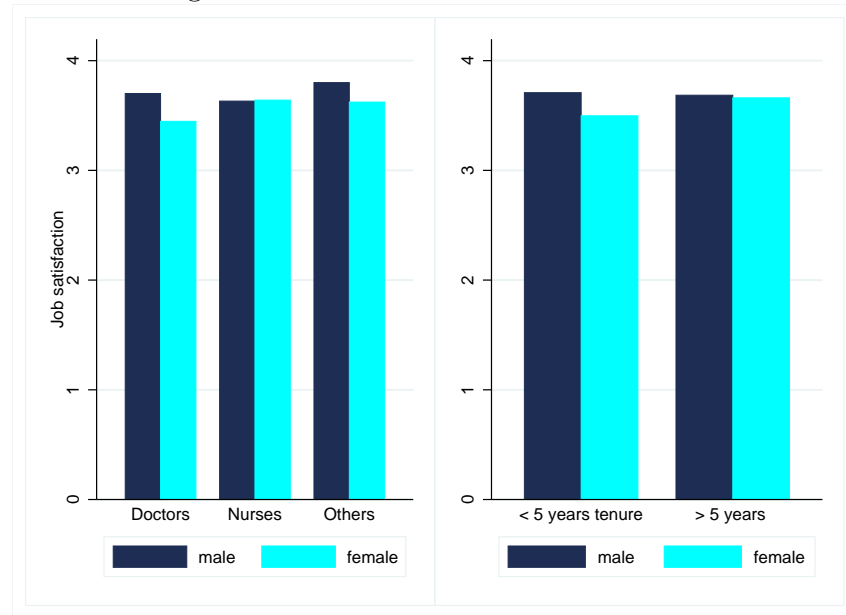
6.3 Results

Descriptive analysis I start the analysis by exploring the descriptive association of job satisfaction and social capital with socio-demographics characteristics. For this purpose, I use the mean scores of job satisfaction and social capital (the scale is 1 to 5). First, I use occupations, gender and tenure to describe both job satisfaction and social capital and second, I use bivariate analysis for all characteristics. Starting with job satisfaction, Figure 6.2 shows that male doctors and male employees in other jobs such as administrative positions enjoy higher levels of job satisfaction than their female counterparts; however, female nurses has showed slightly higher levels of job satisfaction than their male counterparts. Among all occupations, job satisfaction is the highest for male employees who are not doctors or nurses. Job satisfaction is also higher for male employees overall, but those who have worked for more than five years experience a slight decrease in job satisfaction.

Similar individual characteristics are also used to examine both vertical and horizontal social capital. Figure 6.3 shows that levels of vertical social capital differ among different jobs and different length of tenure. The highest level of vertical social capital is found among those who are not doctors or nurses and there are only slight gender differences among them. Vertical social capital is greater for male doctors than male nurses, but not for other male employees. Regarding length of tenure, male employees with shorter tenures have more vertical social capital than their female co-workers. However, the reverse is found for those having worked more than five years as female employees with long tenures show more vertical social

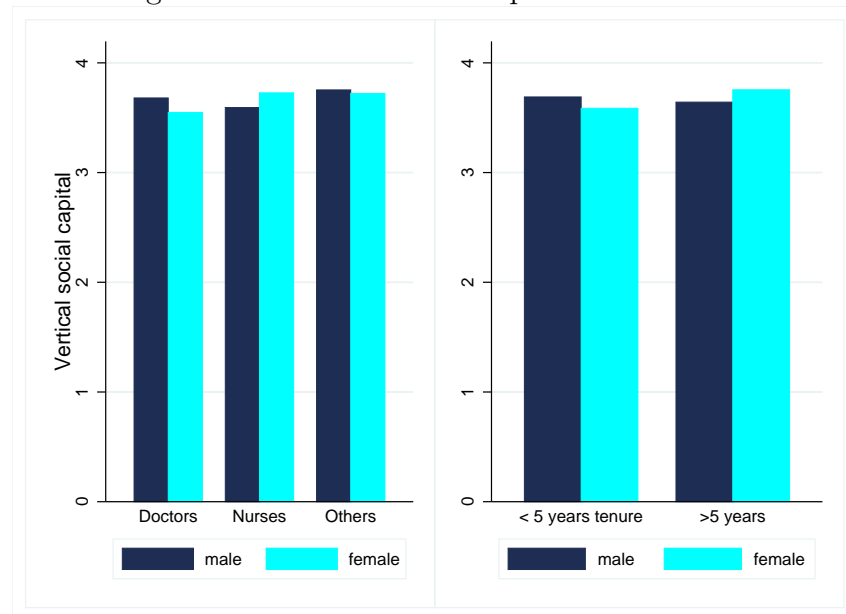
capital (right-hand chart).

Figure 6.2. Job satisfaction in East Java



Source: author's calculation based on primary data (the scale is 1 to 5).

Figure 6.3. Vertical social capital in East Java

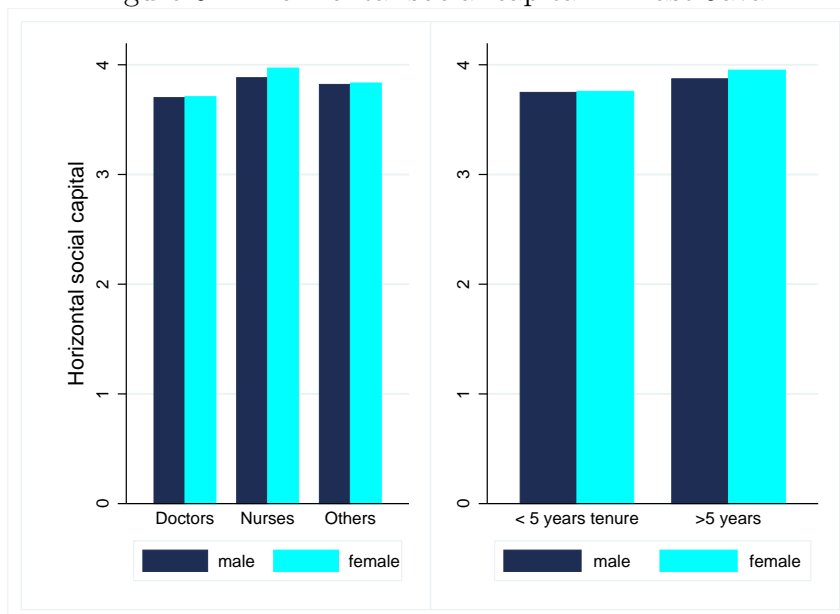


Source: author's calculation based on primary data (the scale is 1 to 5).

In contrast to the results on job satisfaction and vertical social capital, female nurses have higher levels of horizontal social capital than their male counterparts and

even than those in other occupations, as illustrated in Figure 6.3. As a group, nurses show greater horizontal social capital than those in other occupations. There is no difference in the level of horizontal social capital between male and female doctors, and there is only a very slight difference between male and female employees in other occupations. The right-hand chart shows that employees who have worked for more than five years have more horizontal social capital than those with fewer working years. Female employees with tenures of more than five years have the most horizontal social capital of any group in the right-hand chart. Similar to the chart based on occupations, this chart shows that employees who have worked fewer years have the same levels of horizontal capital regardless of gender.

Figure 6.4. Horizontal social capital in East Java



Source: author's calculation based on primary data (the scale is 1 to 5).

Bivariate analysis Table 6.1 also shows bivariate correlations for job satisfaction and several variables. In this analysis, both vertical and horizontal social capitals have positive associations with job satisfaction, however, only vertical social capital has a significant result. Gender does not determine job satisfaction in East Javan hospitals. Employees aged 41 years and older show higher job satisfaction than employees under 40. Surprisingly, being healthy and having a university degree

are not statistically significant for job satisfaction, although the associations are positive. There is no significant differences in job satisfaction among professions in the hospital. Having worked for a longer period in a hospital is associated positively with job satisfaction. Employees who have skills matched with or higher than those required for their jobs enjoy higher levels of job satisfaction. Turning to several workplace variables, employees in Class A and Class B hospitals show greater job satisfaction than those in Class C and D hospitals.

The above preliminary analysis has shown that social capital is positively associated with job satisfaction, I then advance the analysis using a multilevel SEM model to investigate the relationship between job satisfaction and social capital as illustrated previously in Figure 6.1.

Multilevel models Based on the model depicted in Figure 6.1, Table 6.4 shows the progression of the models. Model 1 is the baseline model, while Model 2 includes individual characteristics. Model 3 incorporates the workplace characteristic and Model 4 is the clustered full model. The last model, Model 5, uses a multilevel SEM model. The clustered and multilevel models are used as workers are nested within hospitals. Models 1 through 4 was estimated using Stata 12, while Model 5 used Mplus 5. Model 5 uses maximum likelihood with robust standard error (MLR) in Mplus as the estimator as this is preferable given the model's sample size (Hox et al., 2010). I managed to obtain 54 samples at Level Two to fulfill the requirement of at least 50 samples at Level Two considered by Maas and Hox (2005) to ensure good estimates for two-level research.

The results of the clustered model (Model 4) and multilevel model (Model 5) are similar, although horizontal social capital is non-significant in the clustered model. Having obtained mostly similar results with the clustered SEM model, I can be somewhat relaxed in accepting model fit (RMSEA=0.035, CFI=0.956, and TLI=0.948) in the multilevel model (Model 5). Previous studies found that the multilevel model approach is superior to the clustered model as it is capable of

estimating both individual and contextual effects of the predictor (Gelman, 2006; Arceneaux and Nickerson, 2009) and it is found to be unbiased in two-level data (Harden, 2009). Although Model 5 shows a good fit at the individual level with $SRMR_{(within)}=0.022$, which is below the conventional cut-off point of 0.08 (Hsu, 2009; Cheung et al., 2006), the $SRMR_{(between)}$ at the higher level (workplace) was 0.384, which is higher than the conventional cut-off point. Hsu (2009) found that the conventional cut-off of 0.08 is unlikely to be applied for the $SRMR_{(between)}$ and implied that further research need to be done as the existing cut-off point is only for the $SRMR_{(within)}$.

Not all models show that both vertical and horizontal social capital are significantly and positively associated with job satisfaction starting with Model 1 as the baseline model. The structural portion of the models shows that the coefficient of vertical social capital attenuates somewhat with the introduction of other covariates in Model 2. In contrast, the coefficient of horizontal social capital increases in size as the models become more complex. Model 2 shows that vertical social capital has a significantly positive relationship with job satisfaction ($\beta=0.306$, $p<0.01$) when individual characteristics such as gender, education, skills and training are entered into the model. Similarly, horizontal capital shows a positive relationship with job satisfaction ($\beta=0.099$, $p<0.05$), more so than in the baseline model. These positively significant relationships continue in Model 3, but not in Model 4 as horizontal social capital loses its significance in the clustered model. Nevertheless, both vertical social capital ($\beta=0.263$, $p<0.01$) and horizontal social capital ($\beta=0.158$, $p<0.01$) have significant associations with higher job satisfaction in the multilevel model (Model 5). This may signify the advantage of using multilevel model over the clustered model.

Table 6.4: Social capital and job satisfaction in Indonesia

	Model 1	Model 2	Model 3	Model 4	Model 5
Vertical social capital	0.320(0.049)†	0.306(0.049)†	0.303(0.049)†	0.303(0.056)†	0.263(0.058)†
Horizontal social capital	0.089(0.049)	0.099(0.048)†	0.099(0.048)†	0.100(0.056)	0.158(0.057)†
<i>Individual characteristics:</i>					
Female		-0.093(0.033)†	-0.094(0.034)†	-0.094(0.026)†	-0.079(0.027)†
Highest education		-0.009(0.034)	-0.012(0.035)	-0.012(0.039)	-0.024(0.035)
Matched skill with job		0.186(0.060)†	0.187(0.059)†	0.187(0.064)†	0.185(0.060)†
Over-skilled for job		0.180(0.059)†	0.181(0.059)†	0.181(0.074)†	0.189(0.070)†
Received training in the last 1 year		0.072(0.034)†	0.072(0.034)†	0.072(0.042)	0.080(0.038)†
<i>Workplace characteristics:</i>					
Hospital class			0.026(0.034)	0.026(0.042)	0.086(0.043)†
χ^2	66.095	125.137	133.769		431.377
df	31	66	73		171
p	0.000	0.000	0.000		0.000
CFI	0.993	0.988	0.988		0.956
TLI	0.990	0.983	0.983		0.948
RMSEA	0.032	0.029	0.028		0.035
SRMR	0.020	0.018	0.017	0.017	0.022
SRMR _(within)					0.384
SRMR _(between)					32030.531
AIC	22099.155	27200.484	29769.397		32333.489
BIC	22269.597	27475.603	30029.509		
Individuals	1099	1099	1099	1099	1255
Workplaces				49	54

Note: Reported in standardised coefficient (standard error)

Sig. 1%†; 5%‡

The coefficients of vertical social capital are higher than those of horizontal social capital in all models (Models 1-5). This result suggests that hospital employees in East Java value vertical social capital more than horizontal social capital. Though to a lesser degree, horizontal social capital also shows significant positive associations with job satisfaction. As horizontal social capital includes the bonding and bridging of social capital (Oksanen et al., 2010), the significance of horizontal social capital shows the importance of being accepted and of feeling together as a group in public hospitals in East Java.

As for other covariates, all associations at the individual level show similar directions in the progression from Model 1 to Model 5. Focusing on Model 5, female employees in public hospitals experience lower levels of job satisfaction than their male co-workers ($\beta=-0.079$, $p<0.01$). Having a university degree is also associated with lower job satisfaction, although the association is insignificant. However, having skills matched to one's current jobs is positively and significantly related to job satisfaction compared to those who perceived that their skills are insufficient for what is required ($\beta=0.185$, $p<0.01$). Similarly, having higher skills than one's job requires is associated with higher job satisfaction in East Java hospitals ($\beta=0.189$, $p<0.01$). In a similar vein, having received training in the last twelve months is positively significantly associated with higher job satisfaction ($\beta=0.080$, $p<0.05$). Moreover, Model 5 shows that workers in higher class hospitals have significantly higher job satisfaction than those in lower class hospitals ($\beta=0.086$, $p<0.05$).

The last three models include one workplace characteristic, hospital class, which represents the size and the availability of resources at the workplace. Employees of Class A and B hospitals show a positive association with job satisfaction in Models 3 and 4; however, the associations are not statistically significant. However, the inclusion of hospital class in the multilevel model (Model 5) has a significant positive association with job satisfaction ($\beta=0.086$, $p<0.05$). After this workplace characteristic is introduced into the models, the individual covariates slightly intensify their

associations with higher job satisfaction.

Table 6.5 shows that the intraclass correlation (ICC) in this analysis. The ICCs are quite typical in studies using multilevel SEM (Cheung et al., 2006); Muthén (1994) suggested that typical ICC values ranged from 0.00 to 0.50. The average ICC in this study is 0.038, which suggests that the workplace level, on average, explains about 3.8% of the variance in the variables. The biggest influence of job satisfaction and social capital difference is still at the individual level.

Table 6.5: ICC of individual items

Vertical social capital		Horizontal social capital		Job satisfaction	
Indicators	ICC	Indicators	ICC	Indicators	ICC
KIND	0.046	ACCEPT	0.029	ACH	0.024
CONCERN	0.059	TOGETHER	0.034	INIT	0.022
TRUST	0.054	BEST	0.028	INFL	0.022
		DEVELOP	0.018		
Mean	0.053		0.027		0.023
Overall mean	0.034				

ICC = intraclass correlation

6.4 Discussion

Main findings This study shows that vertical social capital is significantly associated with higher job satisfaction among workers in public hospitals in East Java, thus confirming H1. Similarly, horizontal social capital is significantly positively associated with job satisfaction which confirms H2. To develop workplace social capital, Leana and van Buren (1999) emphasised the importance of stable relationships, strong norms and specified roles within the workplace and Nahapiet and Ghoshal (1998) posited that social capital develops based on personal relationships and it consists of trust, norms, obligations and expectations, and identification. Most workers in public hospitals in East Java are civil servants with long-term employment contracts which may contribute to stable relationships in the workplace.

As government institutions, public hospitals in Indonesia adopt a bureaucratic style according to which workers have well-defined roles in hierarchical organisation with certain norms to follow. Frequently working together throughout their entire careers, workers may know each other well and they may relate to each other; therefore, their leaders may not be strangers to them. They may have developed bonds with their leaders while working together.

When social bonds exist between leaders and their subordinates in the workplace, trust is imperative (Tyler and DeGoey, 1996). Workers' trusts is affected by the actions of their leaders as they respond to the information conveyed by their leaders (Dirks and Ferrin, 2001, 2002; Rich, 1997). Although workers react to both the intentions and the competence of their leaders, they are more affected when leaders show benevolent intention, perceiving this to be an attribute signalling leader trustworthiness (Tyler and DeGoey, 1996). In such situations, workers are willing to accept decisions made by their trustworthy leaders (Rich, 1997; Tyler and DeGoey, 1996). Thus, the legitimacy of leaders is determined by the intentions they have toward their subordinates.

As the association of vertical social capital to job satisfaction has a higher coefficient than that of horizontal social capital using the multilevel SEM model, my finding contradicts the results obtained by Gilson et al. (2005) in South Africa. A plausible explanation for this may be found in the Iranian study that leadership style influences job satisfaction (Rad and Yarmohammadian, 2006). These Iranian scholars emphasised that hospital directors should choose the best suitable leadership style according to the culture of their organisations and their employees' maturity level, following the finding of Mosadeghrad and Malek pour in Iran (as cited in Rad and Yarmohammadian (2006, p.xxiv)) and Dorfman et al. (2004) in other countries. It is possible that my finding reflects the leadership style in East Java or in Indonesia as a whole. According to Suryani et al. (2012) and Pekerti and Sendjaya (2010), the leadership style of Indonesian superiors reflects the Javanese culture of the predom-

inant ethnic group in Indonesia in which a leader is considered a father or *bapak* in the Indonesian language. The relationship between subordinates and the leader is then like the relationship between a father and his children. The leader is considered knowledgeable and is meant to protect the welfare of his or her subordinates. Subordinates tend to follow the leader and generally only voice their opinions when asked, especially in the case of public sector employees in bureaucratic organisations (Suryani et al., 2012). In addition, from the beginning of their educational path, health workers are trained to follow procedures and to proceed with caution since they work with the sick and are responsible for people's lives.

This leadership style is not unique to Indonesia, but also occurs in countries with high power distance, meaning that the leader is perceived to have more power and workers expect their leaders to act autocratically (Carl et al., 2004; Hayes and Prakasam, 1989). Countries in Southern Asia (such as India, Indonesia and the Philippines) and sub-Saharan Africa (e.g. Nigeria and Zambia) are found to have similarities in valuing certain leadership qualities (Dorfman et al., 2004). These societies value leaders who are inspirational, decisive, and performance-oriented and who at the same time are able to work in teams and show compassion towards their subordinates (Dorfman et al., 2004). The vertical social capital then indicates the compassion that leaders extend to workers, which make workers feel happy as reflected in higher job satisfaction.

Looking at the other type of social capital in this study, horizontal social capital is also associated with higher job satisfaction in this study. This result corroborates other findings from other developing countries (Asegid et al., 2014; Dieleman et al., 2003). As horizontal social capital exists among employees in the workplace, working in the same workplace that is bound by norms and roles may condition employees to identify themselves with the groups within the workplace (Nahapiet and Ghoshal, 1998). Identification involves individuals taking the values of the reference group to locate themselves within a system (Turner, 1982). There are several incentives

for employees to have this identification within the workplace (Kramer et al., 1996). First, identification affirms an employee's place in the workplace. Second, it displays respect and acceptance from other members. Lastly, identification serves as a signal to other members that employees maintain the trust bestowed upon them.

However, these positive associations between both vertical and horizontal social capital and job satisfaction is found in public hospitals. Public hospitals are still government institutions which is very hierarchical and bureaucratic (Suryani et al., 2012). Good relationships with superiors and acceptance by co-workers are essentials to advance in their careers. Although they have the regular promotion regardless of their performance, civil servants need recommendations from their superiors to be promoted. Having a good relationship with superiors can guarantee their advancement, while good relationships with their co-workers may be beneficial when those colleagues are promoted and become their superiors. These type of relationships may not always exist in the private sector as they tend to more relaxed relationships in addition to having performance evaluation for promotion and rewards.

The finding may also reflect the nature of work in a hospital, which requires coordination and attention to details regarding patients and their treatments. Those who work in a hospital may work in groups or shifts, which demands continuity in treating in-patients or performing other medical interventions. Fulfilling the demand of their jobs, being able to work together is essential for hospital employees which then lead to the feeling of being part of a group. In addition, individuals belonging to a certain group are more likely to think and act collectively (Turner, 1982). This horizontal social capital may reflect the *esprit de corps*, the sense of being together that is mentioned by Halepota and Shah (2011), this may render occupational groups in public hospitals particularly cohesive groups. Rousseau (1995) suggested that membership or identification facilitates the development of trust as it eliminates doubt about other individuals' motives and intentions, although different

occupational groups within the workplace may not have the same understanding of norms.

To cultivate social capital, previous studies in developed countries suggest that managers and directors need both time and help from the workplace (Brien and Smallman, 2011). Initiatives such a leadership development programme has been suggested to improve the social capital of the leaders (Balkundi and Kilduff, 2006; Day, 2001; Uhl-Bien, 2006; Van De Valk, 2008) as it emphasises the development of reciprocal obligations and commitments based on trust and respect (Day, 2001). Recent studies show that this type of programme improves leaders' ability to use social capital within their workplaces (Burt and Ronchi, 2007) and their contacts (Black, 2006).

Other findings Female employees in public hospitals experience lower levels of job satisfaction than their male co-workers. This result corroborates previous studies in other developing countries (Asegid et al., 2014; Gamboa et al., 2011; Khuwaja et al., 2004; Moghadam et al., 2014) as female employees experience more stress due to family responsibility such as caring for relatively large numbers of children as well as access to fewer promotional opportunities than their male co-workers (Chiu, 1998). Highlighting the reality of better career opportunities for men, there are more male hospital directors in East Java than female directors (33 out of 54), although the majority of the employees are females. The relationship between gender and job satisfaction in this study differs from that found in developed countries where female employees have been found to have higher level of job satisfaction (Clark, 1997) due to lower expectation of their jobs, while male employees show higher job satisfaction when they continue working in the same workplace (Bedeian et al., 1992; Oshagbemi, 2000).

Having skills matched to one's current jobs is positively and significantly related to job satisfaction as opposed the situation of those who perceived that their skills are insufficient for the requirement of their jobs. Similarly, having higher skills

than required is associated with higher job satisfaction in East Java hospitals. In a similar vein, having received training in the last twelve months is significantly associated with higher job satisfaction. These findings corroborate previous findings in Ethiopia, Malawi, Senegal and Vietnam (Asegid et al., 2014; Dieleman et al., 2003; Fogarty et al., 2014; Rouleau et al., 2012; Vujicic et al., 2011).

Findings in developing countries have shown that training opportunities and continuing education are non-financial incentives that motivate healthcare workers. In Ethiopia, health workers with little access to trainings are more likely to leave their jobs (Asegid et al., 2014) and health workers in Senegal with little access to continuing education feel dissatisfied with their jobs (Rouleau et al., 2012). In addition, health workers with more training opportunities are more satisfied in Malawi (Fogarty et al., 2014); likewise government is encouraged to provide short-term trainings for health workers in rural Vietnam as such trainings keep the health workers motivated and working in rural areas and it is the most cost-effective approach to maintain job satisfaction, instead of just increasing the salaries (Vujicic et al., 2011). Moreover, training is found to improve health workers' ability to handle more demanding tasks while also allowing them to cope better with the requirements of their jobs (Mathauer and Imhoff, 2006; Willis-Shattuck et al., 2008), especially for young health professionals (Reid, 2004). However, Dieleman et al. (2003) and Manafa et al. (2009) found that access to those trainings is not equitably available for every health workers. The unequal opportunities may relate to distribution of additional income as these courses provide payment of per diems (Dieleman et al., 2003). In addition, access to training and continuing education is most likely merit- or education-based (Agyepong et al., 2004; Mathauer and Imhoff, 2006).

This study also finds that working in a higher class hospital has a positive association with job satisfaction. Higher class hospitals have more resources and facilities than lower class hospitals and the availability of resources and facilities are factors considered by health workers in determining their job satisfaction (Agyepong et al.,

2004; Dieleman et al., 2003; Fogarty et al., 2014). Having the resources and equipment to do their jobs may support employees' enjoyment of doing their jobs which then increase their job satisfaction. In addition, higher class hospitals may have better reputation than lower class hospitals; thus being associated with such workplace may improve the workers' self-esteem to be associated with such workplace as one's job is part of one's identity (Argyle, 2001).

6.5 Conclusion

This chapter is a part of a research testing whether workplace social capital is related to job satisfaction in developing countries. This chapter investigates the association between workplace social capital and job satisfaction at the individual level in the developing country of Indonesia. Workplace social capital is differentiated into vertical and horizontal social capital in this investigation. This study was conducted using primary data from 54 public hospitals in East Java, the second most populous province in Indonesia. This is the first study investigating such relationships in the healthcare industry covering public hospitals in a province in Indonesia. This is also one of a very few studies considering vertical and horizontal social capital simultaneously.

Both vertical and horizontal social capitals are significantly associated with higher job satisfaction in public hospitals in East Java following the framework of this research. On one hand, leadership style in the hospital may influence perceived vertical social capital as team-oriented leaders are best suited for collective communities like those found in Indonesia. Employees feel that their superiors are concerned about their welfare which make them more willing to do their jobs. On the other hand, horizontal social capital represents acceptance and employees' feeling of being part of the group; this may also enhance the happiness of the employees at work which in turn affects their job satisfaction.

Nevertheless, this study has several limitations. Firstly, job satisfaction is based

on employees' responses in a country where relationship harmony is paramount. Therefore, there may be a bias in the responses (Kwan et al., 1997). However, as the results show that the score of job satisfaction is not as high as other studies in similar culture (Vujicic et al., 2011) I am confident in using it. Secondly, job satisfaction and all of its indicators are treated as continuous variables rather than categorical variables, although those variables use Likert scale in the survey. Ferrer-i-Carbonell and Frijters (2004) found that measures of happiness, such as job satisfaction, can be investigated using cardinal or ordinal approach. However, further study should use the indicators as categorical variables as a more suitable approach. Thirdly, the data was collected in only one province in public hospitals in Indonesia for the sake of parsimony. Future research should include more data from more districts in Indonesia and involving private hospitals to have a better result as the healthcare is provided by both public and private hospitals in the country. Lastly, this is a cross-sectional research. I cannot infer any causal relationship. Future research may include multi-years data to enable a longitudinal study and to investigate the causality.

Despite the limitations, this study contributes to the literature on the associations of both vertical and horizontal social capital with job satisfaction in a developing country, using public hospitals as the sample. These findings enrich the body of knowledge on the association of social capital and job satisfaction in developing countries. In addition, this study provides insights on the possible connections between leadership style and workplace social capital in developing countries which requires further investigations in the future. This study also demonstrates the use of both clustered and multilevel models for nested data.

Last but not least, the findings suggest several implications for public hospitals and local governments. First, with regards to trainings, employees' training opportunities and continuing education should be properly seen to by hospital managers and directors in order to maintain job satisfaction. Moreover, hospital managers can

use trainings as enticing incentives for their employees. Hospital managers should not only make sure that they make trainings opportunities equally available for their workers, but also convey a the message that the benefits of trainings go beyond the opportunity to supplement income. Furthermore, there should be a clear link between training and career development for each employee (Willis-Shattuck et al., 2008). In providing such continuity, the hospital management not only fulfills not only employee expectations, but also improves the quality of service and supports the career development of the employees. Failure to do so leads to the demotivation of employees (Manafa et al., 2009).

Second, to avoid such a situation, hospital managers must understand and execute good human resource practices. This, in turn, raises the question of whether the trainings provided for hospital managers prepares them to perform such practices on behalf of their employees. The local government as the responsible authority for providing the healthcare may need to investigate the effectiveness of educational programmes for public hospital directors and managers in Indonesia.

Third, the authorities may consider suitable leadership development programme for public hospitals as the decision on the capability development now rests with the local governments following the decentralisation in 2001. Exercising suitable leadership not only improves leader acceptance by the workers and enhance the legitimacy of the leaders, but it may also improve hospital performance in general. Hospital managers or directors are hired, among other things, according to their rank and tenure within the system. As civil servants, hospital managers have been trained at the National Institute of Public Administration (LAN) (LAN, 2004, 2013). Local governments may initiate the programme in collaboration with LAN.

Chapter 7

Workplace social capital, job satisfaction and workplace performance in Britain

7.1 Introduction

The previous three chapters have looked into the association of social capital and job satisfaction at the individual level. This chapter, further, examines the consequences of both social capital and job satisfaction on workplace performance using data collected in 2011-2012 for general industry and a specific industry: healthcare. As the data is collected in 2011-2012 after Britain experienced financial crisis (see Chapter 3), I use the crisis as the context of this study. Selected studies from the literature review in Chapter 1 are the basis for this chapter.

An early study that links job satisfaction with workplace performance use samples from the education sector. Ostroff (1992) studied the relationship between teachers' job satisfaction and workplace performance in US secondary schools. She found that organisations with more satisfied employees tend to be more effective than organisations with less satisfied employees. She also found that job dissatisfaction leads to high turnover. A similar result was also found in US healthcare organisations as job satisfaction is associated with higher financial performance measured by operating and net margins (Akdere, 2009). More recent studies using data from a large number of industries in Britain found that job satisfaction is positively re-

lated to workplace performance as measured by productivity, financial performance, quality of service or product and it is negatively associated with absenteeism (Jones et al., 2009; de Menezes, 2012). These findings corroborated and generalised Ostroff's finding (1992) that satisfied employees tend to be more effective for their organisations regardless of the industry. Although Jones et al. (2009) also use quit rate as the workplace performance measure, they failed to establish a significant relationship between job satisfaction and quit rate as suggested by Koster et al. (2009) and Shields and Ward (2001).

Other than job satisfaction, social capital has been suggested to improve workplace performance (Nahapiet and Ghoshal, 1998; Sako, 1998). Similar to research on job satisfaction, an early study also uses data from education sector. Leana and Pil (2006) found that social capital within and outside schools is positively related to the test scores of students both in mathematics and reading. Investigating a British manufacturer, Bandiera et al. (2008) found that having a relationship with the supervisor is associated positively with workers' productivity. Another specific industry that has been investigated for this type of relationship is healthcare. Using data from hospitals in Germany, Ernstmann et al. (2012) studied the relationship of social capital and quality of healthcare. They found that higher social capital among nurses is associated with a higher quality of healthcare in hospitals. Additionally, Driller et al. (2011) found that higher social capital is associated negatively with emotional burnout among physicians. In other words, higher social capital leads to improved results in hospitals.

Comparing data from the last two waves of WERS (WERS2004 and WERS2011) and linking the employee and employers' data, Brown et al. (2013) studied the relationship between trust and workplace performance in different economic conditions in Britain. They measured trust using four statements in the WERS and use them in separate equations to avoid collinearity. They use managers' workplace performance answers to measure productivity, financial performance and quality of service

or product. They found that higher trust in the workplace is significantly associated with higher productivity, stronger financial performance and higher quality of service or product regardless of the economic condition.

However, there is no study that investigates social capital, job satisfaction and workplace performance in one analysis until now. Most studies generally select one of two possible relationships: the relationship between job satisfaction and workplace performance or the relationship between social capital and workplace performance as mentioned above. In addition, most studies did not capture the structure that job satisfaction and social capital belongs to workers or at the individual level, while workplace performance, as suggested by its name, belongs to the workplace or at the higher level. Most studies commonly aggregate job satisfaction or social capital of individuals to represent job satisfaction or social capital within workplace. Aggregating individual level's variables may eliminate the variability between individuals resulting in inappropriate estimates of the standard errors in the regression (Croon and van Veldhoven, 2007). As workers are nested within workplaces, it is more suitable to analyse the relationships using a multilevel approach (Snijders and Bosker, 2012). Therefore, the hypotheses tested in this study are:

1. H1. Social capital has associations with better workplace performance in general industry in a developed country.
2. H2. Job satisfaction has associations with better workplace performance in general industry in a developed country.
3. H3. Social capital has associations with better workplace performance in healthcare industry in a developed country.
4. H4. Job satisfaction has associations with better workplace performance in healthcare industry in a developed country.

The analysis will begin by looking at the relationships between social capital and job satisfaction and workplace performance by studying H1 and H2 in Britain. It

will then move on to focus on those relationships (H3 and H4) within the healthcare industry in Britain which represents approximately 17% of the observations in the survey. I will describe the data, method and results for both general and healthcare industries before finishing the chapter with a conclusion.

7.2 Data and method

7.2.1 Data

Similar to the previous chapter on job satisfaction in Britain (Chapter 5), this study uses WERS2011. WERS2011 provides information on individuals and workplace characteristics which can be linked, as required by this study. The data on employees comprise 21,981 observations, while the data on workplaces sourced from the managerial questionnaires are available for 2,680 workplaces (van Wanrooy et al., 2013). However, as I merged the two datasets, the linked data of employees and their workplaces are available for 21,981 employees in 1,923 workplaces which become the sample of the study. From that sample, approximately 17% are within healthcare industry with 3,653 observations in 316 workplaces. As explained previously, healthcare industry has been used in investigating social capital empirically. In addition, the use of healthcare industry in this study will enable comparison later with the results from Indonesia as I use hospitals as the sample there.

7.2.2 Method

The dependent variable The dependent variable in this analysis is workplace performance. Workplace performance is based on the workplace managers' answers to the management questionnaires in the survey. The question concerning the workplace performance is 'Compared with other workplaces in the same industry how would you assess your workplace's (financial performance/labour productivity/quality of product or service)'. The available answers are: 'a lot better than

average, better than average, about average for industry, below average, a lot below average or relevant data not available'. Instead of using full seven-points Likert scale answers for each workplace performance measure as in the original survey, the answers are reclassified into three categories: better than, similar to and lower than the competitors. This reclassification serves to balance the distribution of the responses.

This study uses four measures of workplace performance: three measures of performance assessed subjectively by the managers of the workplaces as compared to their competitors (as mentioned above) and one objective measure. I use such subjective performance measures as these measures are identical to the objective measures according to Forth and McNabb (2008) and Wall et al. (2004). In addition, those performance measures in WERS have been used in previous studies (Brown et al., 2013; de Menezes, 2012; Jones et al., 2009; Wood et al., 2012). The fourth measure of workplace performance is absenteeism, using the percentage of lost working days in the previous year (Jones et al., 2009; de Menezes, 2012; Wood et al., 2012).

The independent variables The first independent variable is social capital measured with answers from the employees regarding their perceived relationship with their managers. This investigation continues to use the employees' answers from four statements on managers' trustworthiness, honesty, sincerity and fairness following the result of the CFA in Chapter 5. The second independent variable, job satisfaction, is measured by five statements of satisfaction in the Employee Survey Questionnaires, also as a result of the CFA in that previous chapter.

As a reminder, Table 7.1 shows a single- and two-level CFA conducted using Mplus 5.0 in the general industry. The model fit indices for single level are CFI=0.993, TLI=0.987, RMSEA=0.046 and SRMR=0.022. The model fit indices for the two-level CFA are CFI=0.987, TLI=0.981, RMSEA=0.035 together with $SRMR_{(within)}=0.026$ and $SRMR_{(between)}=0.122$. These are all good fit indices (Che-

ung et al., 2006; Iacobucci, 2010; Hsu, 2009; Hooper et al., 2008) except for SRMR (between) which is still debatable.

Table 7.1: CFA of job satisfaction and social capital - general industry

	Single-level		Two-level	
	Job satisfaction	Social capital	Job satisfaction	Social capital
<i>Within level</i>				
Achievement (ACH)	0.737(0.004)‡		0.722(0.006)‡	
Initiative (INIT)	0.747(0.004)‡		0.739(0.006)‡	
Influence (INFL)	0.778(0.004)‡		0.771(0.005)‡	
Skill development (SKILL)	0.725(0.004)‡		0.708(0.006)‡	
Work itself (WORKC)	0.691(0.004)‡		0.672(0.006)‡	
Trust (TRUST)		0.867(0.003)‡		0.844(0.004)‡
Sincere (SINCERE)		0.904(0.003)‡		0.888(0.004)‡
Honest (HONEST)		0.907(0.003)‡		0.892(0.004)‡
Fair (FAIR)		0.832(0.003)‡		0.808(0.005)‡
<i>Between level</i>				
Achievement (ACH)			0.933(0.015)‡	
Initiative (INIT)			0.918(0.016)‡	
Influence (INFL)			0.937(0.012)‡	
Skill development (SKILL)			0.857(0.016)‡	
Work itself (WORKC)			0.968(0.016)‡	
Trust (TRUST)				0.985(0.003)‡
Sincere (SINCERE)				0.991(0.003)‡
Honest (HONEST)				0.993(0.003)‡
Fair (FAIR)				0.997(0.005)‡
α	0.874		0.933	
CFI	0.993		0.987	
TLI	0.987		0.981	
RMSEA	0.046		0.035	
SRMR (within)	0.022		0.026	
SRMR (between)			0.122	
AIC	416853.992		414403.317	
BIC	417117.882		414811.146	

Sig. 1%‡

Similarly, social capital ($\alpha=0.938$) and job satisfaction ($\alpha=0.858$) are the independent variables in healthcare industry. Table 7.2 shows the single- and two-level CFA for this specific industry. The full description of indicators are available in chapter 5. All indicators show loading factors above 0.40 and the model shows good fit indices. The CFI and TLI are above the conventional cut-off of 0.96 and the RMSEA is below 0.06 with SRMR (within) below 0.08 (Hooper et al., 2008; Hu and Bentler, 1999; Iacobucci, 2010).

Table 7.2: CFA of job satisfaction and social capital - the healthcare industry

	Single-level		Two-level	
	Job satisfaction	Social capital	Job satisfaction	Social capital
<i>Within level</i>				
Achievement (ACH)	0.685(0.011)‡		0.679(0.014)‡	
Initiative (INIT)	0.696(0.012)‡		0.696(0.017)‡	
Influence (INFL)	0.770(0.010)‡		0.765(0.005)‡	
Skill development (SKILL)	0.732(0.011)‡		0.716(0.013)‡	
Work itself (WORKC)	0.651(0.012)‡		0.648(0.013)‡	
Trust (TRUST)		0.864(0.007)‡		0.842(0.010)‡
Sincere (SINCERE)		0.904(0.007)‡		0.891(0.009)‡
Honest (HONEST)		0.926(0.006)‡		0.914(0.009)‡
Fair (FAIR)		0.853(0.008)‡		0.838(0.011)‡
<i>Between level</i>				
Achievement (ACH)			0.933(0.015)‡	
Initiative (INIT)			0.918(0.016)‡	
Influence (INFL)			0.937(0.012)‡	
Skill (SKILL)			0.857(0.016)‡	
Work itself (WORKC)			0.968(0.016)‡	
Trust (TRUST)				0.985(0.003)‡
Sincere (SINCERE)				0.991(0.003)‡
Honest (HONEST)				0.993(0.003)‡
Fair (FAIR)				0.997(0.005)‡
α	0.858		0.938	
CFI	0.992		0.987	
TLI	0.986		0.981	
RMSEA	0.049		0.036	
SRMR _(within)	0.023		0.025	
SRMR _(between)			0.101	
AIC	68244.538		67910.945	
BIC	68449.210		68227.258	

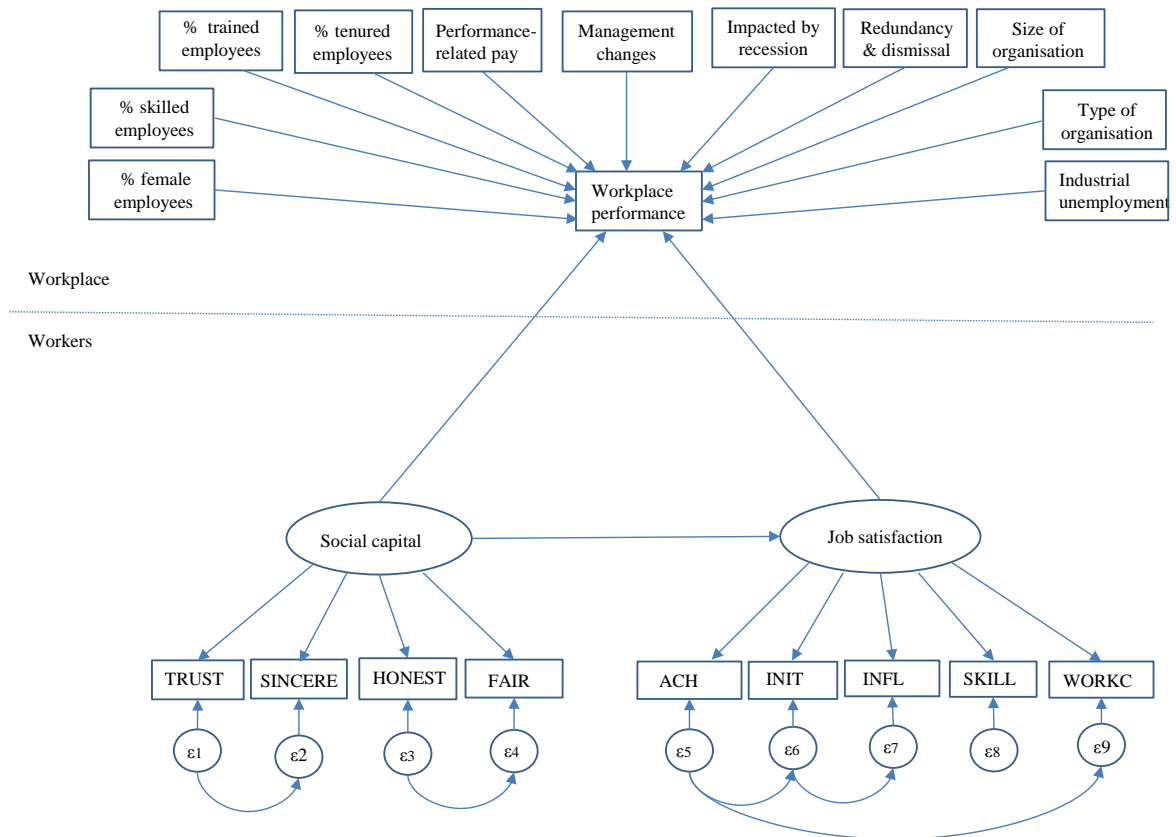
Sig. 1%‡

Several other covariates at the workplace level are then included in the models. These covariates have been used in studies examining workplace performance in developed countries comprising the composition of employees and other workplace characteristics. Covariates for composition of employees are: the proportion of female employees (Russ and McNeilly, 1995; Lavy, 2008), the proportion of tenured employees (with those working under five years as the reference) (Jacobs et al., 1990; Ng and Feldman, 2013; Strober, 1990), the suitability of employee skills for their current jobs (divided into those with well-matched skills, those who are over-skilled, and those who are under, with the proportion of under-skilled workers as the reference)(Allen and van der Velden, 2001; Georgellis and Lange, 2007) and the proportion of trained employee in the largest occupation group (divided into four groups

based on proportion, with the least proportion of trained employees as the reference) (Barrett and O'Connell, 2001; Koster et al., 2009). Whilst other workplace characteristics include the existence of a performance-related pay system (Brown et al., 2013; Jones et al., 2009; Wood et al., 2012), the formal status of the workplace or type of the organisation (public or private, with private as the reference) (Idson, 1990; Gazioğlu and Tansel, 2002), size of the workplace (log of number of employees) (Gazioğlu and Tansel, 2002; Clark et al., 1996), whether the workplace is affected by the crisis and whether management changes have been introduced in the last two years (Østhus, 2007; Schraeder et al., 2006; Verhaeghe et al., 2006). Considering that the unemployment rate is still high during the data collection period, several possible indicators of economic crisis i.e. redundancies and dismissals in organisations (Department for Business, Innovation and Skills, Advisory, Conciliation and Arbitration Service and National Institute of Economic and Social Research, 2013) and industrial unemployment (Office of National Statistics, 2012) are also included in the models.

As job satisfaction and social capital belong to the individual domain, while all performance measures belong to the workplace, the micro-Macro approach in the multilevel model is used (Snijders and Bosker, 2012). As previously explained in the methodology chapter (Chapter 2), the approach is suitable for modelling the relationship between variables at the individual level that affect variables at a higher level in a multilevel analysis. In addition, social capital and job satisfaction are latent variables in this study. Following Croon and van Veldhoven (2007), a multilevel SEM using Mplus 5.0 is applied to analyse the relationships between social capital and job satisfaction with all workplace performance measures. Figure 7.1 shows the multilevel SEM model.

Figure 7.1 Workplace social capital, job satisfaction and workplace performance in Britain



7.3 Results

Descriptive analysis Table 7.3 shows the sample statistics of this study. Looking at the general industry, most of the workplaces assess themselves as better than competitors in: productivity (52.9%), financial performance (52.7%) and in quality of product or service (78.2%). Average absenteeism is 5%. Average proportion of female employees in workplaces in this survey are 54%. Approximately half of the workplaces still give training opportunities to most of their employees. Only one third of the workplaces have more than 250 employees, but most of the workplaces are private organisations. Less than a half of the workplaces in this study have a

performance-related pay system. Although the majority of workplaces claimed that they are impacted by the recession, they still introduced management changes in the past two years.

Table 7.3: Workplaces in WERS2011

	General industry (%)	Healthcare (%)
<i>Performance measures:</i>		
Better than competitors in productivity	52.9	53.2
Better than competitors in financial performance	52.7	46.4
Better than competitors in quality	78.2	81.6
Percentage of lost working days	5.05	6.3
<i>Workplace characteristics:</i>		
Proportion of female employees (average)	54	81.9
Proportion of tenured employees (>5 years)	54.9	51.7
Proportion of trained employees in the largest occupation group:		
≤39%	28.2	8.6
40-59%	9.3	6.1
60-79%	9.9	12.2
≥80%	52.9	73.1
Proportion of skilled workers:		
Under-skilled	4	2.6
Matched skill	44.3	47.5
Over-skilled	51.7	49.9
Size of workplace:		
≤50 employees	32.9	39.5
51-250 employees	36.8	32
≥251 employees	30.3	28.5
Having a performance-pay system	42.3	22.4
Introduced management changes	78.2	75.7
Redundancy in workplace	1.89	0.66
Dismissal in workplace	0.97	0.91
Public sector	37.9	47
Impacted by recession	76.4	77.4
Number of workplaces	1,923	316

Focusing on the workplaces in healthcare industry (column 3 in Table 7.3), approximately half of the workplaces answered that they were better than the competitors in terms of productivity and financial performance. A majority of workplaces claimed that their quality was better than that of their competitors. The percentage of lost working days is 6.3% or slightly higher compared to that of general industry in the previous section. Most of the employee respondents in this industry were females. Most workplaces still provide training opportunities to a large number of their employees at the time of the survey, although a majority of workplaces were impacted by the economic crisis (77.4%). Similarly, only one fourth of workplaces

had not introduced any management changes in the two years prior to the survey. Almost half of the workplaces were in the public sector with less than 250 employees. Only less than a quarter of the workplaces have implemented performance-related pay system.

7.3.1 General industry

Table 7.4: Bivariate analysis - general industry

Covariates	Productivity	Quality	Financial	Absenteeism
Social capital	0.088(0.009)‡	0.075(0.008)‡	0.075(0.008)‡	-0.002(0.001)†
Job satisfaction	0.079(0.011)‡	0.038(0.011)‡	0.038(0.011)‡	-0.002(0.001)
Proportion of female employees	0.243(0.030)‡	-0.048(0.035)	0.013(0.030)	0.052(0.003)‡
Proportion of tenured employees	-0.302(0.036)‡	-0.474(0.041)‡	-0.163(0.035)‡	-0.051(0.005)‡
<i>Proportion of trained employees:</i>				
<39%	-0.157(0.034)‡	-0.417(0.039)‡	0.064(0.033)	0.034(0.003)‡
40-59%	0.036(0.034)	-0.410(0.039)‡	0.099(0.033)‡	0.021(0.003)‡
60-79%	0.106(0.034)‡	-0.315(0.038)‡	0.263(0.033)‡	0.031(0.003)‡
>80%	0.103(0.025)‡	-0.102(0.024)‡	0.269(0.024)‡	0.020(0.003)‡
<i>Proportion of skilled workers:</i>				
Matched skill	0.141(0.052)‡	0.233(0.059)‡	-0.191(0.051)‡	-0.082(0.006)‡
Over-skilled	-0.179(0.133)	-0.247(0.150)	-0.016(0.131)	-0.323(0.032)‡
Having a performance-based pay	0.122(0.017)‡	0.043(0.019)†	0.173(0.017)‡	-0.025(0.002)‡
Introduced management changes	0.016(0.021)	-0.194(0.024)‡	0.138(0.020)‡	-0.000(0.002)
Impacted by recession	-0.237(0.020)‡	-0.420(0.021)‡	-0.420(0.021)‡	-0.005(0.002)‡
Redundancy in workplace	-0.006(0.001)‡	-0.003(0.002)	-0.006(0.001)‡	-0.001(0.000)‡
Dismissal in workplace	-0.020(0.003)‡	-0.001(0.004)	-0.005(0.003)	0.004(0.000)‡
Size of organisation	-0.051(0.005)‡	-0.091(0.006)‡	0.032(0.005)‡	0.004(0.000)‡
Public sector	-0.101(0.017)‡	-0.428(0.019)‡	-0.062(0.017)‡	0.028(0.002)‡
Industrial unemployment	0.008(0.004)†	0.055(0.005)‡	0.023(0.004)‡	-0.004(0.000)‡

Sig. 1%‡; 5%†

Bivariate analysis Table 7.4 explores the correlations between dependent variables and several covariates in the model. Social capital shows significant positive correlations with productivity, quality and financial performance, but not with absenteeism. Job satisfaction also shows similar associations with workplace performance measures, except for absenteeism.

Composition of employees shows mixed results in this bivariate analysis. Proportion of female employees is positively associated with productivity and absenteeism, while proportion of tenured employees is negatively associated with all four work-

place performance measures. Higher numbers of trained employees are associated with higher productivity, better financial performance and higher absenteeism, but it is also associated with lower quality of product or service. The proportion of employees with matched skills required for the job are positively associated with productivity and quality; yet, those matched skill employees are associated with lower financial performance and lower absenteeism. Surprisingly, the over-skilled employees are only negatively associated with absenteeism.

Workplaces with performance-related pay systems have a higher workplace performance as expected. The introduction of management changes is associated with lower quality but higher financial performance. The recession is associated with lower workplace performance in all measures. Redundancy in workplaces negatively affects productivity, financial performance and absenteeism. Similarly, dismissals in workplaces is associated with lower productivity, but it is associated with higher absenteeism. The larger the organisation the higher its association with lower productivity and quality, but it is associated with higher financial performance and absenteeism. Being a public organisation is associated with lower workplace performance. Industrial unemployment has a positive association with productivity, quality and financial performance, but not absenteeism.

Multilevel SEM models Table 7.5 and 7.6 show the effects of both social capital and job satisfaction on workplace performance for British general industry as depicted in Figure 7.1. There are two models for each of the workplace performance. Model 1 is the baseline model, while Model 2 is the complete model with all covariates included. All Model 1s show a good fit in terms of the values of CFI and TLI as they have values above 0.95 (Hooper et al., 2008; Hu and Bentler, 1999). All values for RMSEA are below 0.06 which is a good fit (Iacobucci, 2010; Hu and Bentler, 1999). The models also show a good fit at the individual level with SRMR_(within)=0.022 with SRMR_(between)=0.045 or 0.047 for absenteeism. All SRMR values are below the conventional cut-off of 0.06 (Hooper et al., 2008; Hu and Bentler,

1999).

Similar to Model 1, all Model 2s show model fit indices above 0.95 for CFI and TLI with RMSEA below 0.06 and $SRMR_{(between)}=0.022$ which is lower than the recommended cut-off. However, at the workplace level the value of $SRMR_{(between)}=0.112$ in each model is somewhat higher than the conventional cut-off value (Hsu, 2009; Cheung et al., 2006). The $SRMR_{(between)}$ shows the statistical power for the two-level model, yet Hsu (2009) found that the conventional cut-off of $SRMR_{(between)}$ cannot be applied for $SRMR_{(between)}$. Browne and Cudeck (1992) proposed a principle based on parsimony and information to select a suitable multilevel SEM model with large samples. They used RMSEA, AIC and BIC as fit indices. Looking at those indices, all of them show smaller values for the multilevel models than those for single level models which demonstrate that the multilevel models are more parsimonious (Browne and Cudeck, 1992; Mehta and Neale, 2005; Kuha, 2004), thus, justifying the use of multilevel models.

Focusing on the results in Model 1, social capital is significantly associated with higher productivity ($\beta=0.145$, $p<0.05$) and better financial performance ($\beta=0.221$, $p<0.01$). Although social capital shows positive association with quality, the association is non-significant. The non-significant association also negatively shows between social capital and absenteeism. In contrast, job satisfaction is only significantly associated with higher quality ($\beta=0.130$, $p<0.05$). Turning to Model 2, social capital is still showing positive associations with productivity, quality and financial results as in Model 1, yet, the significant association is only established with the financial results ($\beta=0.250$, $p<0.01$). Job satisfaction also shows a similar pattern in the relationship with workplace performance as in Model 1. Job satisfaction has positive associations with productivity and quality, but it is negatively associated with financial results and absenteeism. After including other covariates, the significant association of job satisfaction with quality intensifies ($\beta=0.142$, $p<0.05$); whilst social capital somewhat attenuates in Model 2, except for financial results.

Table 7.5: Workplace social capital, job satisfaction and workplace performance in Britain (1) - structural model

	Productivity		Quality	
	Model 1	Model 2	Model 1	Model 2
Social capital	0.145(0.057)†	0.097(0.064)	0.094(0.057)	0.065(0.063)
Job satisfaction	0.042(0.061)	0.051(0.068)	0.130(0.061)†	0.142(0.067)†
<i>Workplace characteristics:</i>				
Female employees (%)		0.008(0.028)		-0.051(0.026)†
Tenured employees (%)		-0.007(0.057)		-0.021(0.025)
Matched skill with job (%)		-0.008(0.057)		-0.020(0.058)
Over-skilled for job (%)		0.013(0.025)		0.006(0.059)
Trained employees:				
<39%		-0.010(0.030)		-0.040(0.030)
40-59%		0.036(0.029)		-0.045(0.031)
60-79%		0.049(0.030)		-0.027(0.030)
>80%		0.068(0.036)		0.044(0.032)
Existence of performance-based system		0.052(0.025)†		-0.016(0.024)
Introduction of management changes		0.061(0.026)†		-0.012(0.024)
Size of workplace		-0.034(0.031)		-0.001(0.028)
Public sector		-0.023(0.031)		-0.134(0.030)‡
Redundancy in workplace		-0.044(0.025)		-0.020(0.024)
Dismissals in workplace		-0.066(0.023)‡		-0.029(0.024)
Impacted by recession		-0.057(0.025)†		-0.020(0.023)
Industrial unemployment		0.006(0.028)		-0.005(0.026)
CFI	0.991	0.983	0.991	0.983
TLI	0.986	0.979	0.986	0.979
RMSEA	0.029	0.022	0.029	0.022
SRMR (within)	0.022	0.008	0.022	0.008
SRMR (between)	0.045	0.122	0.045	0.122
AIC	417142.313	381340.232	416449.947	380668.374
BIC	417590.184	381909.728	416897.826	381237.881
Individuals	21976	20124	21979	20127
Workplaces	1923	1777	1923	1777

Note: Reported in standardised coefficients (standard errors)

Sig.: 1%†; 5%‡

Table 7.6: Workplace social capital, job satisfaction and workplace performance in Britain (2) - structural model

	Financial results		Absenteeism	
	Model 1	Model 2	Model 1	Model 2
Social capital	0.221(0.056)‡	0.250(0.061)‡	-0.077(0.055)	-0.001(0.058)
Job satisfaction	-0.095(0.061)	-0.118(0.066)	-0.002(0.060)	-0.084(0.059)
<i>Workplace characteristics:</i>				
Female employees (%)		-0.011(0.028)		0.126(0.028)‡
Tenured employees (%)		-0.018(0.026)		0.042(0.030)
Matched skill with job (%)		0.059(0.056)		-0.100(0.073)
Overskilled for job (%)		0.081(0.057)		-0.110(0.073)
Trained employees:				
<39%		0.022(0.029)		0.052(0.031)
40-59%		0.024(0.029)		0.029(0.030)
60-79%		0.056(0.029)		0.055(0.032)
>80%		0.119(0.035)‡		0.030(0.039)
Existence of performance-based system		0.026(0.025)		-0.098(0.023)‡
Introduction of management changes		0.053(0.025)†		-0.016(0.030)
Size of workplace		0.080(0.030)‡		0.076(0.026)‡
Public sector		0.009(0.030)		0.052(0.028)
Redundancy in workplace		-0.026(0.026)		-0.072(0.021)‡
Dismissals in workplace		-0.022(0.025)		0.141(0.032)
Impacted by recession		-0.135(0.023)‡		-0.036(0.027)
Industrial unemployment		0.057(0.030)		-0.009(0.034)
CFI	0.991	0.983	0.991	0.983
TLI	0.986	0.979	0.986	0.979
RMSEA	0.029	0.022	0.029	0.022
SRMR (within)	0.022	0.008	0.022	0.008
SRMR (between)	0.045	0.122	0.047	0.122
AIC	417387.237	381529.767	411547.779	376055.418
BIC	417835.119	382099.278	411995.645	376624.911
Individuals	21980	20128	21974	20123
Workplaces	1923	1777	1923	1777

Note: Reported in standardised coefficients (standard errors)

Sig.: 1%‡; 5%†

Regarding other workplace characteristics, having performance-based system in the workplace has significant associations with higher productivity ($\beta=0.052$, $p<0.05$) and lower absenteeism ($\beta=-0.098$, $p<0.05$). Workplaces that had introduced management changes in the two years prior to the survey showed higher productivity ($\beta=0.061$, $p<0.05$) and stronger financial performance ($\beta=0.053$, $p<0.05$). Larger workplaces achieve higher financial results ($\beta=0.080$, $p<0.01$) and report higher absenteeism ($\beta=0.076$, $p<0.01$). Compared to those in the private sector, workplaces in the public sector are only significantly associated with lower quality ($\beta=0.134$, $p<0.01$).

Turning to the various factors measuring the impact of recession on workplaces in Britain, those workplaces perceiving impacted show lower workplace performance which resulting in lower productivity ($\beta=-0.057$, $p<0.05$) and weaker financial performance ($\beta=-0.135$, $p<0.05$). Redundancy in workplaces only has a significant association with lower absenteeism ($\beta=0.072$, $p<0.01$), while dismissals in workplaces are significantly associated with lower productivity only ($\beta=0.066$, $p<0.01$). On the contrary, industrial unemployment is non-significantly associated with any of the workplace performance measures.

Workplace social capital has higher ICC than job satisfaction in general industry. Table 7.7 shows the ICCs of those variables. Workplace social capital accounts for 15.5%, while job satisfaction accounts for 9.9% for differences between workplaces. As previous studies found, differences between individuals are evident when investigating variables such as job satisfaction and workplace social capital.

7.3.2 Healthcare industry

Table 7.8: Bivariate analysis - the healthcare industry

Covariates	Productivity	Quality	Financial	Absenteeism
Social capital	0.074(0.021)‡	0.116(0.025)‡	0.016(0.021)	0.007(0.002)‡
Job satisfaction	0.093(0.028)‡	0.124(0.034)‡	-0.033(0.028)	0.009(0.003)‡
Proportion of female employees	0.715(0.142)‡	0.545(0.164)‡	-1.291(0.142)‡	-0.006(0.014)
Proportion of tenured employees	-0.524(0.096)‡	-0.427(0.119)‡	-0.361(0.094)‡	-0.047(0.010)‡
Proportion of trained employees	-0.572(0.150)‡	-0.111(0.180)	-0.100(0.148)	0.000(0.016)
<i>Proportion of skilled workers:</i>				
Matched skill	0.288(0.125)†	-0.417(0.154)‡	0.046(0.124)	0.063(0.013)‡
Over-skilled	0.667(0.442)	0.035(0.499)	3.709(0.467)‡	-0.136(0.045)‡
Having a performance-based pay	0.221(0.051)‡	-0.305(0.056)‡	0.335(0.049)‡	-0.022(0.005)‡
Introduced management changes	-0.369(0.050)‡	-0.777(0.077)‡	0.046(0.047)	-0.004(0.005)
Impacted by recession	-0.249(0.051)‡	-0.614(0.073)‡	0.190(0.050)‡	-0.006(0.005)
Redundancy in workplace	-0.009(0.009)	-0.023(0.010)†	0.021(0.009)†	-0.001(0.001)
Dismissal in workplace	-0.066(0.010)‡	0.079(0.017)‡	-0.081(0.010)‡	0.010(0.001)‡
Size of organisation	-0.103(0.010)‡	-0.212(0.013)‡	0.041(0.010)‡	-0.002(0.001)‡
Public sector	-0.706(0.042)‡	-0.973(0.055)‡	-0.244(0.040)‡	-0.011(0.004)‡

Sig. 1%‡; 5%†

Bivariate analysis Table 7.8 shows the bivariate analysis in healthcare industry. Social capital is associated positively with productivity, quality of product or service and absenteeism, but not with financial results. Similarly, job satisfaction is associated positively with all workplace performance measures, except for financial results.

Turning to the composition of the employees within the workplace, a higher proportion of female employees is associated with higher productivity and quality, but with lower financial results. Higher proportion of tenured employees (with five working years or above) is associated with lower workplace performance in all measures. Proportion of trained employees has a significantly negative association with productivity only. However, the negative relationships between the proportion of trained employees and workplace performance also exists for quality and financial results non-significantly. Employees with the matched skill required by their jobs are associated with higher productivity, lower quality and higher absenteeism. In contrast, over-skilled employees have positive association with financial results, but they have negative relationship with absenteeism. Workplaces with performance-related pay systems are associated with higher productivity and stronger financial results,

but lower quality and lower absenteeism. The introduction of management changes in this industry has negative associations with productivity and quality. Larger organisations are associated negatively with productivity, quality and absenteeism, but it has positive association with financial results. Being a public organisation has negative associations with all workplace performance measures.

Looking into covariates representing the economic crisis, the impact of recession has negative association with productivity and quality, but it has positive association with financial results. Redundancy in the workplace has negative associations with quality and absenteeism, but it is positively associated with financial results. Dismissals in workplaces has mixed associations with workplace performance as it has negative associations with productivity and financial results, but it is positively associated with quality and absenteeism.

Multilevel SEM models Tables 7.9 and 7.10 show models inclusive of both social capital and job satisfaction for workplace performance measures. Model 1 only includes social capital and job satisfaction as the baseline model. Model 2 includes other covariates as a full model. The models show good fit indices as both CFI and TLI are above 0.96, while the RMSEA is below 0.06 and the individual level goodness of fit also shows a value below the conventional cut-off of 0.08 ($SRMR_{(within)}$). However, the workplace level model fit, $SRMR_{(between)}$, show values above the cut-off criteria. Hsu (2009) found that the $SRMR_{(between)}$ did not perform well in his study, particularly in the models with low ICCs. Similar to the models in the general industry, the multilevel models in this industry show AIC and BIC values smaller than those in the single level models based on the CFA results. Encourage by these values comparison, the multilevel models are better for capturing the associations between social capital, job satisfaction and workplace performance; thus, the results are accepted.

Looking at the results, Model 1 shows that social capital has non-significant associations with lower productivity, lower absenteeism, higher quality or higher financial

Table 7.9: Workplace social capital, job satisfaction and workplace performance in the healthcare industry (1) - structural model

	Productivity		Quality	
	Model 1	Model 2	Model 1	Model 2
Social capital	-0.038(0.250)	-0.061(0.258)	0.026(0.236)	0.092(0.238)
Job satisfaction	0.189(0.265)	0.077(0.278)	0.174(0.243)	-0.019(0.253)
<i>Workplace characteristics:</i>				
Female employees (%)		0.065(0.075)		-0.025(0.065)
Tenured employees (%)		-0.021(0.060)		0.066(0.060)
Trained employees (%)		-0.036(0.058)		0.094(0.062)
Matched skill with job (%)		-0.131(0.214)		-0.192(0.119)
Overskilled for job (%)		-0.170(0.217)		0.148(0.117)
Existence of performance-based system		0.092(0.054)		-0.062(0.061)
Introduction of management changes		-0.042(0.057)		-0.144(0.044)†
Size of workplace		-0.020(0.080)		-0.075(0.087)
Public sector		-0.236(0.080)‡		-0.213(0.076)‡
Redundancy in workplace		-0.025(0.064)		-0.020(0.059)
Impacted by recession		-0.082(0.064)		-0.072(0.053)
CFT	0.988	0.984	0.989	0.984
TLI	0.982	0.980	0.983	0.980
RMSEA	0.033	0.025	0.033	0.024
SRMR (within)	0.022	0.011	0.023	0.011
SRMR (between)	0.065	0.173	0.064	0.171
AIC	68406.984	62910.927	68191.793	62711.260
BIC	68754.369	63320.807	68539.147	63121.099
Individuals	3653	3353	3651	3351
Workplaces	316	291	316	291

Note: Reported in standardised coefficients (standard errors)

Sig.: 1%‡; 5%†

Table 7.10: Workplace social capital, job satisfaction and workplace performance in the healthcare industry (2) - structural model

	Financial results		Absenteeism	
	Model 1	Model 2	Model 1	Model 2
Social capital	0.445(0.287)	0.545(0.316)	-0.087(0.212)	-0.074(0.219)
Job satisfaction	-0.490(0.302)	-0.568(0.341)	0.260(0.216)	0.132(0.266)
<i>Workplace characteristics:</i>				
Female employees (%)		-0.109(0.074)		-0.019(0.094)
Tenured employees (%)		-0.011(0.061)		-0.031(0.060)
Trained employees (%)		0.063(0.059)		0.048(0.085)
Matched skill with job (%)		-0.613(0.169)†		0.158(0.112)
Overskilled for job (%)		-0.641(0.163)†		0.158(0.106)
Existence of performance-based system		0.090(0.055)		-0.103(0.049)†
Introduction of management changes		0.023(0.060)		-0.048(0.085)
Size of workplace		0.171(0.075)†		0.163(0.082)†
Public sector		-0.208(0.073)†		-0.021(0.089)
Redundancy in workplace		0.063(0.084)		-0.001(0.063)
Impacted by recession		-0.134(0.061)†		-0.023(0.079)
CFI	0.989	0.984	0.988	0.984
TLI	0.983	0.980	0.983	0.980
RMSEA	0.033	0.024	0.033	0.024
SRMR (within)	0.023	0.011	0.022	0.011
SRMR (between)	0.062	0.169	0.063	0.168
AIC	68431.495	62945.406	67510.010	62103.948
BIC	68778.880	63355.285	67857.334	62513.768
Individuals	3653	3353	3649	3350
Workplaces	316	291	316	291

Note: Reported in standardised coefficients (standard errors)

Sig.: 1%†; 5%‡

Table 7.11: Intraclass correlations (ICCs) for individual items - healthcare industry

Variable	Productivity		Quality		Financial results		Absenteeism						
	ICC	Variable	ICC	Variable	ICC	Variable	ICC	Variable					
ACH	0.078	TRUST	0.143	ACH	0.078	TRUST	0.142	ACH	0.078	TRUST	0.142		
INFT	0.050	SINCERE	0.138	INFT	0.050	SINCERE	0.138	INFT	0.049	SINCERE	0.138		
INFL	0.058	HONEST	0.146	INFL	0.058	HONEST	0.147	INFL	0.059	HONEST	0.145		
SKILL	0.106	FAIR	0.111	SKILL	0.106	FAIR	0.112	SKILL	0.106	FAIR	0.110		
WORKC	0.057			WORKC	0.058			WORKC	0.058				
Mean	0.070		0.135		0.070		0.135		0.070		0.134		
ICC: intra-class correlations												0.069	0.134

results. Job satisfaction has an association with higher productivity, higher quality and higher absenteeism, but with weaker financial performance. Nevertheless, all of these results are non-significant. These non-significant results continue in the full models (Model 2) which means that the relationships between both social capital and job satisfaction with workplace performance measures are not established and the last two hypotheses (H3 and H4) are not supported.

Observing other covariates in the models, different covariates have different associations with workplace performance. Higher proportion of female workers are only associated with higher productivity, yet all associations with workplace performance are non-significant. Higher proportion of tenured employees is only associated with higher quality, but all associations are non-significant. Higher trained employees is positively associated with workplace performance, except for productivity. Workers who have the required skills for their jobs are associated with lower workplace performance, but not with absenteeism. Over-skilled workers have positive associations with quality and absenteeism, but they have negative associations with productivity and financial results. However, workers with the required ($\beta=-0.613$, $p<0.05$) or higher skills ($\beta=-0.641$, $p<0.05$) for their jobs are significantly associated only with higher financial results.

Other than training and skills of workers, workplaces implementing performance-based pay systems are associated with higher productivity, lower quality, higher financial results and lower absenteeism. However, only the association with absenteeism is statistically significant ($\beta=0.103$, $p<0.05$). Regarding changes introduced in workplaces, it has mostly negative associations with workplace performance other than productivity and the significant association is with quality ($\beta=0.144$, $p<0.05$). Interestingly, larger workplaces are associated significantly with higher financial results ($\beta=0.171$, $p<0.05$) and higher absenteeism ($\beta=0.163$, $p<0.05$). Workplaces in the public sector are significantly associated with lower workplace performance measures i.e productivity ($\beta=-0.236$, $p<0.01$), quality ($\beta=-0.213$, $p<0.01$) and financial

results ($\beta=-0.208$, $p<0.01$), except for absenteeism. Although almost a quarter of the workplaces in this industry took redundancies as their reaction to crisis, there is no significance in the association between redundancies and workplace performance measures. However, those workplaces that were impacted by recession are associated significantly with weaker financial performance only ($\beta=-0.134$, $p<0.05$).

The ICCs of the variables are shown in Table 7.11. Most of the social capital and job satisfaction is influenced by individual differences, as differences between workplaces only account for 13.5% of social capital and 7% of job satisfaction in this industry. The numbers are smaller than those in the general industry which may suggest that individual differences are more prominent in this industry.

7.4 Discussion

7.4.1 General industry

Main findings This study analyses the relationships between social capital, job satisfaction and workplace performance both in general industry and a specific industry (healthcare) in Britain. The results within the general industry show the expected associations between social capital and job satisfaction with productivity and absenteeism as both social capital and job satisfaction are associated with higher productivity and lower absenteeism, yet their associations are statistically non-significant. In contrast, significant associations are established between social capital and job satisfaction with financial results and social capital with quality. The association of social capital and job satisfaction with financial results show mixed results. Social capital has a positive association with financial results, while job satisfaction has negative associations with financial results. Regarding quality, only job satisfaction has significant association with higher quality.

One plausible explanation is that social capital is already high in British workplaces as British workers were found to value their relationships with their superiors

more than the financial reward from their jobs (Sousa-Poza and Sousa-Poza, 2000). This high social capital may be related to the size of workplaces in Britain. As most of workplaces in Britain are small and medium-sized workplaces (Cooke, 2007), the relationships between managers and workers can be very intense. These intensive relationships determine the working climate for their workers (Bandiera et al., 2008; Daley and Vasu, 1998). Conducive and fair working climates are beneficial for both workers and workplaces. On the one hand, managers are able to trust that their workers will perform their jobs well enough. On the other hand, workers get assurances regarding their job security and psychological well-being in time of high unemployment (Wood et al., 2012).

Another plausible explanation may stem from the perspective of psychological contracts in employment. As workers enter their employment, they establish psychological contracts between themselves and the employer. Psychological contracts are a 'voluntary commitment that individuals make with others' (Rousseau and Schalk, 2000, p.4). The fulfilment of these contracts requires individual choice and both parties are confident in one another's intention and ability to keep the commitment (Rousseau and Schalk, 2000). As most workers in this study are permanent employees, the type of psychological contracts they have is the relational contract (Robinson et al., 1994) where workers expect to receive both financial and non-financial reward from their workplaces in long-term relationships.

As rewards are expected in this long-term relationship, workers look for evidence for whether workplaces are able to keep their commitment. When they have sufficient rewards, workers are confident that workplaces have the intention of keeping them in employment. However, when workers feel that workplaces cannot keep their commitment, it will be regarded as a breach in the contract (Freese et al., 2011). Parzefall and Coyle-Shapiro (2011) emphasise the need of workplaces to explain the actions taken in changing economic condition to the workers to avoid the workers' misperceptions. In times following the crisis, workplaces may choose actions that

can be considered as a breach of contracts by workers. Having those actions explained provides an opportunity for workers to align their perceptions on fulfilment of the psychological contract with the situation faced by workplaces. Higher social capital may help in the process to enhance workers' understanding and justify fairness in the actions which may eliminate the damage. Higher social capital may assist workers to improve their performance instead of lessen their efforts.

However, I found that the association between social capital and workplace performance is only significant in terms of financial performance. This finding may emphasise previous finding of Forth and McNabb (2008). They argued that the use of subjective measures may challenge the respondents' (managers) ability to assess the workplace performance. Respondents may have difficulty assessing their workplace performance if the measures are not similar to the actual conditions. Moreover, respondents may find it easier to assess financial performance than other measures as almost 30% of the managers filled the questionnaires in WERS2011 is a general manager or owner of the workplaces (van Wanrooy et al., 2013) which tend to focus their attention on workplaces' financial condition.

Turning to job satisfaction, it seems the actions taken by workplaces following the crisis have produced this result. Approximately one third of the workplaces prompted redundancies and one seventh of them froze or cut the wages as their measures against recession (Table 7.12). These actions seem unfavourable for workers. Having seen their colleagues being made redundant, surviving workers may feel relieved that they kept their jobs, hence, boosting their job satisfaction according to the downward social comparison approach (Buunk and Gibbons, 2007). However, redundancies have left workers with higher workloads in the high performance workplaces. The higher workloads experienced after redundancies may result in lower job satisfaction for the remaining workers.

Another plausible explanation is that workers in high performance workplaces may suffer more than those in lower performance workplaces. As one of the con-

sequences of the unfavourable economic condition (at this time the British GDP has not reached the level in 2008 before the crisis, see Figure 3.3 in Chapter 3), workplaces may restrict rewards to their workers, i.e. freeze the wage. The impact of restricted rewards may be considered relatively worse for workers in higher financial performance workplaces than those in lower financial performance workplaces. Thus, instead of having higher job satisfaction by surviving the redundancies, these workers may have lower job satisfaction. However, since the nature of this study is cross-sectional, I cannot investigate further. Investigating the workers' and workplaces' situations in the previous WERS (WERS2004) is needed to further explore this explanation.

In addition, job satisfaction indicators in this study consist of satisfaction with achievement, initiative, influence over job, skill development and work itself. Knowing that keeping their workers is imperative, workplaces may maintain the means they use to satisfy workers. For example, workplaces may still give financial reward using the performance-related pay system for their workers and providing training opportunities for most workers in stronger financial performance workplaces. This chosen policy may not be easy for those workplaces with weaker financial performance as the policy may be too expensive at times of crisis. The costs may rise which results in lower financial performance, although the job satisfaction may still be high.

In contrast with the result in financial performance, only job satisfaction is associated with higher quality of product or service in this study. This positive relationship supports the findings of previous studies (de Menezes, 2012; Wood et al., 2012; Yee et al., 2008). Those studies found that job satisfaction is related with higher quality. Workers need to feel satisfied with their jobs to be able to deliver the better quality required by their customers (Grönroos, 2000). Job satisfaction happens when workers feel good about their jobs as their jobs fulfill their expectations (Green, 2006; Locke, 1976; Spector, 1997). The fulfilled expectations enhance workers' com-

mitment toward their workplaces which may lead them to perform accordingly to achieve the goals of workplaces. These fulfilled expectations also motivate workers to give their best performance which makes them keep the jobs, as having a job is one of many source of happiness in life (Argyle, 2001) and it determines one's place in society (Warr, 2007) by giving extra meaning to life (Layard, 2011).

Other findings Turning to other covariates that have significant associations with workplace performance; higher proportions of female employees is associated with lower quality and higher absenteeism. Recent studies show that women are unlikely to work in competitive environments due to a lack of confidence and their attitudes toward risk aversion (Buser et al., 2014). While gender diversity in workplaces should improve performance, Gill and Prowse (2014) argued that women will perform relatively worse as compared to men when forced to compete. Economic crisis may be seen as a competitive environment by women as they need to justify their existence when workplaces implement redundancies. In addition, the changes in the workplace may raise tension and pressures in workplaces which are detrimental to women as they are more sensitive to their environment (Croson and Gneezy, 2009; Flory et al., 2010) and affect their performance. Previous studies also found that women tend to have higher absence rate than men not only due to their dual responsibility (family and work), but also due to long commuting time, work shifts, long tenure, stressful life events (VandenHeuvel and Wooden, 1995) and health-related behaviour (Mastekaasa and Olsen, 1998).

Regarding training and skills, having a larger numbers of trained employees is only associated with higher financial results which corroborates previous studies (Jones et al., 2009). Training may improve the skills and knowledge of workers, which may enhance their efforts and result in stronger financial results. However, the proportion of trained workers seems to have different results for absenteeism. Although the associations are weak, less than 40% and less than 80% of trained employees resulted in higher absenteeism. Fewer training opportunities mark work-

Table 7.12: Reaction related to recession and management changes in Britain

	General industry (%)	Healthcare industry (%)
<i>Reaction to recession:</i>		
Redundancies	35.9	24.2
Freeze or cut wages	14.3	19.7
Temporary freeze on recruitment	17.4	19
Other actions	17.5	23.1
No actions	14.9	14
<i>Management changes:</i>		
Change in organisation of work	22.2	27.4
Introduction or upgrading new technology	16.3	16.4
Changes in work techniques/procedures	13.8	11.4
Introduction of new product/service	9.7	5.8
No changes applicable	21.7	23.9

places that do not care for the future achievement of workers which leads to lower motivation to be present at work. Having less than 80% of workers being trained in the previous year may also signify problems in the workplaces due to recession and trigger inequity among workers which may lead to workers being absent from the workplace. Another plausible explanation is that when trainings are provided outside the workplaces, the opportunity for networking exists and workers may capitalise on it to explore job-seeking opportunities which may consume more of their time.

To keep up with competition, workplaces took some initiatives such as management changes and performance-related pay systems. The most common management changes in WERS 2011 are changes in the organisation of work (22.2%), upgrading technology (16.3%) and changes in work procedures (13.8%) (Table 7.12). Introduction of management changes is associated with higher productivity and stronger financial results which reflect that the changes are beneficial to workplaces. Workers seems to accept the changes as a way to assist their jobs. The existence of performance-related pay systems is associated with higher productivity and lower absenteeism. Having an opportunity to be fairly rewarded with the performance-related pay system, workers may want to put more efforts into being productive in their jobs and being present in the workplace.

Considering the size and type of workplaces, larger workplaces are associated

with higher absenteeism and stronger financial results, while being in the public sector is associated with lower quality and higher absenteeism. Larger workplaces may increase the gap between managers and workers which also means the relationship gap produces an unfavourable working environment. Alternatively, larger workplaces may lose control over workers which enables workers to be absent from workplaces. The finding on public organisations emphasises the previous finding that public organisations are less flexible in responding to the needs of their workers in addition to the possibility of smaller budgets provided by the government in this time of crisis. The inflexibility combined with budget cuts are most likely bring restrictions to workers as frozen wages and redundancies as these are the most common actions taken by workplaces in this study. These unpleasant consequences may demotivate workers and is reflected in lower quality and higher absenteeism.

Unsurprisingly, there are negative relationships between variables possibly connected with crisis and workplace performance. Productivity and financial performance are severely affected with redundancy, dismissal and the recession impact. Dismissal and redundancy may cut the capacity of workplaces to produce products and services, not only because they have less workers, but also because the remaining workers may have excessive workloads. The remaining workers may not be able or willing to take up all the workload, especially if they feel insecure and inequitable by the workplaces' reaction to crisis. The popular actions taken by workplaces in WERS2011 are redundancies, wage cuts and recruitment freezes for vacant positions which is intended to cut costs, but remains unpopular with workers. Workplaces may be considered to be violating the psychological contracts due to the crisis (Aycan and Kabasakal, 2006). However, with pervasive unemployment prevailing, workplaces may have a slight benefit of taking those actions to secure their financial performance. Similarly, the impact of recession may hit workplaces on their ability to earn revenue as they lose their capacity and their customers which may produce difficult conditions for themselves.

7.4.2 The healthcare industry

Main findings In contrast to the results for general industry, social capital and job satisfaction are non-significantly associated with workplace performance. Thus, I failed to find evidence that both social capital and job satisfaction are associated with better workplace performance. However, social capital shows the expected associations with most workplace performance other than productivity. In contrast, job satisfaction only shows the expected association with productivity. These results are intriguing, particularly for job satisfaction, as job satisfaction was previously found to be associated with higher financial performance in healthcare industry (Akdere, 2009).

Several plausible explanations may shed light on the non-significant results. Firstly, the workplace performance measures used in this study are not specifically designed for the healthcare industry. Therefore, those workplace performance measures may not capture real workplace performance in this industry. Secondly, the workplace performance is assessed by the manager in the workplace. They may not all be familiar with the measures as found by Forth and McNabb (2008). It is a possibility that the managers found it difficult to assess their workplace performance using these general measures. Thirdly, the fact that healthcare industry are dominated by female workers may open a different avenue of explanation. Considering the gender of the majority of workers in this industry, I look for plausible explanations from studies concerning gender differences. Croson and Gneezy (2009) reviewed experiments involving gender differences and preferences. They found that women are more reciprocal than men toward the environmental factors as they act and decide in accordance to the situation they are in. Women build their trusts based on the stimulation they receive and, in a similar vein, females are prone to punish their workplaces as they are treated unfairly (Croson and Gneezy, 2009). Table 7.12 shows that changing the organisation of work is more prevalent in this industry accompanied by freezing or cutting wages. Those actions may be unfavourable for

workers as they may need to adjust their work while their pay remain constant which is considered unfair. This finding may give insights for managers leading workplaces with majority female workers.

Other findings One way to maintain workers' satisfaction in this industry is in providing training opportunities (Bartlett, 2001). Training provision was found to reduce intentions to quit for nurses (Shields and Ward, 2001) and to increase organisational commitment (Bartlett, 2001). In this study, the majority of workplaces keep their training provision for workers as only 1.3% workers have their training opportunities reduced. Although having a higher percentages of trained employees is positively associated with workplace performance, other than productivity, all associations are non-significant. This finding contradicts previous studies on the association of training and job satisfaction (Jones et al., 2009; Shields and Ward, 2001) and also the finding on the general industry in the previous section. This finding may provide evidence that in times of crisis, the benefit of training is less than for other means for job satisfaction.

Providing training opportunities to employees may result in workers with matched and over-skilled for their jobs which is negatively related to financial performance in this study. This result may confirm the finding of Hoyt and Matuszek (2001) that skilled workers do not predict financial performance. Although those workers may do their jobs more efficiently (Ostroff, 1992), they also expect workplaces to reward those skills (Akerlof, 1982). Workplaces may pay higher rewards to keep them, but they are too costly as their contribution may be relatively insufficient to improve the financial performance. The implementation of performance-based related pay system aims to make workers feel rewarded for their efforts. This performance system may justify higher efforts from workers to earn more rewards relatively to their co-workers (Georgellis and Lange, 2007). This system may also prevent the development of social loafing (Lount Jr. and Wilk, 2014) where workers withhold their efforts as they have no incentives. When the workplace gets larger, there are

more workers motivated to do their best which then lead to even higher financial performance.

However, when the workplace is part of the public sector, it is found that it gets less flexible to fulfill the workers' satisfaction (Idson, 1990). Particularly, in times of unfavourable economic condition, governments are eager to do whatever is necessary to survive. Appleby et al. (2009) predicted that the government funding for health-care industry would decrease by approximately 2.3% annually for 2011-17. As budget will be limited, workplaces tend to take several actions such as redundancies and freezing wages, which are unpopular decisions for workers. Moreover, workplaces are required to improve their productivity to achieve their financial performance and to provide necessary healthcare for the society with the limited funding (Appleby et al., 2009; Charlesworth, 2013). From workers' perspective, higher productivity means more efforts which may be unrewarded fairly with the prospect of budget cut and frozen wages. Therefore, it is unsurprising that workplaces impacted by recessions suffer lower workplace performance, particularly, their financial performance.

7.5 Conclusion

This study is an attempt to find evidence whether social capital has associations with better workplace performance in a developed country like Britain and whether also job satisfaction improves workplace performance in such a country taking account both workplace characteristics and individual characteristics of the workers. This study uses general industry and a specific industry linking individuals and workplaces in a developed country to investigate the associations between social capital and job satisfaction with workplace performance. It confirms that social capital is associated with better workplace performance measured by financial results in the general industry, but not in healthcare industry. Nevertheless, it does not support expectations for other measures of workplace performance such as productivity, quality and absenteeism. Similarly, job satisfaction is associated positively with quality

in the general industry, but it has no significant associations with any performance measures in the healthcare industry.

Despite the findings, this study has several limitations. Like authors of previous studies using WERS, I use subjective measures of workplace performance given by the managers of workplaces. Mezas and Starbuck (2003) show that relying on subjective workplace measures may be inaccurate due to a single source of assessment. As discussed above, managers' familiarity with the measures is crucial to have reliable workplace performance (Forth and McNabb, 2008). Their findings may resonate in this study as the associations are only found using financial results. Future research should attempt to use more objective measures of workplace performance other than absenteeism. Furthermore, the treatment of the subjective measures may need to be adjusted. I treat those measures as continuous variables instead of categorical variables due to the complexity of the model. Future research should treat these variables as categorical. The non-significant associations between social capital and job satisfaction in the healthcare industry need further investigation. Future researchers may use a specific performance measurement for that industry or use more refined classification of workplaces. Last but not least, this is a cross-sectional study, thus, neither causality nor long-term effects can be assessed.

On the whole, the current study provides partial evidence that social capital and job satisfaction measured at the individual level are related to workplace performance at the higher level. As it is, management of workplaces need to be concerned with the maintenance of social capital and job satisfaction, especially in changing economic conditions. Their reactions to changing economic conditions may worsen workplace performance when communication between managers and workers fail as workers perceive the actions as a breach of the psychological contract. In addition, several management practices may help the workplace to achieve better workplace performance, such as provision of training for financial results; introduction of management changes and performance-based system pay for productivity and

absenteeism. Nonetheless, management in a specific industry such as the healthcare industry may face more challenges as those management practices may not produce the expected results.

The next chapter will move on to explore the association of social capital and job satisfaction with workplace performance in a developing country, using Indonesian hospitals as the sample.

Chapter 8

Workplace social capital, job satisfaction and workplace performance in Indonesia

8.1 Introduction

It has been suggested in the literature that social capital is related to both job satisfaction and workplace performance. However, evidence from developing countries is still limited as most studies exploring this link in developing countries have focused on small businesses and entrepreneurs. These studies found that bonding social capital of the entrepreneurs (or chief executive officers in small businesses) is a means of business survival in developing countries; this type of social capital provides resources for their daily operation, while bridging and linking social capital with outside parties improves workplace performance (Santarelli and Tran, 2013; Turner, 2007; Turner and Nguyen, 2005; Wu and Leung, 2005). Wu and Leung (2005) also found that reciprocity enhances the quality of the relationships as relational trust is based on repeated actions over time between partners (Rosseau et al., 1998). Relational trust is also associated with higher competitive performance of the workplace. However, these studies emphasised the social capital with outside parties.

Using similar measures of social capital but in larger workplaces, studies in Ghana and China have found that social capital has a positive relationship with

such workplace performance measures as productivity and perceived financial results. These studies measured social capital ties between the manager of a workplace and parties outside the workplace including government officials (Acquaah, 2007; Peng and Luo, 2000), other top managers (Barr, 2000) or even community leaders (Acquaah, 2007). Different ties have different impact on workplace performance depending on the competitive strategy of the workplace (Acquaah, 2007). Despite the workplace size in these studies, they did not measure social capital within the workplace i.e. the relationships between employees and their superiors.

No study has yet investigated large workplaces in Indonesia with respect to social capital, job satisfaction and workplace performance. As mentioned in Chapters 1 and 6, only one study investigated job satisfaction with regard to its facets in a construction industry (Marzuki et al., 2012); both social capital and workplace performance were not considered. Observing changes in the Indonesian government system, one intriguing sector to be studied is the healthcare industry, particularly, public hospitals in Indonesia. Public hospitals are owned by local governments rather than by the central government as healthcare provision became the responsibility of local governments after the decentralisation in 2001 (Rokx et al., 2010; Government of Indonesia, 2004a). Many policies regarding healthcare provision, thus public hospitals, are in the hands of local governments. For example, local governments are granted the authority to hire employees for public hospitals rather than requesting the needed human resources to the Ministry of Health (Government of Indonesia, 2014). These changes have inevitably influenced workers attitudes and workplace performance, especially in the healthcare industry.

The successful delivery of healthcare services relies on the trust among workers within the hospital and between those institutions and patients (Gilson, 2003). In this context, then, trust within the workplace becomes a crucial factor in the performance of the healthcare institution. Moreover, the majority of the healthcare institutions are part of the public sector which depends on trust to maintain

their performance (Gould-Williams, 2003). Franco et al. (2002) offered a framework for the study of those relationships within a healthcare institution in developing countries; the framework includes both individual and workplace characteristics.

Despite the importance of the topic, research on the relationship of trust among health workers and trust between employee and employer in healthcare institutions is still sparse. Several studies have looked at the relationship of workplace social capital as embodied trust within workplace to performance of workplace and attitudinal performance of health workers in developed countries (Driller et al., 2011; Ernstmann et al., 2012; Ommen et al., 2009). However, the concept of workplace social capital for health workers, especially nurses, is still considered novel (Read, 2014); meanwhile, studies in developing countries remain focused on job satisfaction in different industries including the healthcare industry (Bonenberger et al., 2014; Curry et al., 2012; Halepota and Shah, 2011; Dieleman et al., 2003; Mulinge and Mueller, 1998).

This chapter examines the relationships between workplace social capital, job satisfaction and workplace performance in a developing country focusing on social capital within the workplace instead of outside the workplace as in previous studies. Both workplace social capital and job satisfaction are treated as latent variables. This study uses public hospitals as the workplace. The hypotheses tested are:

1. H1. Vertical social capital has associations with better workplace performance in public hospitals in a developing country.
2. H2. Horizontal social capital has associations with better workplace performance in public hospitals in a developing country.
3. H3. Job satisfaction has associations with better workplace performance in public hospitals in a developing country.

Table 8.1 shows the comparison between this study and other studies in developing countries.

Table 8.1: Comparison of studies on social capital and workplace performance in developing countries

Authors	Measure of performance	Social capital	Contingency variables	Control variables	Methods	Country
Peng and Luo (2000)	Individual perceptual measures of market share and return on assets	Managerial ties with: top managers at other firms and government officials	Ownership, business sectors, firm size (number of employees) and industry growth	Quality, payment terms, advertising, pricing, delivery, firm age	regressions	China
Barr (2000)	Productivity (value added per worker)	Managerial contacts with other Ghanaian firms, with overseas firms, with bankers, public servants and politicians		replacement value of capital stock per employee, years of formal education, average years of experience and ethnicity	OLS and two-stage regressions	Ghana
Aequaah (2007)	A composite average of : growth of sales and revenue growth on net income/profits growth in productivity return on assets return on sales	Managerial ties with: top managers at other firms, government officials and community leaders	low-cost strategy; differentiation strategy and integrated low-cost differentiation strategy	Firm size (number of employees), ownership (wholly domestic owned vs. joint venture), business sector (manufacturing vs. service) and market (industry competition)	hierarchical multiple regressions	Ghana
Ofori and Sackey (2010)	Quality of new product, customer satisfaction, satisfaction with organizational income	Personal contacts, diversity of contacts, institutional ties			multiple regressions	Ghana
Current study	Objective measures: revenue per bed, expenditure per bed, bed occupancy ratio and length of stay. Subjective measures: productivity, financial results, quality	Vertical social capital and horizontal social capital		Hospital class, proportion of skilled employees, existence of performance-related pay, having an experienced director	multilevel SEM	Indonesia

Source: Aequaah (2007) and author's own study

As in previous chapters, data and method are introduced before examining the relationships. The discussion will follow before this chapter concludes with an exposition of the findings.

8.2 Data and method

Data Similar to Chapter 6, this study uses data collected in Indonesia during summer 2013. Table 8.2 shows the sample for this study. As mentioned previously, the sample consists of 54 hospitals in East Java; they are almost equally split between those with higher classes (A & B) and those with lower classes (C & D).

Table 8.2: Analytic sample

	No/mean/mode
Number of hospitals	54
<i>Hospital classes:</i>	
Class A & B	46.2%
Class C & D	53.8%
<i>Objective performance:</i>	
Revenue per bed (Rupiahs)	181 millions
Expenditure per bed (Rupiahs)	327 millions
Length of stay (LOS)	6.3 days
Bed occupancy ratio (BOR)	0.70
<i>Subjective performance: (compared to the standards from Ministry of Health)</i>	
Better productivity	52%
Better quality	32%
Better financial results	39.8%
Percentage of directors with hospital directorship experience	64.2%
Percentage of directors with managerial degree in hospital management	43.9%
Percentage of under-skilled employees	9.4%
Percentage of matched-skills employees	54.4%
Percentage of over-skilled employees	35.7%

Dependent variables As for workplace performance, I did attempt to collect workplace performance measures specifically used for hospitals such as death rate, turnover interval, patient satisfaction or post-surgery infections rate from the hospitals. However, the hospitals were unavailable to provide those data. Instead, I use performance measures that are available in the hospitals. I use both objective and subjective performance measures. The objective measures are revenue per bed (log), expenditure per bed (log), bed occupancy ratio and length of stay (inverted),

which are common measures of managerial performance in the healthcare industry (Bergeron, 2006). The subjective performance is derived from the answers of the hospital managers to questions regarding financial results, productivity and quality of service compared to the performance standard issued by the Ministry of Health of the Republic of Indonesia (*Direktorat Jenderal Bina Upaya Kesehatan*, 2011). I classify the answers into three categories: ‘less than required’, ‘similar to the required’ and ‘better than required’.

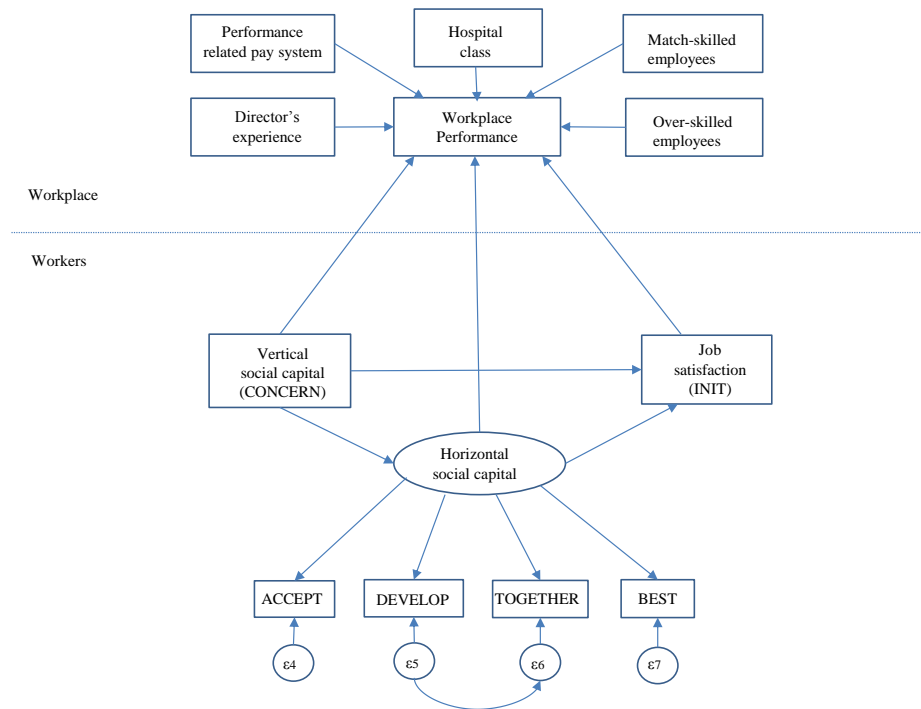
Independent variables Since the number of observations is smaller than that in the British study reported in Chapter 7 of this thesis, the number of variables to be included in the analysis is limited. In addition, the workplace performance is measured at the workplace level, while the predictors are at the individual level. First, I reexamine the latent variables to be used: vertical social capital, horizontal social capital and job satisfaction. Based on the EFA in the previous analysis (Chapter 6), I conducted CFA for each of the latent variable to test the reliability and validity of each construct before modelling. I use three observed variables for vertical social capital (KIND, CONCERN, TRUST), four observed variables for horizontal social capital (ACCEPT, TOGETHER, BEST, DEVELOP and another three observed variables for job satisfaction (ACH, INIT and INFL). The result of individual CFA is shown in Table 8.3. Although each of the latent variable shows good fit index as the CFI and TLI are above 0.95 with SRMR and RMSEA below the conventional cut-off point, the p-value of the vertical social capital and job satisfaction are not available, which may signify convergence problems for both variables. For this reason, I decided only to include the horizontal social capital as the latent variable, while the vertical social capital and job satisfaction are represented with the highest loading factor indicator in the analysis. CONCERN has the highest loading factor for vertical social capital, as does INIT for job satisfaction.

Table 8.3: Individual CFA of social capital and job satisfaction in Indonesia

Indicators	Description	Vertical social capital	Horizontal social capital	Job satisfaction
Within level				
KIND	Our supervisor treats us with kindness and consideration	0.812(0.013)‡		
CONCERN	Our supervisor shows concern for our rights as employees	0.842(0.013)‡		
TRUST	We can trust our supervisor	0.814(0.013)‡		
ACCEPT	People feel understood and accepted by each other		0.701(0.017)‡	
TOGETHER	We have a 'we are together' attitude		0.818(0.016)‡	
BEST	Do members of the work unit build on each other's ideas in order to achieve the best possible outcome?		0.839(0.013)‡	
DEVELOP	People in the work unit cooperate in order to help develop and apply new ideas		0.886(0.013)‡	
ACH	The sense of achievement you get from your work			0.609(0.034)‡
INIT	The sense of achievement you get from your work			0.733(0.032)‡
INFL	The amount of influence you have over your job			0.639(0.036)‡
χ^2		0.000	0.098	0.000
p-value		.	0.755	.
CFI		1.000	1.000	1.000
TLI		1.000	1.002	1.000
RMSEA		0.000	0.000	0.000
SRMR		0.000	0.001	0.000
AIC		7817.901	8181.314	8942.322
BIC		7864.271	8246.818	8988.478

Note: reported in standardised coefficient (standard error). Sig. 1%‡

Figure 8.1. Workplace social capital, job satisfaction and workplace performance in Indonesia



Having determined the latent variable, I select several workplace characteristics that may influence the workplace performance, especially for public sector organisations. I include hospital class as it represents the size of organisation and availability of resources as a binary variable (1 for class A & B and 0 for other classes), the existence of performance-related pay system (1 for those with the system and 0 without), proportion of employees with matched or more than sufficient skills for their jobs (with the under-skilled as the reference). These characteristics have been used to study workplace performance in public sector in the developed countries (Gould-Williams, 2003; Jones et al., 2009; McAllister, 1995). Moreover, several authors have also suggested the use of workplace characteristics to find the association between trust and workplace performance in developing countries (Franco et al., 2002; Gilson et al., 2005; Ofori and Sackey, 2010). In addition, I add the leadership experience of the director as leadership has been discussed in previous studies as an

aspect that can lead to better hospital performance (Curry et al., 2012; Daire et al., 2014; Doherty et al., 2013). Those hospitals with directors who had been a hospital director prior to taking on their current positions now are coded 1, while those without are coded 0. Figure 8.1 shows the multilevel structural equation model of this study.

8.3 Results

Descriptive analysis Table 8.2 includes both objective and subjective measures of performance in 2012. Begin with the objective measures, the annual average revenue of the hospitals is 181 millions Rupiah (Indonesian currency) with an expenditure of 327 millions Rupiah for the year. This discrepancy shows that most hospitals still depend on government subsidy for their sustainability, although almost all of them have been corporatized. Corporatized hospitals mean that they have the freedom to manage their own finances. The average length of stay is 6.3 days, while bed occupancy ratio is 0.70. Both are within the range suggested by the Indonesian Ministry of Health (*Direktorat Jenderal Bina Upaya Kesehatan*, 2011).

Looking into the subjective performance, there are different percentages of hospitals with better performance. Only 32% of the hospitals claim that their quality are better than the standard issued by the Ministry of Health. Approximately 39.8% of managers assess their hospitals as having better financial results. More than half of the hospitals (52%) has better productivity. This may show that the hospitals are more familiar to productivity measures than other measures. Alternatively, they may only pay attention to productivity rather than to quality and financial results. Among those hospitals, 40% of them have directors with a degree in hospital management and the majority have an experienced leader as directors. In other words, those directors have held the position of hospital directors before. Most of the workers in the study claimed they had skills either matched to or higher than required by their jobs in hospitals.

Table 8.4: Bivariate analysis of workplace performance

	Revenue/bed	Expenditure/bed	BOR	LOS	Productivity	Financial	Quality
Vertical social capital	0.033(0.023)	-0.044(0.020)†	0.012(0.006)†	-0.002(0.002)	0.025(0.026)	0.050(0.025)†	-0.021(0.023)
Horizontal social capital	0.041(0.047)	0.002(0.026)	-0.006(0.007)	0.002(0.003)	0.061(0.034)	0.023(0.035)	-0.005(0.031)
Job satisfaction	0.014(0.036)	0.002(0.019)	0.005(0.005)	-0.004(0.002)	-0.001(0.024)	0.023(0.024)	-0.026(0.022)
Hospital class	1.273(0.051)‡	0.357(0.034)‡	0.109(0.009)‡	-0.039(0.004)‡	0.218(0.046)‡	0.507(0.043)‡	0.044(0.041)
Existence of performance-related pay system	0.326(0.066)‡	-0.040(0.039)	0.090(0.011)‡	-0.046(0.004)‡	-0.085(0.049)	0.074(0.049)	-0.045(0.045)
Matched-skill employees	-0.394(0.167)†	-0.898(0.140)‡	-0.053(0.040)	0.080(0.016)‡	-1.415(0.216)‡	-1.697(0.209)‡	-0.343(0.195)
Over-skilled employees	0.546(0.171)‡	1.340(0.141)‡	0.087(0.042)†	-0.119(0.016)‡	1.296(0.213)‡	1.715(0.199)‡	0.594(0.194)‡
Director with managerial degree	-0.236(0.040)‡	-0.214(0.035)‡	-0.064(0.010)‡	-0.008(0.004)†	-0.154(0.046)‡	-0.044(0.046)	0.197(0.041)‡
Experienced director	-0.403(0.040)‡	-0.017(0.038)	-0.060(0.010)‡	-0.010(0.004)†	-0.013(0.050)	-0.055(0.048)	0.173(0.044)‡

Sig: 1%†, 5%‡, BOR: bed occupancy ratio, LOS: length of stay

Bivariate analysis I analyse the relationships between social capital, job satisfaction and workplace performance using correlations. For this analysis, I predict the scores of social capital and job satisfaction. Table 8.4 shows the results of bivariate analysis. To begin with the main independent variables, vertical social capital is significantly associated with lower expenditure per bed, higher BOR and better financial results. Horizontal social capital is associated with higher revenue per bed, higher expenditure per bed, higher LOS, higher financial results, but it is negatively associated with BOR and quality. Whilst job satisfaction is also associated with higher revenue per bed, higher expenditure per bed, higher BOR and better financial results, but it is associated with lower BOR, lower productivity and lower quality. Both horizontal social capital and job satisfaction have non-significant associations with workplace performance measures.

Turning to other covariates, higher hospital class is significantly associated with higher performance on all measures, except quality. The existence of a performance-related pay system is associated with higher revenue per bed, higher BOR, and lower LOS. Having employees with the required skills is associated with lower revenue per bed, lower expenditure per bed, higher LOS and lower subjective performance (productivity, financial results and quality). Unlike the nature of associations found among matched-skill employees, over-skilled employees are associated with higher revenue per bed, higher expenditure per bed, higher BOR, lower LOS and higher subjective performance. Having a director with a managerial degree is significantly associated with lower measures of workplace performance, other than quality. Having a director with previous experience leading a hospital is significantly associated with lower revenue per bed, lower BOR, lower LOS, but higher quality.

Multilevel SEM Tables 8.5 and 8.6 show the models for objective workplace performance in Indonesia in accordance with the model in Figure 8.1. Model 1 is the baseline model, while Model 2 is the complete model including other independent variables. Starting with Model 1, vertical social capital has positive associations

with revenue per bed and BOR, but it has negative associations with expenditure per bed and LOS. In contrast, horizontal social capital is positively related with expenditure per bed and LOS, whilst the associations with revenue per bed and BOR are negative. Like vertical social capital, job satisfaction have positive associations with revenue per bed and BOR, yet, it is negatively associated with expenditure per bed and LOS. All relationships between vertical social capital, horizontal social capital, job satisfaction and objective workplace performance are statistically non-significant.

Focusing on Model 2, vertical social capital has a significant negative association with expenditure per bed ($\beta=-0.517$, $p<0.01$), but not with other measures of objective workplace performance. Horizontal social capital has positive associations with mostly objective workplace performance, but not BOR. In contrast to the relationships of horizontal social capital, job satisfaction has mostly negative associations with workplace performance measures, but not expenditure per bed. However, all associations between horizontal social capital and job satisfaction with workplace performance are statistically non-significant. These results confirms that H1 is partially supported, but both H2 and H3 are rejected.

Considering workplace characteristics, higher hospital class has a positive association with revenue per bed, expenditure per bed and BOR, but the association is only statistically significant with revenue per bed ($\beta=0.222$, $p<0.01$). Higher hospital class has a negative and significant relationship with LOS ($\beta=-0.371$, $p<0.01$). The existence of a performance-related pay system shows positive associations with revenue per bed and BOR, but it is negatively related to LOS and expenditure per bed. Nevertheless, the significant associations are only established with revenue per bed ($\beta=0.274$, $p<0.05$) and LOS ($\beta=-0.300$, $p<0.01$). Higher proportions of employees with the skills required for their jobs have significant associations with both lower revenue ($\beta=-0.628$, $p<0.01$) and lower expenditure per bed ($\beta=-0.329$, $p<0.01$), while the associations with BOR and LOS are non-significantly negative.

Table 8.5: Social capital, job satisfaction and objective workplace performance in Indonesia (1)

	Revenue per bed		Expenditure per bed	
	Model 1	Model 2	Model 1	Model 2
Vertical social capital	0.319(0.191)	0.182(0.142)	-0.098(0.153)	-0.517(0.159)‡
Horizontal social capital	-0.251(0.211)	0.105(0.269)	0.167(0.362)	0.255(0.401)
Job satisfaction	0.078(0.355)	-0.240(0.415)	-0.513(0.383)	0.535(0.339)
Hospital class		0.222(0.102)†		0.137(0.186)
Existence of performance-related pay		0.263(0.074)‡		-0.123(0.106)
Proportion of matched skill employees		-0.628(0.091)‡		-0.329(0.118)‡
Proportion of over-skilled employees		-0.135(0.086)		0.157(0.098)
Having an experienced director		0.169(0.087)		0.153(0.125)
CFI	0.989	0.987	0.987	0.988
TLI	0.980	0.983	0.978	0.984
RMSEA	0.032	0.024	0.034	0.023
SRMR(within)	0.010	0.011	0.018	0.010
SRMR(between)	0.251	0.221	0.254	0.255
AIC	15269.101	13843.315	15180.012	13811.363
BIC	15449.567	14044.867	15360.478	14012.914
Individuals	1282	1140	1282	1140
Workplaces	54	48	54	48

Note: Reported in standardised coefficients (standard errors). Sig. 1%‡; 5%†

Table 8.6: Social capital, job satisfaction and objective workplace performance in Indonesia (2)

	BOR		LOS	
	Model 1	Model 2	Model 1	Model 2
Vertical social capital	0.319(0.191)	0.317(0.203)	-0.098(0.153)	0.065(0.135)
Horizontal social capital	-0.251(0.211)	-0.263(0.195)	0.167(0.362)	0.335(0.292)
Job satisfaction	0.078(0.355)	-0.384(0.533)	-0.513(0.383)	-0.388(0.575)
Hospital class		0.235(0.164)		-0.371(0.136)†
Existence of performance-related pay		0.240(0.137)		-0.300(0.140)†
Proportion of matched skill employees		-0.051(0.201)		-0.160(0.138)
Proportion of over-skilled employees		0.043(0.141)		-0.227(0.103)†
Having an experienced director		0.225(0.127)		-0.057(0.127)
CFI	0.989	0.990	0.987	0.989
TLI	0.980	0.986	0.978	0.985
RMSEA	0.032	0.021	0.034	0.022
SRMR (within)	0.010	0.011	0.010	0.011
SRMR (between)	0.252	0.222	0.251	0.221
AIC	15269.101	13702.585	15180.012	13623.005
BIC	15449.567	13904.136	15360.478	13824.556
Individuals	1282	1140	1282	1140
Workplaces	54	48	54	48

Note: Reported in standardised coefficients (standard errors). Sig. 1%†; 5%†

Table 8.7: Social capital, job satisfaction and subjective workplace performance in Indonesia

	Financial results		Quality		Productivity	
	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Vertical social capital	0.234(0.217)	0.197(0.227)	-0.057(0.205)	-0.156(0.230)	0.099(0.188)	-0.017(0.222)
Horizontal social capital	0.194(0.360)	0.321(0.508)	0.075(0.451)	0.225(0.289)	0.535(0.790)	0.530(0.826)
Job satisfaction	0.230(0.350)	-0.269(0.574)	-0.314(0.417)	-0.405(0.421)	-0.189(0.761)	-0.099(0.694)
Hospital class		0.181(0.200)		0.012(0.195)		0.135(0.182)
Existence of performance-related pay		-0.030(0.154)		-0.099(0.165)		-0.098(0.157)
Proportion of matched skill employees		-0.013(0.181)		-0.008(0.142)		0.096(0.132)
Proportion of over-skilled employees		0.214(0.171)		0.248(0.131)		0.305(0.188)
Having an experienced director		0.002(0.159)		0.245(0.159)		0.149(0.186)
CFI	0.987	0.987	0.983	0.987	0.977	0.981
TLI	0.977	0.982	0.972	0.981	0.960	0.974
RMSEA	0.034	0.023	0.038	0.024	0.046	0.029
SRMR(within)	0.018	0.010	0.018	0.010	0.018	0.010
SRMR(between)	0.257	0.248	0.256	0.251	0.262	0.245
AIC	15406.096	13829.454	15416.283	13837.824	15416.630	13840.481
BIC	15586.562	14041.006	15596.749	14039.376	15597.096	14042.032
Individuals	1282	1140	1282	1140	1282	1140
Workplaces	54	48	54	48	54	48

Note: Reported in standardised coefficients (standard errors).

Higher proportions of employees with skills exceeding the requirement of their jobs have negative associations with two measures of workplace performance: revenue per bed and LOS. The association, however, is significant only with LOS ($\beta=-0.227$, $p<0.01$). Those over-skilled employees are insignificantly associated with revenue per bed and expenditure per bed. Lastly, although leadership experience on the part of the director is mostly positively associated with workplace performance measures, other than LOS, the associations are non-significant.

All models show good fit indices (Hooper et al., 2008; Hu and Bentler, 1999). All CFIs and TLIs are above 0.95, while RMSEAs and SRMRs_(within) are below the cut-off point of 0.06 (Iacobucci, 2010; Hooper et al., 2008; Hu and Bentler, 1999). Similar to the results on the relationships between social capital and job satisfaction, the SRMRs_(between) are above the existing conventional cut-off. there is no studies yet on the cut-off to be applied for SRMR_(between) as suggested by Hsu (2009). For that reason, I also compare the values of AIC and BIC between Model 1 and Model 2 and find that Model 2 is better as those values are smaller. With all fit indices are good, except for SRMR_(between), and the encouraging AIC and BIC values, Model 2 is accepted.

Focusing on subjective workplace performance, I use perceived productivity, quality and financial results. Although the results are mostly non-significant for the associations between independent variables and workplace performance, there are some interesting associations in Table 8.7. As with the models of objective performance, Model 1 is the baseline model, while Model 2 is the complete model. Model 1 shows that vertical social capital is positively associated with financial results and productivity, but not with quality. Horizontal social capital, though, has positive associations with all performance measures. Job satisfaction has a positive association only with financial results. Turning to Model 2, there are slight changes in the nature of the relationships between social capital, job satisfaction and workplace performance. Vertical social capital has a negative association with

productivity instead of a positive association as in Model 1. Job satisfaction is negatively associated with financial results in Model 2. Other associations remain the same.

Turning to other covariates in Model 2, higher hospital class is positively related to all performance measures. The existence of performance-related pay is associated negatively with all performance measures. Regarding the proportion of skilled workers in the hospitals, higher proportions of employees with the required skills for their jobs are negatively associated with financial results and quality, but not productivity; whilst having a higher proportion of over-skilled employees is positively associated with all three performance measures. Having an experienced hospital director has no significant association with higher subjective performance in all measures.

Similar to the models for objective workplace performance, all models of subjective workplace performance show good fit indices. Only the values of $SRMR_{S(between)}$ are higher than the known cut-off point. However, Hsu (2009) has found that the use of the conventional cut-off point may be misleading for this type of SRMR. Following Browne and Cudeck (1992) and Mehta and Neale (2005), the comparison of RMSEA, AIC and BIC values determines the selection of the models. Model 2 results consistently show lesser values of all three indices in Table 8.6; therefore, Model 2 results are generally more efficient than those seen in Model 1 (Browne and Cudeck, 1992; Mehta and Neale, 2005); this encourages the use of the results from Model 2.

The ICCs show that vertical social capital is influenced by the differences between hospitals more than job satisfaction or horizontal social capital (Table 8.8). Vertical social capital has the highest percentage of 6.5%, while both horizontal social capital and job satisfaction are approximately 2.7% and 2.1%.

Table 8.8: ICC of individual items

Horizontal social capital		Vertical social capital*		Job satisfaction*	
Indicators	ICC	Indicators	ICC	Indicators	ICC
ACCEPT	0.028	CONCERN	0.065	INIT	0.021
TOGETHER	0.032				
BEST	0.029				
DEVELOP	0.019				
Mean	0.027		0.065		0.021
Overall mean	0.038				

ICC = intraclass correlation. * not latent variables

8.4 Discussion

This study looks into the associations between vertical social capital, horizontal social capital, job satisfaction and hospital performance in Indonesia. Unlike the study of Britain (Chapter 7), this study uses primary data collected in one province in Indonesia during summer 2013. In addition, the data collected enable me to have different measures of social capital (vertical and horizontal) and of both the objective and subjective measures of workplace performance to be used in this study. The results show that vertical social capital is significantly associated with lower expenditure per bed after controlling for several workplace characteristics. This finding partially confirms H1. However, I failed to find evidence to support H2 and H3 as there are non-significant associations between horizontal social capital and job satisfaction with workplace performance in Indonesia.

Formerly, public hospitals received their funding from the central or local government, and this is still the case with some of the hospitals with lower classes. Hospital management used to have lesser flexibility for their budgets and most likely they attempted to decrease expenditures to optimise their funding as additional funding was not available. Only with a change of status to that of corporatized hospital after the decentralisation in 2001, can hospitals govern their own budgets and retain the remaining revenue for their investments. However, this change of responsibility

seems to be overlooked by managers due to the existence of selective perception (Ireland et al., 1987; Dearborn and Simon, 1958) so they may take whatever is relevant for their unit only or they may never be properly prepared for the change (Heywood and Choi, 2010). Selective perception hinders learning within an organisation as the managers may not be fully prepared for the consequences of change. Consequently, hospitals have been keen to control their budgets as though they have no other funding sources, just as before corporatisation. They needed to manage their expenditures to maintain their operations, so they may have put policies in place that restrict expenditures as in the pre-decentralisation era (Maharani et al., 2014). In addition, previous studies also found that hospital managers were not able to set the correct fee for their services after the health reforms (Maharani et al., 2014; Suwandono et al., 2001) which may also reflect the incapability of the managers and their focus on expenditure.

Leaders may exercise their influence to see that policies are well-executed as leaders' performance, too, depends on how well the budget is disbursed. Leaders may show concern towards their workers as an effective tool for ensuring their workers follow their directions. In a culture like Indonesia's, workers perceive leaders as parents or older siblings (Setiadi, 2007; Shiraishi, 1996; Suryani et al., 2012). Leaders have more power than their workers, as found previously (Pekerti and Sendjaya, 2010). In this high power distance relationship, leaders can influence their workers in certain way that serve their intention. Workers feel obligated to follow guidance from leaders as they would obey their parents at home or in the society. Thus, higher vertical social capital leads to effective control of the budget which then lowers hospital expenditure, and, in turn, expenditure per bed.

Although the result is found among public hospitals in Indonesia, this approach of leadership may not be exclusive to the public sector. As power distance may be more prominent in the public sector, Setiadi (2007) found that leaders in the private sector also act autocratically. The leaders act as 'the father' in the organisation that take

care their subordinates and expect the subordinates to follow and loyal toward them. However, the finding of this study needs to be tested within the private sector to ensure its generalisability as a more current study shows that workers in this sector prefer more democratic leaders in the organisations (Suryani et al., 2012).

Additionally, the above explanation may re-emphasise evidence found in China, although in China it is related to outside parties (Wu and Leung, 2005). In China, reciprocity of the managers toward outside parties increases the quality of the relationship as the trust embodied in the relationship also increases due to the actions of the managers. Whether it is an outside party or an inner party of the workplace, such as workers, the first component of social capital is trust (Leana and van Buren, 1999). What works with outside parties in society should work also within organisations as ‘societal cultural values and practices affect organisational cultural values and practices’ (Carl et al., 2004). Public hospitals in particular, like other government institutions, take a very bureaucratic approach in Indonesia. Power distance are established between the director, managers and workers. Workers follow their director as the director has the highest power and may also have shown trust in a form of concern toward them. This explanation may also be relevant for other countries in Asia where similar power distance exist.

Other than plausible explanations for the significant association, the non-significant associations are also worth to be followed-up. Although an earlier study found that subjective workplace performance is correlated with objective performance measures in hospital industry (McCracken et al., 2001), the study took place in a developed countries. Additional studies from different industries also found similarities between subjective and objective performance measures in developed countries (Forth and McNabb, 2008). The non-significant associations between horizontal social capital and job satisfaction with both objective and subjective workplace performance measures should lead to an opportunity to investigate more appropriate performance measures of healthcare industry in developing countries as it is evident that what

works in developed countries may not always work in developing countries.

Other findings Turning to other covariates, higher hospital class is associated with higher revenue per bed and lower LOS. As the hospital class represents the size of the hospital and its resources, these results are unsurprising. Class A & B hospitals have more beds and facilities than Class C & D hospitals. In addition, not only they can afford to employ more specialist physicians and other medical professionals and to provide more training opportunities for the workers, but they are also eligible to receive more technology-related facilities. The availability of both skilled health professionals and updated facilities are then used as leverage, supposedly representing the level of their services to the community. Having skilled workers and better facilities may enable hospitals to shorten the LOS which explains the lower LOS in this study as well as the association of higher proportions of over-skilled workers with lower LOS. It may also be that Class A & B hospitals they may also charge higher fees for their services which increase their revenue.

Another plausible explanation is available for the shorter LOS, although it is not as encouraging as the above explanation. Class A and B hospitals may act as referral hospitals for neighbouring districts with lower hospital classes - or even the whole province, in the case of Class A hospitals. Referral hospitals then have more patients to attend to, and these usually need beds due to their illnesses. Therefore, these referral hospitals need to act effectively to heal the patients to make beds available for future patients. They may also advise the in-patients to become outpatients once their health has improved reducing the real length of stay needed by inpatients. This policy may also shorten the LOS. However, shorter LOS may increase the cost per day, have adverse effects on the health outcomes, and impair patient recovery process (OECD, 2013).

The existence of performance-related pay seems to lead to better performance as hospitals having a performance-related pay are also associated with higher revenue per bed and lower LOS. However, these results shall be cautiously interpreted since

the performance-related pay system in these hospitals is merely an incentive system based on service fees. It is plausible that hospital employees are keen to have more inpatients as this can increase the service fees they receive in addition to their salaries. It is common in developing countries that salaries of civil servants are low (Berman and Cuizon, 2004; Rokx et al., 2009a). As civil servants in East Javan public hospitals, particularly for those in big cities, their salaries are possibly in par with the district minimum wage (Government Regulation, 2013). Thus, any additional income is greatly valued for their living. Civil servants receive annual salary increases according to the government regulations with an extra increase in case of rank promotion or additional years of service. Both salary increases and rank promotions occur automatically regardless of employee performance (Government Regulation, 1977).

Higher proportions of matched-skill workers are associated with lower expenditure per bed and lower revenue per bed, whilst higher proportion of over-skilled workers is associated with shorter LOS. Those skilled workers may be able to do their jobs efficiently, which may reduce the hospitals' expenses and the length of stay. For example, skilled nurses may be less likely waste disposable medical materials when they treat patients; supporting staffs may do their work in a timelier manner to avoid unnecessary additional costs. However, they may absorb some of the revenue by receiving service fees for their performance. These service fees come from the patients' payments. Patients' payments may not reflect the real cost of services, not to mention an adequate margin for the hospital as part of the cost is not borne by the hospital (i.e. investment of the updated facilities or salaries - see Chapter 1). In addition, hospital management seems to run the hospital without the proper preparation or training offered by local government (Heywood and Choi, 2010). The hospital management are left to their own devices to capitalise on their new responsibility and capability as they only do what they know from the time of their hire by the hospital. In addition, they have restricted decision space compared

to what may have encountered in the era of decentralisation in particular with regard to setting the fees which is subject to local government approval (Maharani et al., 2014).

Learning by doing gives an opportunity for future leaders to develop their leadership skills (Mumford et al., 2000) as they go through the learning curve (Hirst et al., 2004). New leaders have considerably more to learn, so they have steeper learning curves than the experienced leaders, who tend to experience an incremental addition to the knowledge and skills they have already acquired (Hirst et al., 2004). Judging from this evidence, the leader learning process may be costly in terms of both resources and time not only for hospitals, but also for the health system as whole. Performance inequality of hospitals may persist if every hospital must take this path of learning for each of its leaders. Local governments can assist this process by preparing and installing a leadership development program and providing training opportunities in hospitals to generate prepared future leaders in time as leadership skills need experience and time to develop (McCall, 2004; Mumford et al., 2000). Such an initiative should be implemented soon as these directors are mostly older than 51 years (63.4%), while the retirement age for civil servants is 60 years (Republic of Indonesia, 2014).

Other than the findings, the use of one of the indicators for vertical social capital and job satisfaction may be problematic. According to Borsboom (2008), all variables should be latent until proven observed, particularly in psychology and the social sciences. In the case of an observed variable, researchers assume the variable structures to be fully accessible, which assumedly makes it possible to make error-free inferences from data to variable structure. However, it may be difficult to judge whether the variable, or in this case the indicator, is the only one that produces variation in data patterns. When these assumptions are violated, then the interpretation of the data may be prone to error.

However, previous studies in Britain have used the indicators of social capital

and job satisfaction as their variables. Brown et al. (2013) used the indicators of vertical social capital as measures of trust by putting them in the models one at a time. Jones et al. (2009) used the satisfaction indicators individually in their analysis. Both studies found a sound interpretation of the data. Although those studies did not use multilevel SEM models, they are encouraging to the pursuit of this study.

8.5 Conclusion

This chapter investigates the associations of social capital, job satisfaction and workplace performance. There are two types of social capital, vertical and horizontal, and also two types of workplace performance in this analysis: objective and subjective measures. The objective workplace performance measures include revenue per bed, expenditure per bed, LOS, and BOR, all of which are common measures of performance in the healthcare industry. I find vertical social capital to be associated with lower expenditure per bed, which partially confirms that vertical social capital has associations with better workplace performance in the healthcare industry. It is plausible that managers in the hospitals use their power by showing concern toward their workers to manage workplace performance as workers feel obligated to do what their leaders ask in Indonesia. However, the association also gives evidence that the focus of the leaders is still on expenditure instead of other measures which reflect the situation before the decentralisation.

Nevertheless, I fail to find support for the associations between horizontal social capital, job satisfaction and better workplace performance as the associations are non-significant. In particular, there are no significant associations between social capital and job satisfaction with all subjective measures. This finding may underline the difficulty of assessing workplace performance using subjective measures in developing countries due to unavailability of data for every leaders or due to inadequate capacity of hospital leaders.

Despite the value of its findings, this study has limitations. First, this study does not use a full model with three latent variables (vertical and horizontal social capital and job satisfaction) due to the limited observations. Future research should attempt to have larger samples to apply the full model, which might enable a more precise interpretation of the relationships. Second, the subjective measures of workplace performance are treated as continuous variables; in the future, however, they should be treated as categorical variables. Third, another limitation is the findings are found among Indonesian public hospitals. As healthcare is provided by public-private mix, the results need to be cautiously used. There are differences between public and private hospitals in Indonesia. Most likely they have different management styles like other private institutions (Suryani et al., 2012). As they have their own funding, they have more freedom in setting the pay system and investments than those in public hospitals. However, some of their health workers may also serve as civil servants. Lastly, their workplace size may not be as big as that of a public hospital in terms of number of beds which require fewer workers. Further research may include: 1) private hospitals to have a comprehensive understanding on the associations and 2) more districts (provinces) to refine the results. The non-significant results on workplace performance measures opens a new avenue of research on the appropriate workplace performance measure for developing countries as the present measures may not capture the real performance in hospitals.

The results of this study have some implications for both hospital management and local governments. Hospital management may look into the positive relationships of several workplace characteristics with better objective workplace performance to improve the hospital. Higher hospital class is associated with both higher revenue per bed and lower LOS and so does the existence of performance-related pay. One must be cautious in generalising these findings, because it is likely that the performance-related pay mentioned takes form of an incentive by means of service fees rather than the more common method of performance-related pay. Suitable per-

formance appraisal and promotion systems for civil servants are needed to improve individual performance, thus improving workplace performance. Having a higher proportion of employees who are over-skilled for their jobs is associated with lower LOS as these employees may be more capable of giving patients proper treatment. However, the policy is needed to maintain these over-skilled workers' performance as regular promotion may not soon enough to appreciate their professional expertise: regular promotion usually comes every four years for civil servants, which may be too infrequent to help maintaining these workers' performance. Enriching their jobs by increasing responsibilities and developing skills, without increasing the workloads, may be one of several possible solutions.

As local governments became responsible for healthcare provisions after decentralisation in 2001, local governments need to involve themselves more in efforts to expand the capacity of employees in their public hospitals, with particular regard to performance and people management. This study may provide evidence that the hospital management may still focus of expenditures instead of other workplace performance which represents the pre-decentralisation condition. This focus needs to be realigned if public hospitals are to achieve more balanced and better performance. Local governments may continuously monitor public hospital performance within their authorities to evaluate the capability of hospital management before establishing a development programme (including financial management) for hospital management and employees. Local governments may collaborate with the Ministry of Health or private institutions for delivering this programme. Further, local governments may also provide hospital management with knowledge and training for human resource practices. Local governments can also suggest and develop a suitable performance appraisal for hospital employees.

These efforts may not be conducted in isolation. Local governments of neighbouring districts can work together to prepare their hospital employees, so that the levels of professionalism and skills among hospital employees become more equal. Local

governments may consider partnering between districts to accelerate the learning process between higher class hospitals and lower class hospitals. This approach may save money for disadvantaged districts in East Java as well as equate the quality of health services within the province.

Chapter 9

Conclusions

9.1 Introduction

This thesis has investigated the relationships between workplace social capital, job satisfaction and workplace performance in both developed and developing countries. The links between the variables had been revealed in developed countries in greater depth as most of the studies took place in those countries. Based on the premise that research in one context or a country may not be applicable in others, Britain and Indonesia, two contrasting countries, were selected as focal points in this thesis.

First, the two countries differ quite obviously in terms of their economies. Britain is considered a developed country, while Indonesia is a developing country (World Bank, 2014b). Second, Britain and Indonesia have very different cultures (Hofstede et al., 2010), a fact that may influence workers' behaviours (Ng et al., 2009) in each country. Britain is recognised as an individualist, assertive society with relatively more equal distribution of power, while Indonesia's culture emphasises individuals' loyalty to a group, harmonious relationships with others and strictly hierarchical power distribution. Third, in the area of international management, Britain is one of the countries most often studied, while studies on Indonesian organisations are still few (Tsui et al., 2007). The availability of data may explain these contrasting conditions. Britain and Europe have regularly collected data on working conditions (including workers) over the past thirty years, with the most recent data available

from 2011 (Britain) and 2010 (Europe) capturing the conditions under the recent economic crisis. Indonesia, however, has no such data available and is thus less frequently studied than, for instance, China or India. Furthermore, Indonesia suffers from inequality of health worker distribution, a situation that is common among developing countries (Kolstad, 2011; Lori et al., 2012; Raha et al., 2009a, see for example).

The investigation undertaken for this thesis was divided into two parts. The first part examined the relationships between workplace social capital and job satisfaction in Europe, Britain and Indonesia. The second part studied the relationships between workplace social capital, job satisfaction and workplace performance in Britain and Indonesia. The research questions for the study were:

- Does workplace social capital affect job satisfaction (and well-being)?
- What is the relationship of social capital, job satisfaction and workplace performance?
- How do individual characteristics differ in determining job satisfaction in developed and developing countries?
- How do the contexts of organisations in developed and developing countries differ in determining the relationship of social capital, job satisfaction and workplace performance?

This concluding chapter summarises the findings for each research question, posits the implications of those findings and states the limitations of this thesis; it also proposes directions for future research.

9.2 Findings

Does workplace social capital affect job satisfaction? Using the latest data from Europe, Britain and Indonesia, this thesis shows that workplace social capital

is significantly associated with higher levels of job satisfaction in developed and developing countries (Chapters 4, 5 and 6). Other than that, the findings in Europe and Britain give evidence of the relationships in times of crisis. The findings show that workplace social capital enables better interaction between workers and their superiors which may influence their expectations of their jobs and in turn affect their levels of job satisfaction. Better interaction may also evoke a more pleasant working atmosphere and better communication among the workers; superiors may also be able to show more support for the employees, thus increasing workers' job satisfaction. Additionally, workers may receive emotional support from their colleagues to relieve the stress inherent in performing and keeping their jobs (Helliwell et al., 2014) especially in times of crisis like in Britain and Europe.

Workplace social capital is differentiated into vertical and horizontal social capital in the Indonesian study. As almost all Indonesian respondents are civil servants working in a government institution where norms and roles are well-defined, employees in a country like Indonesia may perceive their leaders as father figures; who are knowledgeable and to whom they should defer (Setiadi, 2007; Shiraishi, 1996; Suryani et al., 2012). In return, leaders may show compassion and ensure the welfare of their employees, which leads to increased job satisfaction among those employees. On the other hand, horizontal social capital reflects adherence and acceptance by the group in the workplace; as such, acceptance improves job satisfaction in a country like Indonesia. Evidence from Indonesia and Britain also confirm that social capital enhances one's identity and sense of recognition through social relations (Lin, 2001).

What is the relationship of workplace social capital, job satisfaction and workplace performance? To answer this question, Chapters 7 and 8 used objective and subjective performance measures in Britain, both in general and with regard to the healthcare industry, and in Indonesia. The results show that workplace social capital, particularly vertical social capital, has a significant positive association with financial performance in Britain and in Indonesia. As for British

industries in general, workplace social capital may be a result of the intense working relationships in smaller workplaces in Britain; these continue to be common as shown by WERS2011, which demonstrated that most of British workplaces are small and medium enterprises. Therefore, it seems that workplace social capital is already at high levels in British workplaces. The existence of abundant social capital may assist workplaces to maintain their performance levels, fostering understanding among workers when management must take actions in response to a difficult situation such as economic crisis.

However, the association between workplace social capital and workplace performance is not found in a female-dominated industry, the healthcare industry in Britain. Females tend to use their social relations to obtain support (Argyle, 2001) and more prone to punish their workplaces if they feel that there has been a breach in their contracts (Croson and Gneezy, 2009). As management took actions in times of crisis, female workers may see those actions as breach and their job expectations remain unfulfilled. These unfulfilled expectations may then have a negative effect to workplace performance.

Turning to Indonesia, the positive association between vertical social capital and workplace performance is also limited to a particular objective measure: lower expenditure per bed. Public hospitals in Indonesia have experienced several reforms and most of public hospitals now have more authority to manage their finances, human resources and procurement; however, on the whole, operating routines remained unchanged. This finding may highlight the existence of selective perception - which hinders the organisation from changing if leaders choose only the relevant goals or procedures for themselves - or their lack of preparation to adapt to the change.

Although high levels of social capital may help maintain workplace performance, the evidence shows that job satisfaction does not necessarily lead to improved workplace performance both in developed and developing countries for different reasons.

In developed countries such as Britain, surviving employees may feel relieved that they still have their jobs; one-third of British workplaces admitted implementing redundancies and one-fifth froze their recruitment in responses to the economic crisis. However, these surviving employees then may suffer from excessive workloads, particularly, in high performance workplaces, as they become responsible for doing the jobs of their missing colleagues. With approximately one-fifth of British workplaces having changed their work organisation between 2009 and 2012, employees may feel dissatisfied about their jobs. This results in demotivation, which lowers individual performance and may in turn lead to poor workplace performance. In a developing country like Indonesia, the non-significant association between job satisfaction and workplace performance suggests that public hospitals in Indonesia are very bureaucratic and that relationships with leaders are considered more important than relationships with colleagues, hence the horizontal social capital failed to have any association with workplace performance. Moreover, the fact that most employees are civil servants who attain regular promotion regardless of their individual performance may cause the separation between job satisfaction and workplace performance.

How do individual characteristics differ in determining job satisfaction in developed and developing countries? Several individual characteristics show similarities and dissimilarities in their associations with job satisfaction in Britain and Indonesia. Workers in Britain and Indonesia value training opportunities offered in their workplaces. Having training in the previous twelve months is associated with higher levels of job satisfaction in both countries. Training opportunities are perceived as a signal for further career advancement and workplaces' concern for the employees. These results confirm previous findings in both developed and developing countries.

Contrasting results in Britain and Indonesia are found in the relationship between gender and higher-skilled workers with job satisfaction. Being female is associated

with higher levels of job satisfaction in Britain and Europe, while female workers in Indonesia experience lower levels of job satisfaction. This contrasting result may be due to the position of women in the labour market and their responsibility at home. Female workers in developed countries experience higher levels of job satisfaction as they have previously poor position in the labour market which determines their low level of job expectation. In addition, women in developed countries search for jobs that accommodate their responsibilities at home. On the other hand, female workers in developing countries, like Indonesia, may experience limited promotional opportunities in the labour market as they may not be able to choose jobs that accommodate their responsibility at home. Although these female workers may be able to advance their careers, they may choose not to for the sake of their domestic responsibility. This condition may damage their job satisfaction.

Regarding the skills of the workers, workers that possess higher skills than their jobs require show contrasting effect on job satisfaction in developed and developing countries. Over-skilled workers in developed countries are associated with lower levels of job satisfaction, while those workers in developing countries show higher levels of job satisfaction. Allen and van der Velden (2001) found that skill mismatches impairs job satisfaction and leads to initiative for job searching. Skill mismatches may transfer into wage differentials experienced by the workers. Although they have more skills, the rewards they receive may not sufficient as they have lower jobs and they may not have the achievements they want. In addition, high unemployment in Britain will not allow them to search for new or other jobs as job opportunities are limited. This condition may lead to job dissatisfaction among those over-skilled workers in developed countries.

Turning to Indonesia, over-skilled workers are found to have higher levels of job satisfaction. This evidence suggests that those workers may use their skills to work effectively in the hospitals. Being able to work effectively may be associated with higher opportunities to earn and career advancement. They may be able to handle

more patients (for doctors and nurses) or they can leave on time for their private practices which results in higher rewards as hospitals commonly apply incentives systems. In addition, they may have the opportunities to advance in their careers once the promotion opportunities arrive.

How do the contexts of organisations in developed and developing countries differ in determining the relationship of social capital, job satisfaction and workplace performance? Using the results from healthcare industries in Britain and Indonesia, several characteristics show similarities and dissimilarities in determining the relationship between social capital, job satisfaction and workplace performance. As mentioned above, workplace social capital is found to be associated with better workplace performance in this study, while job satisfaction failed to do so. The existence of performance-based systems in Britain and Indonesia are associated with improved performance, for example better financial performance and lower absenteeism in Britain and higher revenue per bed and lower LOS in Indonesia. This evidence suggests that monetary rewards still have positive influence on workers' motivation in both developed and developing countries. This may related to the fact that workers in Indonesia may not have sufficient salaries, while workers in Britain may experience hardship because of the economic crisis.

Another characteristic that show similar results in Britain and in Indonesia is the effect of workplace size on workplace performance. Larger workplaces are associated with higher financial performance in Britain, while larger workplaces in Indonesia (measured by the hospital class) are associated with higher revenue per bed and lower LOS. Larger workplaces may have more resource and capable workers to handle more patients, resulting in higher financial performance in this industry. Indonesian public hospitals which have higher class are associated with better resource, skilled workers and better facilities which enable them to offer high quality healthcare and charge higher fees for their patients. However, larger workplaces is also prone to higher absenteeism as evidenced in Britain.

Skills of the workers in the health care industries in Britain and Indonesia show both similarities and dissimilarities regarding their effects on workplace performance. Workers who have skills exactly as their jobs require are associated with lower financial performance in Britain and in Indonesia. While those with skills beyond their job requirements are associated with lower financial performance in Britain, in contrast to their association with lower LOS in Indonesia. The contrasting associations between workers' skills and workplace performance may owe its explanation to the economic conditions and other unobserved factors. As Britain was experiencing economic crisis when the data is collected, those workers who have skills matched with their job requirements may not feel motivated to work as their workplaces freeze the pay and recruitment in response to the economic crisis and also change the organisation of work. Consequently, their workloads may have increased due to the organisational change, and they have received no increase in their rewards. These unfavourable conditions may damage individual performance, which may lead to poor workplace performance. As mentioned above, over-skilled workers may get higher salaries; however, their salaries may be too costly for workplaces as revenue may slow down due to the economic crisis.

Turning to Indonesia, a similar explanation may hold for workers with skills that match their jobs requirement. However, those with skills beyond their jobs are associated with better workplace performance. Workers who have higher skills than their jobs require shorten the LOS in hospitals. This evidence suggests that workers with better skills may offer high quality work for hospitals and their skills contribute to effective treatment for the patients which may cut the length of in-patient care without damaging the quality.

Table 9.1: Overview of results on studies between workplace social capital, job satisfaction and workplace performance

Chapters	Workplace social capital	Job satisfaction	Workplace performance	Results
Chapter 4: Workplace social capital and well-being of workers across Europe in times of crisis	Best friends at work	Overall job satisfaction		⊕
Chapter 5: Workplace social capital and job satisfaction in Britain	Vertical social capital: trust, honesty, sincerity, fairness	Satisfaction with achievement, influence, initiative, skill development, work itself		⊕
Chapter 6: Workplace social capital and job satisfaction in Indonesia	Vertical social capital: kind, concern, trust Horizontal social capital: acceptance, idea development, togetherness, do the best	Satisfaction with influence, initiative, achievement		⊕
Chapter 7: Workplace social capital, job satisfaction and workplace performance in Britain	Vertical social capital: trust, honesty, sincerity, fairness	Satisfaction with achievement, influence, initiative, skill development, work itself	Financial Productivity Quality Absenteeism Financial Productivity Quality Absenteeism	⊕ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊕ ⊖
1) general industry				

Continued on the next page

Table 9.1 – continued from the previous page

Chapters	Workplace social capital	Job satisfaction	Workplace performance	Results
2) healthcare industry	Vertical social capital: trust, honesty, sincerity, fairness	Satisfaction with achievement, influence, initiative, skill development, work itself	Financial Productivity Quality Absenteeism Financial Productivity Quality Absenteeism	⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖
Chapter 8: Workplace social capital, job satisfaction and workplace performance in Indonesia	Vertical social capital: concern		Financial Productivity Quality Revenue\bed Expenditure\bed LOS BOR	⊖ ⊖ ⊖ ⊖ ⊕ ⊖ ⊖
	Horizontal social capital: acceptance, idea development, togetherness, do the best		Financial Productivity Quality Revenue\bed Expenditure\bed LOS BOR	⊖ ⊖ ⊖ ⊖ ⊕ ⊖ ⊖
		Satisfaction with initiative	Financial Productivity Quality Revenue\bed Expenditure\bed LOS BOR	⊖ ⊖ ⊖ ⊖ ⊖ ⊖ ⊖

Notes: ⊕ hypothesis supported; ⊖ hypothesis rejected

Turning to other contextual characteristics, the evidence from results in Britain confirms that workplaces impacted by the economic crisis are associated with lower financial performance as expected. Workplaces still need to keep workers at least at a minimum to be able to operate; however, since the economy slows down the revenue may not be as high as in the normal condition. Whilst having an experienced director is not significantly associated with better workplace performance in Indonesian public hospitals which may question the role of leadership and whether a learning curve exists in the government institutions such as public hospitals.

Table 9.1 shows the resulting associations in this research. Vertical social capital is associated with job satisfaction in developed countries, while both vertical and horizontal capital have positive associations with job satisfaction in developing countries. On this note, it is similar to the hypothesized association in the framework of this study. However, the association between workplace social capital, job satisfaction and workplace performance show differently between industries and economies. Only vertical social capital has positive association with workplace performance in developed and developing countries. The associations are established for general industry in developed countries and public hospitals in developing countries. This study failed to establish the associations for both vertical social capital and job satisfaction with workplace performance in healthcare industry in developed countries. Similarly, horizontal social capital and job satisfaction are not associated with workplace performance in developing countries.

These unsuccessful associations may raise questions. Why workplace social capital and job satisfaction are not associated with workplace performance in healthcare industry in both countries? Workplace and individual characteristics may play their roles in these results. As workplace characteristics may influence both job satisfaction and workplace performance, it may also influence the social relationships in the workplace. This influence is neglected in the framework of this study. In addition, individual characteristics are excluded when analysing the associations

between workplace performance, job satisfaction and workplace performance. These exclusions may contribute to the failed associations.

Although previous studies use the healthcare industry, the measurement of workplace performance may pose a challenge in this study. The use of general subjective measures may not be suitable for the industry; hence, the workplace measurement may not capture the real performance. As explained before in Chapter 3, there are different measures requested by stakeholders for hospitals in Britain. These various performance measures may not be able to be adjusted when the managers are asked to assess using subjective measures such as productivity. The results from the developing countries may echo this assumption as the associations are found using the objective measures. As for the developing countries, public hospitals may not be the best workplace for this study as it is hierarchical and bureaucratic. Future research should attempt to investigate the relationships between horizontal social capital, job satisfaction and workplace performance in developed and developing countries by collecting data on relationships between coworkers (in developed countries) and in the private sector (in developing countries).

9.3 Implications

The findings of this thesis have made several contributions to the literature and can be of use to policy makers in both developed and developing countries.

9.3.1 Contributions to the literature

Using data collected in a time of economic crisis, workplace social capital has been found to significantly improve both well-being and job satisfaction in developed countries. Job aspects such as career advancement opportunities, desiring to do one's best and having a well-paid job are significant in determining job satisfaction and well-being of workers. Although previous research has found similar aspects to

affect job satisfaction under normal economic conditions, this finding enriches the evidence relating to times of crisis.

In contrast to the similar influence of job aspects on both well-being and job satisfaction, this thesis has shown that different activities outside work have different relationships to well-being and job satisfaction; this signifies a difference between general and domain-specific well-being. Sporting, gardening and cultural activities contribute significantly to higher well-being, while participating in training contributes to higher job satisfaction. However, caring for elderly relatives diminishes both well-being and job satisfaction.

This thesis also adds to evidence of the existence of the survivor effect in times of economic crisis in Europe. Being employed significantly improves workers' well-being in times of crisis as they compare themselves to the unemployed, yet staying on in their organisations lowers workers' job satisfaction since they suffer from increased workloads and the loss of their colleagues. In Britain, too, lower job satisfaction is confirmed when investigated using recession-related characteristics such as redundancy, industrial unemployment and whether the workplace is impacted by recession or not.

As for developing countries, this thesis, using public hospitals as the sample, contributes to the literature on the associations of both vertical and horizontal social capital with job satisfaction. The findings enrich the body of knowledge with regard to the association of social capital and job satisfaction in developing countries as both vertical and horizontal social capital are positively related to job satisfaction. Although individual differences account for the largest share in the relationships, the association between vertical social capital and job satisfaction is more influenced by workplace differences than is the association between horizontal social capital and job satisfaction. This result yields the insights that leadership style and type of organisation may determine workplace social capital in developing countries.

Turning to workplace performance, this thesis partially charts the relationships

between workplace social capital, job satisfaction and workplace performance both in developed and developing countries. Workplace social capital and job satisfaction are associated with better workplace performance in developed countries using subjective performance measures such as financial results and quality of product and service. Whilst in the developing countries, the association is only found between workplace social capital and workplace performance using objective measures. This may account for the differences in managers' knowledge of, familiarity with, access to information and the sectors investigated in developed and developing countries.

9.3.2 Policy makers

In developed countries Given that training opportunities are associated with higher levels of job satisfaction, policy makers in developed countries should maintain the attractiveness of a job even in times of crisis by providing these particular paths to career advancement. The abovementioned finding may justify the provision of training opportunities in developed countries in a way that is beneficial for both employees and workplaces. Policy makers may also wish to set work arrangements that enable workers to pursue their training and to fulfil their family obligations in order to improve workers' well-being and job satisfaction.

Policy makers also need to consider sector and workplace size when designing work units or hierarchies; working in the public sector showed mixed results for job satisfaction in Europe and Britain, while working in a large workplace is negatively associated with job satisfaction in Britain. Therefore, policy makers for workplaces in the public sector or those that are larger in size should be aware that a significant and positive relationship exists between workplace social capital and job satisfaction showing that trusting relationships with superiors affects the well-being of employees. The hierarchy or organisational structure of a workplace should enable the development of trusting relationships. More importantly, these relationships can only be cultivated by trusted superiors, a fact which may encourage workplaces to

invest in social capital (Cohen and Prusak, 2001; Ellinger et al., 2013). Doing so can enable superiors to maintain trusting relationships with workers and enable firms to retain those superiors. In addition, less-rigid and less bureaucratic workplaces allow more freedom and empowerment for the employees, which may enhance their job satisfaction.

When workplaces experience the pressure of a crisis, it may be unavoidable to reduce the number of employees to a minimum, however, management must maintain good communication and preparation for both departing and remaining employees as the changes in the workplace may impair workers' well-being. Failure to communicate with and prepare the employees may worsen workplace performance as such actions are perceived by employees as a breach of the psychological contract.

In developing countries For the developing country of Indonesia, this study has implications for policy makers at the levels of hospital and local government. At the hospital level, training opportunities and continuing education for the employees should be properly arranged and evaluated as managers can use training to motivate their workers rather than the promise of additional income. As a follow-up to training, management should illustrate a clear link between the training received and opportunities for workers' career development. Moreover, workers with higher skill levels are associated with reducing LOS which contributes to performance in public hospitals. As regular promotion may be infrequent for these workers, job enrichment may provide an intermediary solution to maintain their motivation. All employees in public hospitals need more suitable performance appraisals and promotion systems to prevent demotivation.

Considering the effects of the policies taken at the hospital level, local governments need to become more involved in efforts to expand the capacity of employees in their public hospitals, with particular regard to human resource management and workplace performance. Given that the development of leadership skills takes time and requires experience (McCall, 2004; Mumford et al., 2000), local governments

may wish to take inventory of human resource practices in the public hospitals and provide necessary development programmes for future management and directors in order to ensure availability of prepared leaders when they are needed. Such an initiative should be implemented as soon as possible as most current directors are older than 51 years (with 60 being the age of retirement).

The central government institution known as LAN may offer managers and directors of public hospitals training as civil servants. However, local governments may take a more active approach by understanding and evaluating the performance of those leaders in public hospitals to give feedback to LAN or supplement the training. This thesis demonstrates that good human resource practices are essential for the managers and directors so that they may succeed in their work on behalf of their employees. It is necessary for those leaders to understand the future directions of public hospitals so that the hospitals can achieve more balanced performance.

9.4 Limitations

Although this thesis yields interesting findings and important implications, several limitations in this study may lead to the desire for future research on this topic.

A cross-sectional study This thesis uses data from Europe, Britain and Indonesia in certain years which may limit the possibility of interpreting those data, and no causality can be inferred. To achieve a more rounded perspective of the effect of economic crisis, for example, future studies must include data from before the crisis.

The use of subjective workplace performance measures Due to data availability, this study used more subjective than objective workplace performance measures in its consideration of Britain. Although previous studies in Britain (Brown et al., 2013; Jones et al., 2009; de Menezes, 2012; Wood et al., 2012) inspire confidence in doing so, early assessment of those measures (Forth and McNabb, 2008;

Wall et al., 2004) has found that managers' familiarity with the measures is crucial to be able to respond to the questions about workplace performance in the survey. In addition, Mezas and Starbuck (2003) found that relying on subjective workplace measures may lead to inaccurate results due to the existence of a single source of assessment. In the case of Indonesia, the use of subjective performance measures may have caused difficulty for the hospital managers as results there tend to be drawn from objective performance measures such as revenue or expenditure per bed. Managers may therefore not be familiar with the subjective indicators; they may also be unable to answer because they have less access to information in comparison to their colleagues in developed countries.

Treatment of workplace social capital and job satisfaction variables Both workplace social capital and job satisfaction are multidimensional constructs (Oksanen et al., 2010; Spector, 1997). They are measured on a Likert-scale in this thesis, which may signify that they are more appropriately treated as categorical variables. However, they are treated in this thesis as continuous variables. Ferrer-i-Carbonell and Frijters (2004) found that measures of happiness differ little when treated as ordinal or cardinal measures. In addition, vertical social capital and job satisfaction are only represented by one dimension in the developing countries when investigating the associations between workplace social capital, job satisfaction and workplace performance.

Limited data from Indonesia The data from developing countries in this thesis comes from one province in Indonesia and from a specific type of workplace: the public hospital. This data may limit the generalisation of the findings for other industries. However, previous research has also used data from the health industry to pioneer the study of certain topics (Vokurka and O'Leary-Kelly, 2000), and studies exploring workplace social capital do generally begin with the public sector (Leana and Pil, 2006; Ostroff, 1992). As it is rare for data from diverse industries in a

developing country like Indonesia to be available, this single province, single industry study was the most realistic choice for this thesis project.

Nature of respondents in Indonesia Most Indonesian respondents are civil servants. As such, they may consider their superiors' feelings when completing questionnaires: maintenance of harmony in relationships, especially in a government institution, is important for career advancement. This fact was anticipated and addressed in this study by distributing and collecting the questionnaires directly to and from the employees; respondents were assured that their answers would not be checked or passed to their superiors and that their questionnaires would remain anonymous. These precautionary actions were intended to prevent the respondents from fearing the reactions of their superiors. However, the results may suggest that those actions may not completely eliminate the fear.

9.5 Directions for future research

Future research on this topic should consider the abovementioned limitations and expand the understanding in both developed and developing countries. With this in mind, the first avenue is to use more data from different years in the study. A longitudinal study then may be more appropriate to search for causality in the relationship between workplace social capital, job satisfaction and workplace performance. In addition, a longitudinal study would help explain the effect of crisis in developed countries.

The second avenue involves more data collection in developing countries. Data from the private sector in the analysis may provide a more rounded perspective on Indonesian working relationships as workers in this sector are considered more open and egalitarian than those in the public sector (Suryani et al., 2012). Furthermore, managers in the private sector are potentially more knowledgeable on their workplace performance measures as they have those measures as their performance indicators.

Those conditions may assist researchers in this kind of study. Future research should also expand into different industries to ensure the generalisability of the results. As this study only collect data from one province in Indonesia, future researchers may also wish to collect more data from different provinces in Indonesia to capture the diversity of the country in economic, social and development perspectives.

The third avenue of research should attempt to use objective workplace performance measures for studies in developed and developing countries. The British study may use data available from the Financial Performance Questionnaire in WERS2011 in order to ensure more accurate and bias-free measures. This would also yield evidence from another specific industry, as those objective measures are largely for the trading industries. The use of objective measures specific to the industry is also encouraged in future studies involving developing countries as it may eliminate ambiguity for the respondents.

The fourth avenue of research may extend the methodology applied in this research. Rather than treating the workplace social capital and job satisfaction as the continuous variables, future research may consider to treat both variables as categorical variables and use multilevel SEM with item response theory approach as workers are nested within their workplaces. Another extension may take account inequality between regions within a country. Regions may influence one another and may affect job satisfaction and workplace performance in neighbouring regions. The spatial multilevel modelling can be used to investigate such effect in a diverse country such as Indonesia and also in a developed country like Britain which still has inequality gaps among its regions. Both approaches may enrich the literature and help the policy makers in governing regions and countries.

Other than charting the relationships between workplace social capital, job satisfaction and workplace performance, this thesis has given more evidence on the similarities and dissimilarities between developed and developing countries using data from a less studied country (Indonesia). This type of comparative study should con-

tinue to investigate workplace-related topics capturing diverse contexts. In addition, this kind of study may motivate scholars to collect data and to investigate under researched countries in order to contribute to the body of knowledge and policy making.

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Appendix A

Questionnaires for Indonesia (in Indonesian language)

A.1 Hospital characteristics

Pengaruh korporatisasi dan modal sosial di tempat kerja terhadap motivasi dan kepuasan karyawan serta kinerja rumah sakit umum daerah di Jawa Timur
The University of Manchester, United Kingdom

Kuesioner ini terdiri dari beberapa bagian yang semuanya perlu diisi selengkap mungkin.

Untuk mengisi kuesioner ini:

- Gunakan tinta biru atau hitam untuk menulis.
- Beri tanda (✓) pada kotak yang relevan sesuai dengan instruksi dalam pertanyaan.
- Isilah titik-titik dengan huruf cetak untuk menjawab pertanyaan.

Terimakasih atas kerjasama Anda.

Karakteristik umum rumah sakit

- 1. Apakah kegiatan utama rumah sakit ini? Harap jelaskan selengkap mungkin.**

- 2. Apakah status rumah sakit ini? Beri tanda (✓) pada satu kotak saja**

- Swadana
- Badan Layanan Umum
- Lainnya, sebutkan _____

- 3. Sejak tahun berapa rumah sakit ini memiliki status tersebut diatas? Tahun _____**

- 4. Apakah status kepemilikan rumah sakit ini? Beri tanda (✓) pada satu kotak saja**

- Pusat
- Propinsi
- Kabupaten/Kotamadya
- Instansi pemerintah lain (contoh: PT Perkebunan)

- 5. Berapa banyak jumlah seluruh karyawan di rumah sakit ini? Beri tanda (✓) pada satu kotak saja**

- hingga 149 orang
- 150-249 orang
- 250-499 orang
- 500-749 orang
- 749-999 orang

- 1.000-1.499 orang
- 1.500-1.999 orang
- 2.000-2.499 orang
- 2.500-2.999 orang
- lebih dari 3.000 orang

6. Berapa lama rumah sakit ini telah beroperasi, termasuk jika pernah berada/menggunakan alamat lain? *Beri tanda (✓) pada satu kotak saja*

- kurang dari 10 tahun
- 11-19 tahun
- 20-29 tahun
- 40-49 tahun
- 50-59 tahun
- lebih dari 60 tahun

7. Hal apa saja yang terjadi pada tempat kerja ini dalam 2 tahun terakhir? *Beri tanda (✓) pada semua kotak yang relevan*

- Perubahan nama
- Perubahan alamat
- Perubahan kegiatan
- Perubahan status hukum
- Perubahan kelas
- Bukan hal-hal tersebut

8. Apa pendapat Anda terhadap pernyataan-pernyataan berikut? *Beri tanda (✓) pada satu kotak saja pada setiap barisnya*

Pernyataan	Sangat setuju	Setuju	Ragu-ragu	Tidak setuju	Sangat tidak setuju
Keseimbangan antara tanggungjawab keluarga dan pekerjaan tergantung pada masing-masing karyawan					
Kami tidak membuat perubahan tanpa mendiskusikan implikasinya lebih dahulu dengan para karyawan					

9. Apakah rumah sakit ini memiliki misi? Ya Tidak

10. Bila jawaban pertanyaan diatas YA, apakah misi rumah sakit meliputi hal-hal dibawah ini? *Beri tanda (✓) pada semua kotak yang relevan*

- masyarakat yang menjadi sasaran pelayanan
- jenis pelayanan kesehatan yang ditawarkan
- perubahan program rumah sakit
- peningkatan kualitas
- bukan semuanya

11. Apakah rumah sakit ini memiliki tujuan jangka panjang? Ya Tidak

12. Bila jawaban pertanyaan diatas YA, apakah tujuan jangka panjang rumah sakit meliputi hal-hal dibawah ini? *Beri tanda (✓) pada semua kotak yang relevan*
- peningkatan layanan kesehatan
 - peningkatan kinerja keuangan
 - peningkatan jumlah kerja sama dengan instansi lain
 - penyelenggaraan sarana layanan baru
 - bukan semuanya
13. Apakah rumah sakit ini memiliki tujuan jangka pendek? Ya Tidak
14. Bila jawaban pertanyaan diatas YA, apakah misi rumah sakit meliputi hal-hal dibawah ini? *Beri tanda (✓) pada semua kotak yang relevan*
- peningkatan kualitas layanan kesehatan
 - penurunan lama waktu tunggu
 - rasionalisasi penggunaan sumber daya dan fasilitas
 - peningkatan *cost recovery rate*
 - peningkatan keahlian sumber daya manusia
 - bukan semuanya

Pimpinan rumah sakit

15. Direktur rumah sakit ini seorang: laki-laki perempuan
16. Usia Direktur rumah sakit ini: *Beri tanda (✓) pada satu kotak saja*
- kurang dari/sama dengan 30 tahun
 - 31 sampai 40 tahun
 - 41 sampai 50 tahun
 - lebih dari 51 tahun
17. Tingkat pendidikan terakhir Direktur rumah sakit ini: *Beri tanda (✓) pada satu kotak saja*
- S1 Kedokteran umum/gigi
 - Sarjana (S1) pada bidang lain
 - Pasca Sarjana (S2) Manajemen/Administrasi Rumah Sakit
 - Pasca Sarjana (S2) Bidang lain
 - Spesialis
 - Doktoral (S3)
 - Lainnya, sebutkan _____
18. Apakah Direktur rumah sakit ini memiliki pengalaman memimpin di tempat lain sebelumnya? *Beri tanda (✓) pada satu kotak saja*
- Ya, pada bidang kesehatan
 - Ya, pada bidang lainnya, sebutkan _____
 - Tidak

Fasilitas rumah sakit

19. Menurut Anda, berapa persentase kelengkapan fasilitas (termasuk gedung dan peralatan) rumah sakit ini berdasarkan tipe rumah sakit pada Peraturan Menteri Kesehatan Republik Indonesia No 340/MENKES/PER/III/2010 tentang Klasifikasi Rumah Sakit? *Beri tanda (✓) pada satu kotak saja*
- lengkap (100%)
 - hampir lengkap (80-99%)
 - sebagian besar tersedia (60-79%)
 - sekitar separuh tersedia (40-59%)
 - beberapa tersedia (20-39%)
 - sedikit tersedia (1-19%)
 - tidak ada (0%)
20. Manakah dari fasilitas yang tersebut dibawah ini yang tersedia di rumah sakit ini? *Beri tanda (✓) pada semua kotak yang relevan*
- instruksi dan informasi yang jelas perihal alur pelayanan gawat darurat
 - instruksi dan tanda khusus bagi orang dengan gangguan penglihatan
 - akses khusus bagi orang cacat
 - parkir
 - semua tidak tersedia
21. Apakah rumah sakit ini memiliki perencanaan pengadaan fasilitas baru dan perbaikan fasilitas yang telah ada? Ya Tidak
22. Siapa yang berhak mengadakan barang dan jasa di rumah sakit ini? *Beri tanda (✓) pada semua kotak yang relevan*
- manajemen rumah sakit sendiri
 - DPRD
 - gubernur
 - walikota/bupati
 - Lainnya, sebutkan _____

Manajemen personalia dan hubungan ke karyawanan

23. Jenis kelamin Anda: laki-laki perempuan

24. Nama jabatan Anda:

25. Apakah jabatan Anda setara dengan: *Beri tanda (✓) pada satu kotak saja*

- Pemilik
- Direktur
- Pejabat struktural
- Supervisor/penyelia

26. Dari daftar hal-hal yang berhubungan dengan karyawan dibawah ini, mana yang menjadi bagian pekerjaan Anda atau bawahan Anda? *Beri tanda (✓) semua kotak yang relevan*
- Tingkat gaji/upah/insentif
 - Jam kerja
 - Hak libur
 - Pensiun
 - Rekrutmen atau seleksi karyawan
 - Kedisiplinan atau prosedur pendisiplinan
 - Kesehatan dan keselamatan kerja
 - Penilaian kinerja
 - Komunikasi dengan karyawan
 - Kenaikan pangkat
 - Bukan semua
 - Semua yang disebutkan
27. Apakah Anda pejabat yang tanggungjawab utamanya adalah hal-hal tersebut (pada pertanyaan diatas dan hubungan kekaryawanan lainnya pada tempat kerja ini?)
- Ya Tidak
28. Kira-kira berapa persentase dari jam kerja Anda dihabiskan untuk mengurus hubungan kekaryawanan? _____ %.
29. Berapa lama Anda telah melakukan pekerjaan tersebut di tempat kerja ini? _____ tahun *bulatkan pada angka terdekat.*
30. Apakah Anda memiliki kualifikasi/pendidikan formal dalam bidang manajemen personalia atau bidang yang terkait? Ya Tidak
31. Hal-hal mana saja yang dapat diputuskan oleh manajemen tanpa perlu berkonsultasi dengan pihak pemerintah atau badan pemerintah yang menaungi rumah sakit ini? *Beri tanda (✓) semua yang relevan*
- Tingkat gaji/upah/insentif
 - Jam kerja
 - Hak libur
 - Hak pensiun
 - Rekrutmen atau seleksi karyawan
 - Hal kedisiplinan atau prosedur pendisiplinan
 - Rencana penempatan karyawan
 - Kesehatan dan keselamatan kerja
 - Penilaian kinerja
 - Bukan semua
 - Lainnya, sebutkan _____
32. Apakah Anda pernah meminta saran dari pihak-pihak berikut mengenai isu-isu hubungan kekaryawanan dalam 12 bulan terakhir? *Beri tanda (✓) semua yang relevan*
- Konsultan manajemen

- Ahli hukum
 - Departemen Tenaga Kerja
 - Kantor Menteri Penertiban Aparatur Negara
 - Departemen Kesehatan
 - Departemen pemerintah lainnya, sebutkan _____
 - Bukan semuanya
- 33. Apakah rumah sakit ini memiliki rencana strategik formal yang menentukan tujuan-tujuan dan cara-cara mencapainya?** Ya Tidak
- 34. Isu manakah yang termasuk dalam rencana strategik tersebut? Beri tanda (✓) semua yang relevan**
- Pengembangan karyawan
 - Kepuasan kerja karyawan
 - Rekrutmen penduduk sekitar sebagai karyawan
 - Pengembangan jasa/produk
 - Peningkatan kualitas produk/jasa
 - Rencana investasi
 - Perencanaan jumlah karyawan yang diperlukan
 - Strategi pemasaran/pengembangan pasar baru
 - Bukan semua
 - Lainnya, sebutkan _____

Rekrutmen, pelatihan dan pengorganisasian kerja

- 35. Pernyataan mana yang paling menggambarkan cara Anda dalam mengisi lowongan kerja pada rumah sakit ini? Beri tanda (✓) pada semua kotak yang relevan**
- melalui rekrutmen Departemen Kesehatan
 - melalui rekrutmen rumah sakit sendiri
- 36. Faktor mana saja yang penting pada saat melakukan rekrutmen karyawan melalui jalur rekrutmen rumah sakit sendiri? Beri tanda (✓) pada semua kotak yang relevan**
- referensi
 - kesediaan calon karyawan
 - rekomendasi dari karyawan lain
 - umur
 - pengalaman
 - motivasi
 - kualifikasi/pendidikan
 - Lainnya, sebutkan _____
- 37. Pada saat melakukan rekrutmen rumah sakit sendiri untuk mengisi lowongan kerja dalam rumah sakit, apakah Anda pernah melakukan tes sejenis tes kepribadian atau tes perilaku untuk calon karyawan atau tidak pernah samasekali melakukan tes jenis tersebut? Beri tanda (✓) pada semua kotak yang relevan**

- hanya untuk posisi pejabat struktural
 - hanya untuk posisi non pejabat struktural
 - untuk kedua posisi (pejabat struktural dan non pejabat struktural)
 - tidak ada tes jenis ini
- 38. Pada saat melakukan rekrutmen rumah sakit sendiri untuk mengisi lowongan kerja dalam rumah sakit ini, apakah Anda pernah melakukan tes kinerja atau tes kompetensi untuk calon karyawan atau tidak ada tes jenis ini samasekali? Beri tanda (✓) pada semua kotak yang relevan**
- hanya untuk posisi pejabat struktural
 - hanya untuk posisi non pejabat struktural
 - untuk kedua posisi (pejabat struktural dan non pejabat struktural)
 - tidak ada tes jenis ini
- 39. Apakah ada lowongan kerja pada kelompok penunjang medis perawatan (perawat/bidan) di tempat kerja ini dalam 12 bulan terakhir?** Ya Tidak
- 40. Sebutkan tiga jalur yang digunakan untuk mengisi lowongan kerja pada kelompok penunjang medis perawatan (perawat/bidan) tersebut? Beri tanda (✓) pada tiga kotak saja**
- Koran lokal/regional
 - Pemberitahuan internal
 - Rekrutmen melalui universitas/akademi
 - Pengangkatan karyawan kontrak menjadi PNS
 - Rekomendasi atau pencarian oleh karyawan
 - Informasi dari mulut ke mulut
 - Intranet atau laman internal
 - Internet atau laman eksternal
 - Lainnya, sebutkan _____
- 41. Apakah ada program orientasi yang baku (sesuai aturan kepegawaian) untuk mengenalkan rumah sakit ini kepada karyawan baru dari kelompok penunjang medis perawatan (perawat/bidan)? (Catatan: masa percobaan tidak termasuk program orientasi)** Ya Tidak
- 42. Berapa lama waktu normal yang diperlukan oleh karyawan baru kelompok penunjang medis perawatan (perawat/bidan) untuk mampu mengerjakan pekerjaannya sebaik karyawan yang sudah lebih dulu bekerja pada rumah sakit ini? Beri tanda (✓) pada satu kotak saja**
- 1 minggu atau kurang
 - lebih dari 1 minggu hingga 1 bulan
 - lebih dari 1 bulan hingga 6 bulan
 - lebih dari 6 bulan hingga 1 tahun
 - lebih dari 1 tahun
- 43. Apakah ada karyawan yang berpengalaman dari kelompok penunjang medis perawatan (perawat/bidan) yang diberi ijin menggunakan waktu kerja untuk mengikuti pelatihan selama 12 bulan terakhir?** Ya Tidak

44. Berapa persentase karyawan berpengalaman dari kelompok penunjang medis perawatan (perawat/bidan) yang diijinkan menggunakan waktu kerja untuk mengikuti pelatihan selama 12 bulan terakhir? *Beri tanda (✓) pada satu kotak saja*
- semua (100%)
 - hampir semua (80-99%)
 - kebanyakan (60-79%)
 - sekitar separuh (40-59%)
 - beberapa (20-39%)
 - sedikit (1-19%)
 - tidak ada (0%)
 - tidak tahu
45. Jika jawaban untuk pertanyaan nomor 43 adalah YA dan jawaban untuk pertanyaan 44 antara 1-100%, berapa rata-rata jumlah hari pelatihan yang diperoleh setiap karyawan berpengalaman dari kelompok penunjang medis perawatan (perawat/bidan) selama 12 bulan terakhir? *Beri tanda (✓) pada satu kotak saja*
- tidak ada waktu
 - kurang dari 1 hari
 - 1 hingga kurang dari 2 hari
 - 2 hingga kurang dari 5 hari
 - 5 hingga kurang dari 10 hari
 - 10 hari atau lebih
46. Jika jawaban untuk pertanyaan nomor 43 adalah YA dan jawaban untuk pertanyaan 44 antara 1-100%, apakah pelatihan tersebut meliputi materi yang disebutkan di bawah ini? *Beri tanda (✓) pada semua kotak yang relevan*
- keahlian komputer
 - kerjasama tim
 - keahlian berkomunikasi
 - keahlian memimpin
 - mengoperasikan peralatan baru
 - pelayanan pelanggan
 - keselamatan dan kesehatan kerja
 - metode pemecahan masalah
 - kehandalan dan bekerja sesuai tenggat waktu
 - prosedur kendali mutu
 - pelatihan spesifik keperawatan
 - bukan semuanya
 - Lainnya, sebutkan _____
47. Menurut Anda, berapa persentase karyawan dari kelompok penunjang medis perawatan (perawat/bidan) dilatih secara formal untuk mampu melakukan pekerjaan selain pekerjaan mereka sendiri? *Beri tanda (✓) pada satu kotak saja*
- semua (100%)

- hampir semua (80-99%)
- kebanyakan (60-79%)
- sekitar separuh (40-59%)
- beberapa (20-39%)
- sedikit (1-19%)
- tidak ada (0%)

48. Menurut Anda, berapa persentase karyawan dari kelompok penunjang medis perawatan (perawat/bidan) secara nyata melakukan pekerjaan selain pekerjaan mereka sendiri paling tidak seminggu sekali? *Beri tanda (✓) pada satu kotak saja*

- semua (100%)
- hampir semua (80-99%)
- kebanyakan (60-79%)
- sekitar separuh (40-59%)
- beberapa (20-39%)
- sedikit (1-19%)
- tidak ada (0%)

49. Sampai seberapa jauh menurut Anda bahwa setiap karyawan dalam kelompok penunjang medis perawatan (perawat/bidan) memiliki: *Beri tanda (✓) pada satu kotak saja pada setiap barisnya*

Pernyataan	Besar	Sedang	Kecil	Tidak ada
keragaman dalam pekerjaan mereka?				
kebebasan memilih cara melakukan pekerjaannya?				
kendali atas kecepatan kerja mereka?				
keterlibatan dalam pengambilan keputusan atas pengorganisasian kerja mereka?				

50. Jika ada, berapa besar persentase karyawan dari kelompok penunjang medis perawatan (perawat/bidan) bekerja dalam tim yang dibentuk secara formal (sesuai dengan SK Direktur)? *Beri tanda (✓) pada satu kotak saja*

- semua (100%)
- hampir semua (80-99%)
- kebanyakan (60-79%)
- sekitar separuh (40-59%)
- beberapa (20-39%)
- sedikit (1-19%)
- tidak ada (0%)

51. Apakah setiap pernyataan di bawah ini berlaku untuk kerjasama tim dalam kelompok penunjang medis perawatan (perawat/bidan) di tempat kerja ini? *Beri tanda (✓) pada satu kotak saja pada setiap barisnya*

Pernyataan	Ya	Tidak	Kecil	Tidak ada
Anggota tim saling tergantung pada pekerjaan anggota lainnya untuk mampu mengerjakan pekerjaan mereka.				
Anggota tim bersama-sama memutuskan bagaimana pekerjaan akan dilaksanakan.				
Tim diberi tanggungjawab atas produk/jasa tertentu.				

52. Berapa prosentase dari semua karyawan menggunakan komputer sebagai alat kerja pada tugas normal mereka? _____ % bulatkan ke puluhan % terdekat.

Komunikasi dengan karyawan

53. Apakah rumah sakit ini mengadakan pertemuan antara pejabat struktural tertinggi dengan seluruh karyawan? Ya Tidak
54. Jika jawaban pertanyaan diatas YA, berapa sering pertemuan dilaksanakan? *Beri tanda (✓) pada satu kotak saja*
- harian
- lebih jarang dari harian, namun paling tidak sekali seminggu
- lebih jarang dari mingguan, namun paling tidak sekali dalam 2 minggu
- lebih jarang dari 2 minggu sekali, namun paling tidak sekali sebulan
- lebih jarang dari satu bulan sekali, namun paling tidak sekali dalam 3 bulan
- lebih jarang dari 3 bulan sekali
55. Sebutkan tiga isu yang sering didiskusikan dalam pertemuan tersebut! *Beri tanda (✓) pada 3 kotak saja*
- isu jasa pelayanan
- isu kekaryawanan
- isu keuangan
- rencana-rencana mendatang
- isu gaji/upah/insentif
- pengaturan cuti dan waktu kerja
- fasilitas kesejahteraan karyawan
- pengorganisasian kerja
- regulasi pemerintah
- keselamatan dan kesehatan kerja
- kesetaraan kesempatan
- pelatihan-pelatihan
- lainnya, sebutkan _____

56. Secara rata-rata, berapa persentase waktu yang tersedia bagi karyawan untuk mengajukan pertanyaan atau mengajukan pandangan mereka dalam pertemuan tersebut? *Beri tanda (✓) pada satu kotak saja*
- tidak ada (0%)
 - sedikit (kurang dari 10%)
 - hingga seperempat (10-24%)
 - seperempat atau lebih (25% atau lebih)
57. Apakah ada pertemuan antara kepala bidang/kepala urusan/kepala seksi dengan para bawahannya? Ya Tidak
58. Jika jawaban pertanyaan diatas YA, berapa sering pertemuan dilaksanakan? *Beri tanda (✓) pada satu kotak saja*
- harian
 - lebih jarang dari harian, namun paling tidak sekali seminggu
 - lebih jarang dari mingguan, namun paling tidak sekali dalam 2 minggu
 - lebih jarang dari 2 minggu sekali, namun paling tidak sekali sebulan
 - lebih jarang dari satu bulan sekali, namun paling tidak sekali dalam 3 bulan
 - lebih jarang dari 3 bulan sekali
59. Sebutkan tiga isu yang sering didiskusikan dalam pertemuan tersebut! *Beri tanda (✓) pada 3 kotak saja*
- isu jasa pelayanan
 - isu kekaryawanan
 - isu keuangan
 - rencana-rencana mendatang
 - isu gaji/upah/insentif
 - pengaturan cuti dan waktu kerja
 - fasilitas kesejahteraan karyawan
 - pengorganisasian kerja
 - regulasi pemerintah
 - keselamatan dan kesehatan kerja
 - kesetaraan kesempatan
 - pelatihan-pelatihan
 - lainnya, sebutkan _____
60. Secara rata-rata, berapa persentase waktu yang tersedia bagi karyawan untuk mengajukan pertanyaan atau mengajukan pandangan mereka dalam pertemuan tersebut? *Beri tanda (✓) pada satu kotak saja*
- tidak ada (0%)
 - sedikit (kurang dari 10%)
 - hingga seperempat (10-24%)
 - seperempat atau lebih (25% atau lebih)

61. Apakah ada komite bersama yang terdiri dari pejabat struktural dan karyawan di tempat kerja ini, yang sifatnya konsultatif dan bukan negosiatif? Komite ini mungkin disebut dewan kerja, forum perwakilan atau komite bersama.
 Ya Tidak
62. Jika jawaban untuk pertanyaan diatas adalah YA, berapa banyak komite yang ada di tempat kerja ini? _____ buah
63. Isu apa sajakah yang didiskusikan oleh komite-komite tersebut? *Beri tanda (✓) pada semua yang relevan*
- isu jasa pelayanan
 - isu kekaryawanan
 - isu keuangan
 - rencana-rencana mendatang
 - isu gaji/upah/insentif
 - pengaturan cuti dan waktu kerja
 - fasilitas kesejahteraan karyawan
 - pengorganisasian kerja
 - regulasi pemerintah
 - keselamatan dan kesehatan kerja
 - kesetaraan kesempatan
 - pelatihan-pelatihan
 - lainnya, sebutkan _____
64. Dari semua komite yang ada, apakah setiap komite yang menangani banyak isu, atau setiap komite hanya menangani isu tunggal saja, seperti keselamatan dan kesehatan kerja? *Beri tanda (✓) pada satu kotak saja*
- banyak isu
 - isu tunggal
 - bisa keduanya
65. Jika ada satu komite dengan isu terbanyak yang ditangani, sebutkan tiga isu yang paling sering didiskusikan oleh komite ini? *Beri tanda (✓) pada tiga kotak saja*
- isu jasa pelayanan
 - isu kekaryawanan
 - isu keuangan
 - rencana-rencana mendatang
 - isu gaji/upah/insentif
 - pengaturan cuti dan waktu kerja
 - fasilitas kesejahteraan karyawan
 - pengorganisasian kerja
 - regulasi pemerintah
 - keselamatan dan kesehatan kerja
 - kesetaraan kesempatan
 - pelatihan-pelatihan

- lainnya, sebutkan _____
66. Apakah ada pemilihan diantara karyawan untuk menunjuk wakil mereka dalam komite tersebut? Ya Tidak
67. Jika tidak ada pemilihan, siapa yang memilih wakil karyawan untuk duduk dalam komite-komite? *Beri tanda (✓) pada semua kotak yang relevan*
- karyawan
- wakil karyawan yang sekarang
- pejabat struktural
- sukarelawan
- lainnya, sebutkan _____
68. Berapa kali komite-komite ini melakukan pertemuan dalam 12 bulan terakhir? _____ kali
69. Pernyataan mana yang paling sesuai menggambarkan pendekatan manajemen saat berkonsultasi dengan para anggota komite? *Beri tanda (✓) pada satu kotak saja*
- Mencari solusi masalah
- Mencari umpanbalik atas pilihan-pilihan yang disodorkan manajemen
- Mencari umpanbalik atas pilihan yang disukai manajemen
70. Secara umum, seberapa besar peran komite-komite tersebut dalam mempengaruhi keputusan manajemen yang menyangkut karyawan? Menurut Anda _____
Beri tanda (✓) pada satu kotak saja
- sangat berpengaruh
- cukup berpengaruh
- tidak begitu berpengaruh
- samasekali tidak berpengaruh
71. Apakah ada kelompok karyawan non-struktural yang memecahkan masalah khusus atau mendiskusikan aspek-aspek kinerja atau kualitas? Mungkin mereka disebut sebagai kelompok gugus kendali mutu. Ya Tidak
72. Apakah Anda atau pihak ketiga pernah menyelenggarakan survei resmi mengenai pandangan atau pendapat karyawan selama 2 tahun terakhir? Ya Tidak
73. Selain cara-cara diatas, apakah ada cara lain bagi manajemen untuk berkomunikasi atau berkonsultasi dengan para karyawan di tempat kerja ini? *Beri tanda (✓) semua yang relevan*
- papan pengumuman
- penggunaan jalur struktural untuk membagi informasi secara sistematis
- skema usul
- berita perusahaan berkala yang dibagikan kepada seluruh karyawan
- surat elektronik yang teratur kepada seluruh karyawan
- informasi yang ditaruh pada intranet perusahaan yang bisa diakses oleh seluruh karyawan
- cara-cara lain, sebutkan _____
- bukan semuanya, tidak ada cara lain
74. Apakah manajemen secara berkala memberikan informasi di bawah ini kepada karyawan atau perwakilan karyawan? *Beri tanda (✓) satu kotak pada setiap barisnya*

	Ya	Tidak
rencana renovasi dan/atau pengembangan karyawan		
penerimaan rumah sakit secara berkala		
rencana pengembangan usaha		
rencana penempatan karyawan		

75. Apakah rumah sakit memiliki sistem promosi (pengembangan karier) karyawan yang berpengalaman dari kelompok penunjang medis perawatan (perawat/bidan)?
 Ya Tidak
76. Bagaimana cara karyawan dalam kelompok penunjang medis perawatan (perawat/bidan) memperoleh promosi? *Beri tanda (✓) pada satu kotak saja*
- lama kerja (tahun)
 - memperoleh kualifikasi keahlian/akademis
 - hasil penilaian kinerja yang bagus
 - kenaikan pangkat berkala
 - tingkat kehadiran
 - lainnya, sebutkan _____

Penentuan gaji/upah/insentif

77. Apakah semua karyawan di rumah sakit ini menerima gaji sesuai dengan gaji PNS?
 Ya Tidak
78. Jika ada karyawan yang menerima gaji tidak sesuai/dibawah gaji PNS, maka kelompok karyawan tersebut adalah kelompok: *Beri tanda (✓) pada satu kotak saja*
- medis (dokter)
 - penunjang medis (perawat/bidan)
 - administrasi
79. Apakah ada karyawan di tempat kerja ini yang menerima gaji berdasarkan prestasi kerja? Ya Tidak
80. Jika ada sistem gaji berdasarkan prestasi kerja, maka kelompok karyawan yang menggunakan sistem ini adalah kelompok: *Beri tanda (✓) pada satu kotak saja*
- pejabat struktural
 - non-struktural
 - keduanya
81. Berapa besar persentase karyawan non-struktural pada tempat kerja ini yang digaji berdasarkan prestasi kerja? *Beri tanda (✓) pada satu kotak saja*
- semua (100%)
 - hampir semua (80-99%)
 - kebanyakan (60-79%)
 - sekitar separuh (40-59%)
 - beberapa (20-39%)
 - sedikit (1-19%)

- tidak ada (0%)
82. Jika penggajian berdasarkan prestasi kerja berlaku pada tempat kerja ini, apakah ukuran kinerja yang dipakai untuk menentukan besar gaji yang diterima oleh karyawan? *Beri tanda (✓) pada semua kotak yang relevan*
- kinerja/hasil individual
- kinerja/hasil kelompok/tim
- kinerja/hasil bagian/unit kerja
- kinerja/hasil rumah sakit secara keseluruhan
- ukuran kinerja lain, sebutkan _____
83. Apakah ada karyawan pada tempat kerja ini yang menerima insentif sehubungan dengan besarnya penerimaan rumah sakit? Ya Tidak
84. Jika jawaban pertanyaan diatas adalah YA, kelompok karyawan mana yang menerima skema insentif sehubungan dengan penerimaan rumah sakit? Apakah ada karyawan di tempat kerja ini yang menerima gaji berdasarkan prestasi kerja?
- pejabat struktural
- karyawan non struktural
- keduanya
85. Berapa besar persentase karyawan non-struktural pada rumah sakit ini (dalam 12 bulan terakhir) yang menerima insentif sehubungan dengan penerimaan rumah sakit? *Beri tanda (✓) pada satu kotak saja*
- semua (100%)
- hampir semua (80-99%)
- kebanyakan (60-79%)
- sekitar separuh (40-59%)
- beberapa (20-39%)
- sedikit (1-19%)
- tidak ada (0%)
86. Faktor-faktor mana di bawah ini yang mempengaruhi besar gaji pokok untuk karyawan pada kelompok penunjang medis perawatan (perawat/bidan)? *Beri tanda (✓) pada semua kotak yang relevan*
- perubahan biaya hidup/inflasi
- kemampuan untuk merekrut atau mempertahankan karyawan
- kinerja keuangan rumah sakit
- produktivitas rumah sakit
- upah minimum kabupaten (UMK)
- lainnya, sebutkan _____
87. Apakah keputusan besarnya perubahan gaji pokok kelompok penunjang medis perawatan (perawat/bidan) dibuat oleh rumah sakit ini, atau instansi lain? *Beri tanda (✓) pada satu kotak saja*
- rumah sakit ini
- departemen/badan pemerintah
- lainnya, sebutkan _____

88. Bagaimana cara karyawan dalam kelompok penunjang medis perawatan (perawat/bidan) memperoleh kenaikan gaji jika mereka tetap pada pekerjaan yang sama? *Beri tanda (✓) pada satu kotak saja*
- lama kerja (tahun)
 - memperoleh kualifikasi keahlian/akademis
 - mengerjakan tugas tambahan
 - mengambil tanggungjawab penyeliaan
 - kinerja yang bagus
 - kenaikan pangkat berkala
 - bekerja lembur lebih banyak
 - bekerja dalam waktu kerja yang kurang menyenangkan
 - tingkat kehadiran
 - lainnya, sebutkan _____
 - tidak ada kesempatan untuk menaikkan gaji pada pekerjaan yang sama
89. Beberapa organisasi memiliki kontrak kekaryawanan yang seragam yang menawarkan hal-hal diluar gaji untuk berbagai kelompok karyawan. Apakah semua karyawan dalam kelompok penunjang medis perawatan (perawat/bidan) pada rumah sakit ini memiliki kontrak kekaryawanan yang seragam? Ya Tidak
90. Apakah para karyawan dari kelompok penunjang medis perawatan (perawat/bidan) berhak atas hal-hal non-gaji berikut? *Beri tanda (✓) pada semua kotak yang relevan*
- tunjangan kendaraan
 - lebih dari 12 hari cuti tahunan
 - asuransi kesehatan
 - gaji tetap dibayarkan meski sakit panjang
 - bukan semuanya
 - lainnya, sebutkan _____
91. Apakah pejabat struktural di rumah sakit ini berhak atas hal-hal non-gaji berikut? *Beri tanda (✓) pada semua kotak yang relevan*
- tunjangan kendaraan
 - lebih dari 12 hari cuti tahunan
 - asuransi kesehatan
 - gaji tetap dibayarkan meski sakit panjang
 - bukan semuanya
 - lainnya, sebutkan _____
92. Mana kelompok karyawan yang mengalami penilaian kinerja secara formal? *Beri tanda (✓) pada semua kotak yang relevan*
- pejabat struktural
 - non-struktural
 - bukan keduanya
93. Berapa besar persentase karyawan non-struktural di tempat kerja ini mengalami penilaian kinerja secara formal? *Beri tanda (✓) pada satu kotak saja*

- semua (100%)
 - hampir semua (80-99%)
 - kebanyakan (60-79%)
 - sekitar separuh (40-59%)
 - beberapa (20-39%)
 - sedikit (1-19%)
 - tidak ada (0%)
94. Apakah penilaian kinerja berakibat pada evaluasi kebutuhan pelatihan karyawan?
 Ya Tidak
95. Apakah besar gaji pokok yang diterima karyawan secara individual terkait dengan hasil penilaian kinerja formal? Ya Tidak
96. Apakah besar insentif yang diterima karyawan secara individual terkait dengan hasil penilaian kinerja formal? Ya Tidak

Perlakuan di tempat kerja

97. Apakah tempat kerja atau organisasi ini memiliki kebijakan tertulis mengenai kesetaraan kesempatan? Ya Tidak
98. Jika YA, apakah kebijakan tersebut secara nyata menyebutkan dasar kesetaraan seperti yang ada dalam daftar di bawah ini? *Beri tanda (✓) pada semua yang relevan*
- gender/jenis kelamin
 - suku bangsa
 - agama/kepercayaan
 - status pernikahan
 - umur
 - keterbatasan fisik
 - lainnya, sebutkan _____
 - kebijakan kami tidak menyebutkan dasar tertentu
99. Jika rumah sakit ini melakukan rekrutmen sendiri, apakah kriteria di bawah ini diperhatikan dalam rekrutmen? *Beri tanda (✓) pada semua yang relevan*
- gender/jenis kelamin
 - suku bangsa
 - agama/kepercayaan
 - umur
 - keterbatasan fisik
 - lainnya, sebutkan _____
 - bukan semuanya
100. Apakah kriteria dibawah ini diperhatikan dalam promosi karyawan? *Beri tanda (✓) pada semua yang relevan*
- gender/jenis kelamin
 - suku bangsa

- agama/kepercayaan
 - umur
 - keterbatasan fisik
 - lainnya, sebutkan _____
 - bukan semuanya
- 101. Apakah Anda mengkaji tingkat upah/gaji/insentif berdasarkan kriteria dibawah ini? *Beri tanda (✓) pada semua yang relevan***
- gender/jenis kelamin
 - suku bangsa
 - agama/kepercayaan
 - umur
 - keterbatasan fisik
 - lainnya, sebutkan _____
 - bukan semuanya
- 102. Apakah rumah sakit ini menerima karyawan atau pelamar yang memiliki keterbatasan fisik/cacat tubuh? Ya Tidak**
- 103. Apakah Anda memiliki pengaturan waktu kerja untuk karyawan seperti disebutkan di bawah ini? *Beri tanda (✓) pada semua yang relevan***
- kesempatan untuk mengurangi jam kerja dalam setiap minggunya
 - kesempatan untuk mengurangi hari kerja pada setiap minggunya dengan jumlah jam kerja yang tetap sama seperti sebelumnya (misal jumlah jam kerja per minggu tetap dengan jumlah hari kerja yang lebih sedikit)
 - kesempatan untuk bekerja dalam *shift*
 - kesempatan untuk tidak bekerja dalam *shift*
 - bukan semuanya
 - lainnya, sebutkan _____
- 104. Jika ada pengaturan seperti yang disebutkan dalam pertanyaan nomor 6, kelompok karyawan mana yang bisa memanfaatkannya? *Beri tanda (✓) pada semua yang relevan***
- semua karyawan
 - hanya tingkatan pejabat struktural/pejabat struktural saja
 - karyawan yang memiliki alasan kuat
- 105. Apakah karyawan wanita yang mengambil cuti melahirkan akan hanya menerima gajinya saja selama cuti? Ya Tidak**
- 106. Jika jawaban pertanyaan diatas adalah TIDAK, berapa besar nilai uang tambahan yang diberikan selama cuti dilaksanakan? *Beri tanda (✓) pada satu kotak saja***
- sesuai gaji normal
 - lebih kecil dari gaji normal
 - lainnya, sebutkan _____
- 107. Jika seorang karyawan perlu mengambil cuti secara mendadak untuk menangani keadaan darurat dalam keluarganya, bagaimana hal ini dilaksanakan? *Beri tanda (✓) pada semua yang relevan***

- menggunakan waktu kerja namun akan dikompensasikan kemudian
 - cuti tanpa gaji
 - cuti sakit
 - cuti khusus yang dibayar
 - mengurangi jatah cuti tahunan
 - lainnya, sebutkan _____
 - tidak pernah ditanyakan
 - tidak diijinkan
108. Apakah ada komite bersama yang terdiri dari pejabat struktural dan karyawan yang menangani isu keselamatan dan kesehatan kerja? Ada Tidak ada
109. Jika jawaban pertanyaan diatas adalah ADA, apakah komite ini hanya mengurus keselamatan dan kesehatan kerja saja? *Beri tanda (✓) pada satu kotak saja*
- komite ini khusus keselamatan dan kesehatan kerja
 - komite ini merupakan komite bersama yang sifatnya umum
110. Jika komite ini khusus untuk keselamatan dan kesehatan kerja, apakah biasanya diadakan pemilihan diantara karyawan untuk menunjuk wakil karyawan dalam komite? Ya Tidak
111. Jika tidak ada pemilihan, siapa yang memilih wakil karyawan untuk duduk dalam komite? *Beri tanda (✓) pada satu kotak saja*
- para karyawan
 - perwakilan karyawan yang ada sekarang
 - sukarelawan
 - para pejabat struktural
 - lainnya, sebutkan _____
112. Jika tidak ada komite keselamatan dan kesehatan kerja, apakah ada karyawan yang bertindak sebagai wakil para karyawan untuk berbicara dengan manajemen mengenai isu keselamatan dan kesehatan kerja? Ya Tidak
113. Jika jawaban pertanyaan diatas YA, apakah ada pemilihan untuk wakil karyawan bidang keselamatan dan kesehatan kerja ini? Ya Tidak
114. Jika tidak ada pemilihan, siapa yang memilih wakil karyawan tersebut? *Beri tanda (✓) pada satu kotak saja*
- para karyawan
 - perwakilan karyawan yang ada sekarang
 - sukarelawan
 - para pejabat struktural
 - lainnya, sebutkan _____
115. Apakah wakil karyawan tersebut dibekali pelatihan untuk mendukung kinerja mereka sebagai perwakilan keselamatan dan kesehatan? Ya Tidak
116. Jika tidak ada komite dan tidak ada perwakilan karyawan, langkah apa saja yang diambil untuk memberitahu dan berkomunikasi dengan para karyawan? *Beri tanda (✓) pada semua yang relevan*
- tidak ada langkah apapun

- berita rumah sakit/papan pengumuman/surat elektronik
- komunikasi melalui jalur struktural
- pertemuan manajemen-karyawan/konsultasi langsung dengan angkatan kerja
- lainnya, sebutkan _____

117. Dalam 12 bulan terakhir, apakah ada karyawan yang menderita penyakit, keterbatasan fisik atau masalah fisik yang disebabkan atau memburuk akibat pekerjaan mereka? *Beri tanda (✓) pada semua yang relevan*

- masalah tulang, persendian, otot (termasuk nyeri punggung)
- masalah pernapasan atau paru-paru (termasuk asma)
- masalah kulit
- masalah pendengaran
- stres, depresi, atau kecemasan
- kelelahan mata
- penyakit/serangan jantung, atau masalah peredaran darah lainnya
- bukan semuanya

118. Jika ada karyawan yang menderita hal-hal pada pertanyaan diatas, berapa banyak karyawan yang telah absen kerja karena masalah tersebut selama 12 bulan terakhir? _____orang

119. Berdasarkan skala nilai dibawah ini, berapa nilai resiko potensial keselamatan dan kesehatan kerja yang dihadapi karyawan pada tempat kerja? *Lingkari angka yang sesuai*

1	2	3	4	5	6	7	8	9	10
Tidak ada resiko sama sekali	—————→								Resiko yang tinggi

120. Berdasarkan skala nilai dibawah ini, berapa nilai kendali yang dimiliki karyawan atas risiko potensial keselamatan dan kesehatan kerja yang dapat mempengaruhi mereka? *Lingkari angka yang sesuai*

1	2	3	4	5	6	7	8	9	10
Tidak ada resiko sama sekali	—————→								Resiko yang tinggi

Keluhan karyawan dan tindakan pendisiplinan

121. Apakah ada prosedur resmi untuk menangani keluhan karyawan di rumah sakit ini?

- Ada Tidak ada

122. Jika karyawan memiliki keluhan kerja, bagaimana cara menyelesaikannya? *Beri tanda (✓) pada semua yang relevan*

- berdiskusi dengan atasan langsung
- berdiskusi dengan bagian personalia

- berdiskusi dengan wakil karyawan, atasan, serta karyawan itu sendiri
 - mediasi dengan melibatkan pihak netral
 - cara lain, sebutkan _____
- 123. Dalam menyampaikan keluhannya, apakah karyawan perlu menyampaikannya secara tertulis? *Beri tanda (✓) pada satu kotak saja***
- Ya, selalu
 - Tergantung jenis keluhan
 - Tidak
- 124. Berapa orang karyawan yang mengajukan keluhan kerja secara resmi selama 12 bulan terakhir di rumah sakit ini? _____orang**
- 125. Jika ada keluhan dalam 12 bulan terakhir ini, maka jenis keluhannya menyangkut: *Beri tanda (✓) pada semua yang relevan***
- gaji
 - promosi, kenaikan pangkat dan kemajuan karir
 - kondisi tempat kerja
 - waktu kerja
 - ketidakadilan oleh atasan
 - pelecehan di tempat kerja
 - lainnya, sebutkan _____
 - tidak ada keluhan
- 126. Apakah ada prosedur untuk tindakan indisipliner/pelanggaran yang dilakukan karyawan? Ya Tidak**
- 127. Apakah selalu ada pemberitahuan resmi tertulis bila terpaksa diambil tindakan pendisiplinan terhadap karyawan? *Beri tanda (✓) pada satu kotak saja***
- Ya, selalu
 - Tergantung jenis pelanggaran
 - Tidak
- 128. Apakah akan diadakan pertemuan resmi antara karyawan dan pejabat struktural yang berwenang untuk membicarakan alasan tindakan pendisiplinan? *Beri tanda (✓) pada satu kotak saja***
- Ya, selalu
 - Tergantung jenis pelanggaran
 - Tidak
- 129. Apakah ada pihak lain yang diundang dalam pertemuan resmi tersebut? *Beri tanda (✓) pada satu kotak saja***
- Tidak ada
 - Wakil ikatan karyawan
 - Atasan langsung
 - Rekan sekerja
 - Ahli hukum
- 130. Apakah karyawan boleh mengajukan banding atas tindakan pendisiplinan yang dijatuhkan? Ya Tidak**

- 131. Selama 12 bulan terakhir ini apakah tindakan pendisiplinan di bawah ini sempat diberlakukan oleh rumah sakit? Beri tanda (✓) pada semua yang relevan**
- peringatan lisan resmi
 - peringatan tertulis resmi
 - skors tanpa gaji
 - pemotongan gaji
 - pemindahan tugas
- 132. Alasan apa yang biasanya berakibat pada tindakan pendisiplinan karyawan? Beri tanda (✓) pada semua yang relevan**
- absen berkepanjangan
 - kinerja yang buruk
 - ketidakpatuhan
 - penggunaan tempat/fasilitas kerja untuk kepentingan pribadi
 - pencurian atau ketidakjujuran
 - pelanggaran peraturan kesehatan dan keselamatan kerja
 - melakukan tindakan pelecehan terhadap rekan kerja/pasien
 - lainnya, sebutkan _____
- 133. Apakah manajemen rumah sakit pernah menggunakan bantuan mediasi untuk menyelesaikan keluhan atau tindakan pelanggaran oleh karyawan dalam 12 bulan terakhir ini? Beri tanda (✓) pada satu kotak saja**
- Ya, dengan bantuan pihak eksternal
 - Ya, dengan bantuan pihak internal
 - Ya, dengan bantuan pihak internal dan eksternal
 - Tidak pernah menggunakan mediasi

Fleksibilitas tempat kerja

- 134. Apakah ada kegiatan di bawah ini yang dikerjakan oleh kontraktor luar/independen/outsourcing? Beri tanda (✓) pada semua yang relevan**
- pembersihan gedung dan daerah sekitarnya
 - keamanan
 - jasaboga
 - pemeliharaan gedung
 - jasa fotokopi
 - pengiriman barang/dokumen
 - jasa komputer
 - pelatihan
 - bukan semuanya
 - lainnya, sebutkan _____
- 135. Apakah pekerjaan yang dikerjakan kontraktor luar/independen ini merupakan pekerjaan yang dilakukan sendiri oleh karyawan rumah sakit ini pada 5 tahun yang lalu?** Ya Tidak

136. Jika dulunya pekerjaan ini dilakukan oleh karyawan, mengapa pekerjaan tersebut sekarang dilakukan oleh pihak luar? *Beri tanda (✓) pada semua yang relevan*
- penghematan biaya
 - mutu pekerjaan yang lebih baik
 - mampu fokus pada bisnis utama
 - lebih fleksibel
 - lainnya, sebutkan _____
137. Apakah ada dari kontraktor luar tersebut yang merupakan mantan karyawan dari rumah sakit ini? Ya Tidak
138. Dalam 5 tahun terakhir, pekerjaan mana saja dalam daftar di bawah ini yang tadinya dikerjakan oleh kontraktor luar/independen kemudian dialihkan untuk dikerjakan sendiri oleh karyawan rumah sakit ini? *Beri tanda (✓) pada semua yang relevan*
- pembersihan gedung dan daerah sekitarnya
 - keamanan
 - jasaboga
 - pemeliharaan gedung
 - jasa fotokopi
 - pengiriman barang/dokumen
 - jasa komputer
 - pelatihan
 - bukan semuanya
 - lainnya, sebutkan _____
139. Jika ada kegiatan yang dialihkan kepada karyawan rumah sakit ini, apa alasannya? *Beri tanda (✓) pada semua yang relevan*
- penghematan biaya
 - peningkatan mutu kerja
 - lainnya, sebutkan _____
140. Apakah ada karyawan kontrak non PNS pada rumah sakit ini? Ya Tidak
141. Jika ada karyawan kontrak non PNS, mengapa Anda menggunakan mereka? *Beri tanda (✓) pada semua yang relevan*
- mencapai kinerja yang lebih baik
 - memperoleh keahlian yang spesifik
 - percobaan untuk pekerjaan yang permanen
 - pengganti karyawan yang cuti melahirkan/absen panjang
 - alasan lain, sebutkan _____
142. Apakah ada pekerja lepasan di rumah sakit ini? Ya Tidak
143. Apakah ada kebijakan mengenai jaminan keamanan pekerjaan atau tidak ada penghentian kerja terpaksa bagi kelompok karyawan? *Beri satu tanda (✓) saja pada setiap baris*

	Ya	Tidak
Pejabat struktural		
Karyawan non-pejabat struktural		

144. Apakah Anda berkomunikasi dengan para karyawan atau wakil mereka sebelum menghentikan seseorang? (Pensiun dini termasuk penghentian kerja)
 Ya Tidak
145. Jika ada proses komunikasi mengenai penghentian kerja (termasuk pensiun dini), siapa yang Anda ajak bicara? *Beri tanda (✓) pada semua yang relevan*
 komite bersama
 wakil karyawan
 langsung dengan karyawan yang bakal terimbas
146. Manakah yang merupakan hari operasional normal bagi tempat kerja ini? *Beri tanda (✓) pada satu kotak saja*
 Senin hingga Jumat
 Enam hari seminggu
 Tujuh hari seminggu
 lainnya, sebutkan _____
147. Apakah pejabat struktural memiliki perjanjian kerja khusus yang menyatakan bahwa mereka mungkin bekerja lebih dari 48 jam seminggu? Ya Tidak
148. Apakah karyawan non-pejabat struktural memiliki perjanjian kerja khusus yang menyatakan bahwa mereka mungkin bekerja lebih dari rata-rata 48 jam seminggu?
 Ya Tidak

Kinerja tempat kerja

149. Pernyataan mana yang paling menggambarkan aktivitas yang dilakukan di rumah sakit ini? *Beri tanda (✓) pada semua yang relevan.*
 Kami menyediakan jasa untuk khalayak umum
 Kami menyediakan jasa untuk organisasi lain
150. Apakah rumah sakit Anda menjadi _____ *Beri tanda (✓) pada satu kotak saja*
 rujukan di kota/kabupaten sekitar
 rujukan di kota/kabupaten pada satu provinsi
 rujukan nasional
151. Berapa banyak pesaing yang Anda miliki untuk jasa utama rumah sakit ini? *Beri tanda (✓) pada satu kotak saja*
 tidak ada
 sedikit pesaing
 banyak pesaing
152. Bagaimana penilaian Anda atas persaingan dalam industri rumah sakit di daerah ini? *Beri tanda (✓) pada satu kotak saja*
 sangat tinggi

- tinggi
- sedang
- rendah
- sangat rendah

153. Apakah rumah sakit ini menghadapi persaingan dari rumah sakit asing untuk jasa utamanya? Beri tanda (✓) pada satu kotak saja

- Ya, banyak
- Ya, sedikit
- Tidak

154. Berapa besar persentase masyarakat umum mengunjungi rumah sakit ini untuk memperoleh layanan kesehatan di kabupaten ini dalam setahun terakhir? Beri tanda (✓) pada satu kotak saja

- kurang dari 15%
- 15-25%
- 26-50%
- 51-75%
- lebih dari 75%

155. Mana dari pernyataan di bawah ini yang paling menggambarkan pandangan masyarakat umum terhadap jasa pelayanan rumah sakit ini? Beri tanda (✓) pada satu kotak saja

- selalu menjadi pilihan
- banyak pilihan rumah sakit lain
- lebih baik ke rumah sakit lain
- hanya dipilih jika kondisi terpaksa

156. Berapa besar persentase penerimaan rumah sakit ini yang dihabiskan untuk biaya belanja pegawai? Beri tanda (✓) pada satu kotak saja

- kurang dari 25%
- 25-49%
- 50-74%
- 75% atau lebih

157. Berdasarkan skala nilai dibawah ini, seberapa tergantung tingkat permintaan produk/jasa Anda pada kemampuan untuk menawarkan tarif/harga yang lebih rendah dibandingkan para pesaing Anda? Lingkari angka yang sesuai

1	2	3	4	5
Permintaan tidak tergantung pada harga sama sekali	—————→			Permintaan sangat tergantung pada harga yang lebih rendah

158. Berdasarkan skala nilai dibawah ini, seberapa besar ketergantungan tingkat permintaan produk/jasa Anda pada kemampuan untuk menawarkan kualitas yang lebih baik dibandingkan para pesaing Anda? *Lingkari angka yang sesuai*

1	2	3	4	5
Permintaan tidak tergantung pada kualitas sama sekali	—————→			Permintaan sangat tergantung pada kualitas yang prima

159. Berdasarkan skala nilai dibawah ini, seberapa sering rumah sakit ini menjadi pionir dalam hal pengembangan jasa atau teknik baru? *Lingkari angka yang sesuai*

1	2	3	4	5
Sangat jarang	—————→			Seringkali terdepan

160. Pilih 3 metode yang digunakan untuk mengawasi kualitas kerja yang dilakukan di rumah sakit ini. *Beri tanda (✓) pada tiga kotak saja*

- pejabat struktural mengawasi kualitas
- para ketua tim kerja mengawasi kualitas di bagiannya/departemennya
- setiap karyawan mengawasi kualitas
- menyimpan catatan atas tingkat kesalahan, keluhan dan umpan balik pelanggan
- survei pelanggan
- lainnya, sebutkan _____
- tidak ada, kualitas tidak diawasi

161. Apakah rumah sakit melakukan pencatatan mengenai hal-hal di bawah ini? *Beri tanda (✓) pada semua yang relevan*

- penjualan/pendapatan/anggaran
- biaya-biaya
- laba
- biaya karyawan/biaya belanja pegawai
- produktivitas
- kualitas produk/jasa
- pemberhentian dan penerimaan karyawan
- ketidakhadiran karyawan
- pelatihan karyawan
- tidak ada semuanya

162. Apakah rumah sakit memiliki target untuk hal-hal di bawah ini? *Beri tanda (✓) pada semua yang relevan*

- volume penjualan/jasa yang diberikan
- total biaya
- laba/tingkat pengambalian investasi
- biaya karyawan/unit
- produktivitas

- kualitas jasa
 - pemberhentian dan penerimaan karyawan
 - ketidakhadiran karyawan
 - pelatihan karyawan
 - kepuasan kerja karyawan
 - kepuasan pelanggan
 - bukan semuanya
- 163. Selama dua tahun belakangan ini, apakah tempat kerja ini melakukan *benchmark* terhadap tempat kerja lain? (*benchmark* adalah memperhatikan cara kerja/metode pelaksanaan di tempat kerja lain dan membandingkannya dengan cara kerja/metode pelaksanaan di tempat kerja ini)** Ya Tidak
- 164. Dari daftar di bawah ini, mana yang merupakan ukuran kinerja keuangan menurut Anda? Beri tanda (✓) pada satu kotak saja**
- laba
 - anggaran
 - nilai tambah
 - pengeluaran
 - penjualan
 - surplus/defisit kas
 - biaya-biaya
 - lainnya, sebutkan _____
- 165. Bagaimana Anda menilai kinerja keuangan di rumah sakit ini dibandingkan dengan standar Departemen Kesehatan Republik Indonesia untuk kelas rumah sakit yang sama? Beri tanda (✓) pada satu kotak saja**
- jauh lebih baik di atas standar
 - lebih baik dari standar
 - sama dengan standar
 - di bawah standar
 - sangat jauh di bawah standar
 - perbandingan tidak tersedia
 - data yang relevan tidak tersedia
- 166. Bagaimana Anda menilai produktivitas karyawan di rumah sakit ini dibandingkan dengan standar Departemen Kesehatan Republik Indonesia untuk kelas rumah sakit yang sama? Beri tanda (✓) pada satu kotak saja**
- jauh lebih baik di atas standar
 - lebih baik dari standar
 - sama dengan standar
 - di bawah standar
 - sangat jauh di bawah standar
 - perbandingan tidak tersedia
 - data yang relevan tidak tersedia

167. Bagaimana Anda menilai kualitas pelayanan di rumah sakit ini dibandingkan dengan standar Departemen Kesehatan Republik Indonesia untuk kelas rumah sakit yang sama? *Beri tanda (✓) pada satu kotak saja*

- jauh lebih baik di atas standar
- lebih baik dari standar
- sama dengan standar
- di bawah standar
- sangat jauh di bawah standar
- perbandingan tidak tersedia
- data yang relevan tidak tersedia

Perubahan rumah sakit

168. Dalam dua tahun terakhir ini, apakah manajemen rumah sakit ini melakukan perubahan-perubahan dibawah ini? *Beri tanda (✓) semua yang relevan*

- pengenalan gaji/insentif terkait kinerja
- pengenalan atau peningkatan teknologi baru (termasuk komputer)
- perubahan-perubahan dalam pengaturan waktu kerja
- perubahan-perubahan dalam pengorganisasian kerja
- perubahan-perubahan dalam teknik atau prosedur kerja
- pengenalan inisiatif untuk melibatkan karyawan
- pengenalan produk/jasa yang lebih baik mutunya
- tidak ada

169. Perubahan mana yang memiliki pengaruh terbesar pada karyawan yang bekerja di sini? *Beri tanda (✓) pada satu kotak saja*

- pengenalan gaji/insentif terkait kinerja
- pengenalan atau peningkatan teknologi baru (termasuk komputer)
- perubahan-perubahan dalam pengaturan waktu kerja
- perubahan-perubahan dalam pengorganisasian kerja
- perubahan-perubahan dalam teknik atau prosedur kerja
- pengenalan inisiatif untuk melibatkan karyawan
- pengenalan produk/jasa yang lebih baik mutunya
- tidak ada

170. Bagaimana keterlibatan komite bersama dalam mengenalkan dan mengimplementasikan perubahan-perubahan tersebut? *Beri tanda (✓) pada satu kotak saja*

- mereka memutuskan
- mereka menegosiasikan
- mereka diajak bicara
- mereka diberitahu
- mereka tidak terlibat

Informasi umum

171. Bagaimana Anda menilai hubungan antara manajemen dan karyawan secara umum pada tempat kerja ini? *Beri tanda (✓) pada satu kotak saja*
- sangat baik
 - baik
 - tidak baik namun juga tidak buruk
 - buruk
 - sangat buruk
172. Siapa yang mengisi kuesioner kinerja keuangan?
Jabatan: _____
173. Siapa yang mengisi kuesioner kinerja pelayanan rumah sakit?
Jabatan: _____
174. Jika riset ini memerlukan informasi tambahan, apakah Anda bersedia dihubungi?
 Ya Tidak
175. Jika ada studi kelanjutan dari penelitian ini, apakah Anda bersedia menjadi responden? Ya Tidak
176. Jika memungkinkan untuk mengaitkan data yang telah kami kumpulkan dari Anda dengan survei lain yang aksesnya kami miliki, apakah Anda berkeberatan bila kami melakukannya karena hal tersebut dapat memberikan kemungkinan analisa lebih dalam? Dalam melakukan hal tersebut kami tetap menjaga kerahasiaan karena data yang dikaitkan bersifat anonim dan digunakan untuk keperluan statistik serta analisis. Ya Tidak

Terimakasih atas kesediaan Anda.

A.2 Hospital performance

Pengaruh korporatisasi dan modal sosial di tempat kerja terhadap motivasi dan kepuasan karyawan serta kinerja rumah sakit umum daerah di Jawa Timur
The University of Manchester, United Kingdom

Kuesioner ini terdiri dari 2 bagian: kinerja keuangan dan kinerja pelayanan. Kedua bagian perlu diisi selengkap mungkin.

Untuk mengisi kuesioner ini:

- Gunakan tinta biru atau hitam untuk menulis.
- Beri tanda (✓) pada kotak yang relevan sesuai dengan instruksi dalam pertanyaan.
- Tulis jawaban dalam titik-titik atau kotak yang tersedia bila diminta.
- Harap lengkapi kuesioner ini sebelum mengisi Kuesioner Karakteristik Rumah Sakit.

Informasi yang Anda berikan akan digunakan hanya untuk keperluan akademik dan akan dijaga kerahasiaannya.

Tidak ada nama seorang pun maupun nama perusahaan yang akan disebutkan dalam publikasi study ini.

Terimakasih atas kerjasama Anda.

Kinerja keuangan

- 1. Jika memungkinkan, semua angka yang Anda berikan dalam bagian ini (contohnya, mengenai penerimaan/pendapatan) hanya terkait dengan rumah sakit yang alamatnya tercantum dalam surat pengantar. Harap beritahukan kepada kami apakah hal tersebut berlaku dengan memberi tanda pada pilihan yang sesuai dengan kondisi Anda di bawah ini. *Beri tanda (✓) pada satu kotak saja***

- angka-angka ini berkaitan dengan rumah sakit ini saja
- angka-angka ini berkaitan dengan rumah sakit lain (harap sebutkan) _____
Jumlah rumah sakit yang termasuk dalam angka ini _____ buah

- 2. Angka-angka dalam rupiah dan data lain yang diberikan harus mencakup periode yang sama. Angka-angka rupiah dan data lain yang diberikan rumah sakit ini mencakup periode mana? *Beri tanda (✓) pada satu kotak saja***

- angka-angka ini mencakup periode 1 Januari - 31 Desember 2012
- angka-angka ini mencakup periode lain (harap sebutkan):
dari _____(tanggal/bulan/tahun)
hingga _____(tanggal/bulan/tahun)

Angka-angka dalam rupiah harap dibulatkan ke atas atau ke bawah sesuai dengan nilai jutaan terdekat seperti contoh di bawah ini.

Contoh, jika jawaban Anda adalah Rp 376.525.000 maka bulatkan angka ini menjadi Rp 377.000.000 dan tuliskan dalam tempat yang tersedia.

Jika jawaban Anda adalah Rp 900.000 maka bulatkan menjadi Rp 1.000.000 dan tuliskan dalam tempat yang tersedia.

Jika jawaban Anda lebih kecil dari Rp 500.000, maka tuliskan NOL dalam tempat yang tersedia.

Penerimaan

3. Berapa jumlah penerimaan dari jasa pelayanan rumah sakit selama periode yang disebutkan dalam pertanyaan 2? Harap berikan perkiraan yang terbaik jika Anda tidak memiliki data yang akurat. Angka dalam rupiah harus dibulatkan ke atas atau ke bawah sesuai dengan jutaan terdekat.

Total penerimaan Rp _____.

Tidak termasuk:

- PPN
- Penjualan harta tetap
- Hibah

4. Apakah rumah sakit ini mendapatkan subsidi dari pemerintah? Ya Tidak
5. Bila jawaban pertanyaan diatas YA, berapa persen subsidi pemerintah dari seluruh pendapatan rumah sakit ini? _____ persen.

Nilai Harta Perusahaan

6. Berapa perkiraan nilai bangunan, mesin dan peralatan? Harap berikan perkiraan terbaik Anda jika Anda tidak memiliki data yang akurat. Angka dalam rupiah harus dibulatkan ke atas atau ke bawah sesuai dengan jutaan terdekat. Nilai total bangunan yang dimiliki Rp _____.

Termasuk:

- Kendaraan bermotor dan peralatan transportasi lainnya
- Perangkat keras dan perangkat lunak komputer
- Mesin-mesin dan peralatan lainnya

Pengeluaran untuk barang modal

7. Berapa besar nilai pengeluaran untuk pembelian/perbaikan barang modal seperti yang disebutkan di bawah ini sepanjang periode tersebut? Harap berikan perkiraan terbaik Anda jika Anda tidak memiliki data yang akurat. Angka dalam rupiah dibulatkan ke atas atau ke bawah sesuai dengan jutaan terdekat.

Besar pengeluaran Rp _____.

Termasuk:

- Pembangunan/perbaikan gedung
- Pembelian atau penjualan:
 - tanah dan bangunan
 - kendaraan bermotor dan peralatan transportasi lainnya
 - perangkat keras dan perangkat lunak komputer
 - mesin-mesin dan peralatan lainnya

Tidak termasuk:

- Penyisihan penyusutan atas harta tetap

Pengeluaran untuk Pembelian Barang, Perlengkapan Kantor/Medis dan Jasa

8. Berapa pengeluaran total pembelian barang/perlengkapan kantor/alat tulis/medis serta obat-obatan dan jasa selama periode ini? Harap berikan perkiraan terbaik Anda jika Anda tidak memiliki data yang akurat. Angka dalam rupiah harus dibulatkan ke atas atau ke bawah sesuai dengan jutaan terdekat.

Besar pengeluaran Rp _____.

Tidak termasuk:

- Biaya belanja pegawai

- Piutang macet/tidak tertagih atau penyusutan
- Pembayaran bunga pinjaman
- Jumlah yang dibayarkan untuk pembelian barang modal
- Kapitalisasi perbaikan bangunan

Biaya Belanja Pegawai

9. Berapa besar biaya belanja pegawai selama periode ini? Harap berikan perkiraan terbaik Anda jika Anda tidak memiliki data yang akurat. Angka dalam rupiah harus dibulatkan ke atas atau ke bawah sesuai dengan jutaan terdekat.

Besar biaya belanja pegawai Rp_____.

Termasuk:

- Gaji kotor dan upah kotor (dalam bentuk tunai atau natura)
- Kontribusi Askes

Jumlah Karyawan

10. Berapa banyak karyawan yang bekerja di rumah sakit ini (rata-rata) selama periode tersebut? Harap berikan angka yang terpisah untuk karyawan PNS dan non-PNS (kontrak). Harap berikan perkiraan terbaik Anda jika Anda tidak memiliki data yang akurat.

Jumlah karyawan PNS _____ orang.

Jumlah karyawan non-PNS (kontrak) _____ orang.

Riset dan pengembangan

Riset dan pengembangan adalah kegiatan kreatif yang dilakukan secara sistematis untuk meningkatkan pengetahuan dan menggunakan pengetahuan tersebut untuk menciptakan metode kerja/teknik /pelayanan baru.

11. Apakah ada kegiatan riset dan pengembangan yang dilaksanakan pada rumah sakit ini?

Ya Tidak

Jika YA: berapa besar prosentase dari pengeluaran saat ini digunakan untuk riset dan pengembangan? _____%

12. Apakah ada kegiatan riset dan pengembangan dilaksanakan diluar rumah sakit ini namun hasilnya digunakan oleh rumah sakit ini? Ya Tidak

Kinerja pelayanan

13. Jenis Rumah Sakit: Umum Khusus

14. Kelas Rumah Sakit: A B C D

15. Jumlah tempat tidur yang tersedia: _____ buah

16. Bagaimanakah komposisi dan jumlah kelas perawatan di rumah sakit ini?

Kelas perawatan	Jumlah tempat tidur
VIP (kelas utama)	
Kelas I	
Kelas II	
Kelas III	

17. Kelas perawatan manakah yang mendapat subsidi dari pemerintah? Beri tanda (✓) pada semua kotak yang relevan

- kelas VIP (utama)
- kelas I
- kelas II
- kelas III
- Lainnya, sebutkan _____

18. Jenis pelayanan yang tersedia di rumah sakit ini: *Beri tanda (✓) pada semua kotak yang relevan*

- Pelayanan medik umum
- Pelayanan gawat darurat
- Pelayanan medik dasar:
 - Penyakit dalam
 - Kesehatan anak
 - Bedah
 - Obstetri dan ginekologi
- Pelayanan spesialis penunjang medik:
 - Anestesiologi
 - Radiologi
 - Rehabilitasi medik
 - Patologi klinik
 - Patologi anatomi
- Pelayanan medik spesialis lain:
 - Mata
 - Telinga hidung tenggorokan
 - Syaraf
 - Jantung dan pembuluh darah
 - Kulit dan kelamin
 - Kedokteran jiwa
 - Paru
 - Orthopedi
 - Urologi
 - Bedah Syaraf
 - Bedah Plastik
 - Kedokteran forensik
- Pelayanan medik spesialis gigi mulut:
 - Bedah mulut
 - Konservasi/endodonti
 - Orthodonti
 - Periodonti
 - Prosthodonti
 - Pedodonti
 - Penyakit mulut
- Pelayanan medik sub spesialis:
 - Penyakit dalam
 - Kesehatan anak

- Bedah
- Obstetri dan ginekologi
- Mata
- Telinga hidung tenggorokan
- Syaraf
- Jantung dan pembuluh darah
- Kulit dan kelamin
- Kedokteran jiwa
- Paru
- Orthopedi
- Gigi mulut

- Pelayanan keperawatan dan kebidanan
- Pelayanan penunjang klinik
- Pelayanan penunjang non-klinik
- Pelayanan administrasi

19. Jumlah pasien rawat inap dan rawat jalan yang dilayani untuk setiap jenis pelayanan dalam periode 1 Januari-31 Desember 2012 adalah:

Pelayanan	Rawat jalan (orang)	Rawat inap (orang)
Pelayanan medik umum		
Pelayanan gawat darurat		
Pelayanan medik dasar		
Pelayanan spesialis penunjang medik		
Pelayanan medik spesialis lainnya		
Pelayanan medik spesialis gigi mulut		
Pelayanan medik sub spesialis		
Pelayanan penunjang klinik		
Pelayanan administrasi		

20. Angka-angka kinerja pelayanan yang diberikan rumah sakit ini mencakup periode mana?

- angka-angka ini mencakup periode 5 tahun terakhir hingga Desember 2012
- angka-angka ini mencakup periode 3 tahun terakhir hingga Desember 2012
- angka-angka ini mencakup periode 1 tahun terakhir hingga Desember 2012
- angka-angka ini mencakup periode lain, sebutkan:
sejak_____ (tanggal/bulan/tahun)
sd_____ (tanggal/bulan/tahun)

21. Lengkapi daftar di bawah ini dengan angka-angka kinerja pelayanan rumah sakit ini sesuai dengan periode di atas:

Indikator	2012	2011	2010	2009	2008
Bed occupancy rate (BOR)					
Length of stay (LOS)					
Turn over interval (TOI)					
Kunjungan rawat inap					
Kunjungan rawat jalan					
Net death rate (NDR)					
Gross death rate (GDR)					
Angka kejadian infeksi nosokomial					
Angka kejadian infeksi pasca operasi					
Tingkat kepuasan pelanggan					

Terimakasih atas kesediaan Anda.

A.3 Employee profile

Pengaruh korporatisasi dan modal sosial di tempat kerja terhadap motivasi dan kepuasan karyawan serta kinerja rumah sakit umum daerah di Jawa Timur
The University of Manchester, United Kingdom

Untuk mengisi kuesioner ini:

- Gunakan tinta biru atau hitam untuk menulis.
- Beri tanda (✓) pada kotak yang relevan sesuai dengan instruksi dalam pertanyaan.
- Tulis jawabannya dalam titik-titik (tempat) yang tersedia bila diminta.
- Harap lengkapi kuesioner ini sebelum mengisi Kuesioner Karakteristik Rumah Sakit.

Tidak ada nama seorang pun maupun rumah sakit yang akan muncul dalam publikasi hasil studi.

Informasi yang Anda berikan hanya untuk keperluan statistik dan akan diperlakukan secara rahasia.

Terimakasih atas kerjasama Anda.

Tujuan kuesioner ini untuk mengumpulkan informasi mengenai jumlah dan struktur angkatan kerja di rumah sakit Anda. Data yang diberikan sebaiknya sesuai dengan kondisi saat Anda mengisi kuesioner ini. Semua pertanyaan mengacu pada kondisi normal.

'Rumah sakit' mengacu pada tempat yang disebutkan dalam surat pengantar. Rumah sakit tidak termasuk tempat lain yang terpisah dari alamat rumah sakit ini.

'Karyawan' mengacu pada karyawan PNS maupun non-PNS yang memiliki kontrak dengan rumah sakit. Istilah ini tidak memasukkan pekerja lepas/musiman atau pekerja dari luar rumah sakit ini.

Harap berikan perkiraan Anda yang terbaik jika Anda tidak memiliki data yang pasti. Tulislah NOL jika Anda tidak memiliki karyawan dalam suatu kategori tertentu.

1. Pada saat ini berapa orang karyawan termasuk dalam daftar gaji di tempat kerja ini? _____ orang.

Pastikan Anda menghitung diri Anda sendiri jika Anda adalah karyawan di tempat kerja ini, namun JANGAN HITUNG karyawan lepasan atau karyawan sementara/musiman tanpa kontrak.

2. Gunakanlah tabel di bawah ini untuk mengisi jumlah karyawan pria dan wanita pada setiap kelompok pekerjaan.

Kelompok karyawan	Pria	Wanita	Total
Karyawan struktural (tercantum dalam struktur organisasi)			
Dokter umum			
Dokter gigi dan spesialis gigi mulut			
Dokter spesialis lainnya			
Perawat dan bidan			
Fungsional terkait pelayanan medis lainnya			
Fungsional administratif dan keuangan			
Tenaga keamanan, kebersihan, juru masak			
Total karyawan			

3. Gunakanlah tabel di bawah ini untuk mengisi jumlah karyawan purna waktu (40 jam atau lebih dalam seminggu) dan karyawan paruh waktu (kurang dari 40 jam seminggu)

Kelompok karyawan	Purna waktu (40 jam atau lebih dalam seminggu)	Paruh waktu (kurang dari 40 jam seminggu)
Karyawan struktural (tercantum dalam struktur organisasi)		
Dokter umum		
Dokter gigi dan spesialis gigi mulut		
Dokter spesialis lainnya		
Perawat dan bidan		
Fungsional terkait pelayanan medis lainnya		
Fungsional administratif dan keuangan		
Tenaga keamanan, kebersihan, juru masak		
Total karyawan		

4. Dari seluruh karyawan yang bekerja di rumah sakit ini, berapa orang yang:

	Jumlah
berusia sampai dengan 21 tahun?	
berusia 22-49 tahun?	
berusia 50 tahun atau lebih?	
bukan asli penduduk Jawa Timur?	
memiliki keterbatasan fisik jangka panjang yang mempengaruhi jumlah atau jenis pekerjaan yang bisa dilakukan?*	

(*Keterbatasan fisik jangka panjang adalah penyakit, masalah kesehatan atau gangguan fisik lain yang berlangsung lebih dari setahun)

5. Berapa orang karyawan yang bekerja di rumah sakit ini yang memiliki kontrak kerja (non PNS)? _____ orang.
Jangan hitung karyawan yang sedang dalam masa percobaan untuk menjadi karyawan tetap.
6. Berapa orang karyawan di rumah sakit ini yang digaji berdasarkan:

	Jumlah
Upah minimum kabupaten (UMK)	
Gaji pegawai negeri sipil	
Pengaturan lainnya (selain UMK atau gaji pegawai negeri sipil)	
bukan asli penduduk Jawa Timur?	

7. Apakah ada ikatan karyawan dalam rumah sakit ini?

- Ya
 Tidak

8. Jika ada, berapa banyak jumlah ikatan karyawan tersebut dalam rumah sakit ini? _____ buah.

9. Berapa orang karyawan di rumah sakit ini yang menjadi anggota ikatan karyawan tersebut? _____ orang.

10. Harap tuliskan semua ikatan karyawan yang memiliki anggota di rumah sakit ini.

No.	Ikatan karyawan
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

11. Selama 12 bulan terakhir ini berapa persentase jumlah hari kerja yang hilang karena sakitnya karyawan atau ketidakhadiran di tempat kerja ini? _____ %.

Jangan hitung ketidakhadiran dengan ijin atasan, penugasan atau mengikuti pelatihan atau karena pemogokan.

12. Berapa orang tenaga *outsourcing* yang ada di tempat kerja ini? _____ orang.

Tenaga *outsourcing* adalah orang yang dikontrak secara temporer dari luar rumah sakit. Mereka ini semestinya tidak dimasukkan dalam jumlah total karyawan dalam pertanyaan nomor 1 (pada halaman 1).

13. Secara keseluruhan, berapa orang karyawan (PNS dan non-PNS) yang ada dalam daftar gaji rumah sakit pada bulan Desember 2012 yang lalu? _____ orang.

14. Dan berapa banyak dari jumlah tersebut (dalam pertanyaan diatas) yang berhenti bekerja di sini akibat:

Alasan	Jumlah(orang)
berhenti atas alasan pribadi? (seperti menikah, bersekolah, mengikuti suami/istri bertugas)	
dipindahtugaskan?	
pindah bekerja ke rumah sakit swasta	
habis masa kontrak dan tidak diperpanjang lagi	
membuka usaha sendiri/wirausaha	
alasan lain (misal: pensiun)	
diberhentikan/dipecat?	

15. Secara total, berapa jumlah karyawan (PNS dan non-PNS) di rumah sakit ini pada bulan Desember 2012? _____ orang.

Terimakasih atas kesediaan Anda.

A.4 Employees survey

Pengaruh korporatisasi dan modal sosial di tempat kerja terhadap motivasi dan kepuasan karyawan serta kinerja rumah sakit umum daerah di Jawa Timur
The University of Manchester, United Kingdom

Kuesioner ini merupakan bagian penting dari riset doktoral karena kami ingin mengetahui pandangan Anda masing-masing mengenai pekerjaan Anda dan rumah sakit ini.

Jawaban Anda dalam kuesioner ini akan dijaga kerahasiaannya. Anda tidak perlu menuliskan nama Anda pada kuesioner ini.

Kuesioner ini akan memakan waktu sekitar 75 menit untuk mengisinya

Jawablah semua pertanyaan dengan sebenar-benarnya dengan cara:

- Gunakan tinta biru atau hitam untuk menulis.
- Beri tanda (✓) pada kotak yang relevan sesuai dengan instruksi dalam pertanyaan.
- Isilah titik-titik dengan huruf cetak untuk menjawab pertanyaan.
- Lingkari angka yang sesuai jika ada skala penilaian dalam pertanyaan.

Terimakasih atas kerjasama Anda.

Perihal pekerjaan anda

1. Sudah berapa tahun Anda bekerja di rumah sakit ini?

- kurang dari setahun
- 1 tahun lebih namun belum mencapai 2 tahun
- 2 tahun hingga kurang dari 5 tahun
- 5 tahun hingga kurang dari 10 tahun
- 10 tahun atau lebih

2. Mana istilah yang tepat untuk menggambarkan status kepegawaiannya Anda di rumah sakit ini?

- pegawai negeri sipil (PNS)
- kontrak (non-PNS)

3. Anda bekerja pada unit apa di rumah sakit ini? Beri tanda (✓) pada satu kotak saja

- pelayanan medik umum
- pelayanan medik dasar
- pelayanan medik spesialis lain
- pelayanan medik subspecialis
- pelayanan penunjang klinik
- pelayanan gawat darurat
- pelayanan spesialis penunjang medik
- pelayanan medik spesialis gigi mulut
- pelayanan keperawatan dan kebidanan
- pelayanan penunjang non-klinik

- pelayanan administrasi
4. Bagaimana pengaturan waktu kerja Anda di rumah sakit ini? *Beri tanda (✓) pada satu kotak saja*
- sesuai jam kerja normal (dinas pagi)
- berdasarkan jam kerja *shift*
5. Berapa jam kerja Anda per minggu sesuai dengan peraturan kerja di rumah sakit ini, tidak termasuk lembur (baik dibayar maupun tidak)? _____ jam.
Bulatkan ke angka jam penuh terdekat, misal 41,5 jam, maka harap ditulis 42 jam
6. Dalam kenyataannya, berapa lama jam kerja Anda biasanya setiap minggu, termasuk lembur atau kerja ekstra? _____ jam.
Tidak termasuk istirahat makan dan lama perjalanan pergi dan pulang ke rumah sakit. Bulatkan ke angka jam penuh terdekat, misal 41,5 jam, maka harap ditulis 42 jam
7. Apakah Anda setuju bahwa karyawan yang ingin maju karirnya di rumah sakit ini (seperti memperoleh promosi) biasanya bekerja dengan jam kerja yang lebih lama dibandingkan dengan jam kerja yang lebih lama dibandingkan yang lain? *Beri tanda (✓) pada satu kotak saja*
- sangat setuju
- setuju
- tanpa pendapat
- tidak setuju
- sangat tidak setuju
8. Apakah Anda setuju atau tidak setuju dengan pertanyaan berikut mengenai pekerjaan Anda? *Beri satu tanda (✓) saja pada setiap baris*

	Sangat setuju	Setuju	Tanpa pendapat	Tidak setuju	Sangat tidak setuju	Tidak tahu
Pekerjaan saya menuntut saya untuk bekerja keras						
Nampaknya saya tidak memiliki waktu cukup untuk menyelesaikan pekerjaan saya						
Saya merasa aman bekerja karena saya tidak mungkin diberhentikan/dipecat tanpa sebab dari pekerjaan saya di rumah sakit ini						

9. Secara umum, berapa besar peran Anda dalam menentukan hal-hal berikut? *Beri satu tanda (✓) saja pada setiap baris*

	Sangat besar	Cukup besar	Sedikit	Tidak ada	Tidak tahu
Tugas-tugas yang dilaksanakan dalam pekerjaan Anda					
Kecepatan kerja Anda					
Cara Anda melaksanakan pekerjaan Anda					
Urutan tugas Anda					
Waktu Anda memulai dan mengakhiri hari kerja Anda					

10. Seberapa puas Anda dengan aspek-aspek berikut dalam pekerjaan Anda? Beri satu tanda (✓) saja pada setiap baris

	Sangat puas	Puas	Tanpa pendapat	Tidak puas	Sangat tidak puas	Tidak tahu
Rasa pencapaian yang Anda terima dari pekerjaan Anda						
Kebebasan berinisiatif						
Besarnya pengaruh yang dimiliki atas pekerjaan Anda						
Pelatihan/pendidikan lanjutan yang Anda terima						
Kesempatan untuk mengembangkan keahlian Anda dalam pekerjaan						
Besar gaji yang Anda terima						
Bebas dari kemungkinan dipecat/dihentikan tanpa sebab dari pekerjaan Anda						
Pekerjaan itu sendiri						

11. Pikirkan beberapa minggu terakhir ini, berapa sering pekerjaan membuat Anda merasakan hal-hal di bawah ini? Beri satu tanda (✓) saja pada setiap baris

	Selalu	Seringkali	Kadang-kadang	Jarang	Tidak pernah
Tegang					
Tertekan					
Khawatir					
Muram					
Cemas					
Sedih					

Perihal rumah sakit Anda

12. Dalam 12 bulan terakhir, apakah Anda pernah menggunakan pengaturan kerja di bawah ini, dan jika tidak, apakah pengaturan kerja seperti ini tersedia jika Anda memerlukannya? *Beri satu tanda (✓) saja pada setiap baris*

	Saya pernah menggunakan	Tersedia, namun saya tidak menggunakannya	Tidak tersedia bagi saya	Tidak tahu
Waktu kerja fleksibel, termasuk bertukar shift				
Berbagi pekerjaan (berbagi pekerjaan dengan orang lain)				
Jumlah jam kerja sama dengan hari kerja yang lebih sedikit (misal 40 jam dalam 4 hari dan bukan 5 hari)				
Cuti dengan tetap digaji untuk merawat keluarga dalam keadaan darurat				

13. Sekarang pikirkan komitmen Anda terhadap rumah sakit ini dan diluar rumah sakit, apakah Anda setuju atau tidak setuju dengan pertanyaan berikut? *Beri satu tanda (✓) saja pada setiap baris*

	Sangat setuju	Setuju	Tanpa pendapat	Tidak setuju	Sangat tidak setuju
Seringkali saya merasa sulit untuk memenuhi komitmen diluar rumah sakit karena banyaknya waktu yang dihabiskan untuk pekerjaan saya					
Seringkali saya merasa sulit untuk melaksanakan pekerjaan saya dengan benar karena komitmen saya diluar rumah sakit					

14. Selain pelatihan keselamatan kerja, berapa lama hari pelatihan yang Anda alami selama 12 bulan terakhir, baik yang diselenggarakan oleh pihak diluar rumah sakit ini atau diselenggarakan sendiri oleh rumah sakit? *harap hanya hitung pelatihan dimana Anda mendapatkan ijin untuk meninggalkan pekerjaan Anda untuk mengikuti pelatihan tersebut. Beri tanda (✓) pada satu kotak saja*

- tidak pernah
- kurang dari 1 hari
- 1 hingga kurang dari 2 hari
- 2 hingga kurang dari 5 hari
- 5 hingga kurang dari 10 hari
- lebih dari 10 hari

15. Seberapa cocok tingkat keahlian yang Anda miliki dengan keahlian yang diperlukan untuk melakukan pekerjaan Anda? Beri tanda (✓) pada satu kotak saja

Keahlian saya:

- lebih tinggi
- sedikit lebih tinggi
- kira-kira sama
- sedikit lebih rendah
- jauh lebih rendah

16. Secara umum, seberapa baik para pejabat struktural/atasan di rumah sakit ini untuk memberikan informasi kepada karyawan mengenai hal-hal berikut? Beri satu tanda (✓) saja pada setiap baris

	Sangat baik	Baik	Tanpa pendapat	Buruk	Sangat buruk	Tidak tahu
Perubahan cara menjalankan organisasi						
Perubahan dalam penyusunan karyawan						
Perubahan dalam cara Anda melaksanakan pekerjaan Anda						
Perihal keuangan, termasuk anggaran dan penerimaan rumah sakit						

17. Secara keseluruhan, seberapa baik para pejabat struktural/atasan di rumah sakit ini dalam hal _____ ? Beri satu tanda (✓) saja pada setiap baris

	Sangat baik	Baik	Tanpa pendapat	Buruk	Sangat buruk	Tidak tahu
Mencari pandangan karyawan atau wakil karyawan						
Merespons usulan karyawan atau wakil karyawan						
Mengijinkan karyawan atau wakil karyawan untuk mempengaruhi keputusan akhir manajemen						

18. Secara keseluruhan, seberapa puas Anda dengan tingkat keterlibatan Anda dalam pengambilan keputusan di rumah sakit ini? *Beri tanda (✓) pada satu kotak saja*

- sangat puas
 puas
 tanpa pendapat
 tidak puas
 sangat tidak puas

Pandangan Anda mengenai bekerja di tempat ini

19. Seberapa jauh Anda setuju atau tidak setuju dengan pernyataan berikut mengenai bekerja di rumah sakit ini? *Beri satu tanda (✓) saja pada setiap baris*

	Sangat setuju	Setuju	Tanpa pendapat	Tidak setuju	Sangat tidak setuju	Tidak tahu
Dengan inisiatif sendiri saya melakukan tugas yang bukan diharuskan sebagai bagian dari pekerjaan saya						
Saya memiliki nilai-nilai yang sama dengan rumah sakit saya						
Saya merasa loyal terhadap rumah sakit saya						
Saya bangga menyebutkan nama rumah sakit tempat saya bekerja pada orang lain						

20. Sekarang pikirkan para pejabat struktural/atasan yang berada di rumah sakit ini, seberapa jauh Anda setuju atau tidak setuju dengan pernyataan berikut? Beri satu tanda (✓) saja pada setiap baris

Para pejabat struktural/atasan di rumah sakit ini _____

	Sangat setuju	Setuju	Tanpa pendapat	Tidak setuju	Sangat tidak setuju	Tidak tahu
Memegang janjinya						
Tulus berusaha memahami pandangan para karyawan						
Jujur dalam berhubungan dengan karyawan						
Memahami bahwa karyawan memiliki tanggungjawab diluar kerja						
Mendorong karyawan untuk mengembangkan keahliannya						
Memperlakukan karyawan dengan adil						

21. Secara umum, bagaimana Anda menggambarkan hubungan antara para pejabat struktural/atasan dengan para karyawan disini? Beri tanda (✓) pada satu kotak saja

- sangat baik
 baik
 tidak baik tapi juga tidak buruk
 buruk
 sangat buruk

22. Berdasarkan skala penilaian di bawah ini, berilah nilai untuk pernyataan berikut. Beri tanda (✓) pada satu kotak saja

	Sangat sedikit	Sedikit	Cukup	Banyak	Sangat banyak
Para karyawan dalam satu unit kerja saling bekerjasama untuk mengembangkan dan melaksanakan ide-ide baru					

23. Berdasarkan skala penilaian di bawah ini, bagaimana Anda menilai setiap pernyataan berikut? Beri satu tanda (✓) saja pada setiap baris

	Sangat tidak setuju	Tidak setuju	Tanpa pendapat	Setuju	Sangat setuju
Atasan kami memperlakukan kami dengan baik dan penuh pertimbangan					
Atasan memperhatikan hak kami sebagai karyawan					
Kami dapat mempercayai atasan kami					
Para karyawan saling menginformasikan satu sama lain mengenai isu-isu yang terkait dengan pekerjaan dalam unit kerja					
Karyawan merasa dipahami dan diterima oleh sesama karyawan					
Apakah para karyawan dalam satu unit kerja membangun ide satu sama lain untuk mencapai hasil terbaik?					
Kami memiliki sikap 'kebersamaan'					

Perwakilan karyawan dalam rumah sakit

24. Apakah ada ikatan karyawan di rumah sakit ini? Beri tanda (✓) pada satu kotak saja

- Ya, silahkan lanjutkan ke pertanyaan 25 dan seterusnya
- Tidak, silahkan langsung ke pertanyaan 27 dan seterusnya
- Tidak tahu, silahkan langsung ke pertanyaan 27 dan seterusnya

25. Apakah Anda anggota ikatan karyawan tersebut? Beri tanda (✓) pada satu kotak saja

- Ya
- Tidak, tapi dulu pernah
- Tidak, tidak pernah menjadi anggota

26. Apakah Anda setuju atau tidak setuju dengan pernyataan berikut mengenai ikatan karyawan di rumah sakit ini? Beri satu tanda (✓) saja pada setiap baris

Ikatan karyawan di rumah sakit ini _____

	Sangat setuju	Setuju	Tanpa pendapat	Tidak setuju	Sangat tidak setuju	Tidak tahu
Memperhatikan masalah dan keluhan anggota						
Dianggap serius oleh manajemen/pejabat struktural						
Berpengaruh terhadap kondisi kerja disini						

27. Secara ideal, siapa yang paling tepat mewakili Anda untuk berurusan dengan para pejabat struktural di rumah sakit ini mengenai hal-hal berikut? Beri satu tanda (✓) saja pada setiap baris

	Saya sendiri	Wakil karyawan (pengurus ikatan karyawan)	Atasan langsung	Karyawan lain yang saya percayai
Memperoleh kenaikan gaji				
Jika perusahaan ingin mengurangi gaji atau jam kerja Anda				
Mendapatkan pelatihan				
Jika Anda ingin mengajukan keluhan mengenai bekerja di tempat ini				
Jika seorang atasan ingin mendisiplinkan Anda				

Perihal karakteristik pribadi Anda

28. Apakah Anda setuju atau tidak setuju dengan pernyataan berikut mengenai pekerjaan Anda?
Beri tanda (✓) pada satu kotak saja

No	Pernyataan	Sangat setuju	Setuju	Ragu-ragu	Tidak setuju	Sangat tidak setuju
1	Saya merasa malu bila atasan saya mengatakan bahwa hasil pekerjaan saya buruk					
2	Keluarga saya turut merasa malu bila saya tidak dapat diandalkan dalam bekerja					
3	Saya merasa menyesal bila hasil pekerjaan saya buruk, meskipun tidak ada orang lain yang tahu					
4	Memiliki dedikasi adalah hal yang penting dalam bekerja					
5	Memiliki kemampuan bekerja sama sangat penting dalam bekerja					
6	Pekerjaan harus dilakukan dengan usaha yang giat					
7	Konsultasi memudahkan penyelesaian masalah dan menghindari kesalahan					
8	Memiliki loyalitas adalah hal yang penting dalam bekerja					
9	Kemandirian diperlukan untuk mencapai kesuksesan dalam bekerja					
10	Karyawan yang sukses adalah mereka yang mampu menyelesaikan pekerjaan sesuai tenggat waktu					
11	Seseorang yang melakukan pekerjaannya dengan baik pada umumnya dapat mengatasi kesulitan dalam hidupnya dengan lebih baik					
12	Saya dapat tetap fokus pada pekerjaan saya walau pekerjaan tersebut membosankan					
13	Saya mengevaluasi kemajuan pekerjaan saya, terutama pada pekerjaan yang sulit					
14	Saya menetapkan tujuan kerja bagi diri saya sendiri					
15	Saya merasa percaya diri dalam mengatasi masalah saat bekerja					
16	Saya merasa pekerjaan saya berjalan sesuai keinginan saya					
17	Sangat penting bagi saya untuk melakukan yang terbaik dalam bekerja, walaupun tidak mendapatkan pujian					
18	Saya suka bekerja keras					

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No	Pernyataan	Sangat setuju	Setuju	Ragu-ragu	Tidak setuju	Sangat tidak setuju
19	Kinerja saya meningkat bila ada hal-hal yang saya sukai dari pekerjaan saya					
20	Saya tidak dapat bekerja bila saya merasa cemas					
21	Saya tidak dapat berkonsentrasi bila saya sedang sedih					
22	Pekerjaan adalah sesuatu yang berarti bagi saya					
23	Besar kecilnya pendapatan saya tergantung pada nasib					
24	Besar kecilnya pendapatan saya tergantung ada tidaknya orang yang saya kenal pada jabatan tertentu					
25	Saya mampu menyelesaikan pekerjaan dengan tuntas					
26	Saya memiliki kebebasan untuk melakukan metode yang saya inginkan dalam bekerja					
27	Saya mampu mengukur kinerja saya pada saat saya sedang melakukan pekerjaan tersebut					
28	Jika terjadi perubahan di rumah sakit ini, saya akan berusaha mengikuti perubahan tersebut					
29	Saya mampu beradaptasi lebih baik terhadap perubahan dibandingkan rekan kerja yang lain					
30	Saya merasa perubahan yang terjadi di rumah sakit ini sebagai jalan bagi karier yang lebih baik					

Perihal motivasi kerja Anda

29. Apakah Anda setuju atau tidak setuju dengan pernyataan berikut mengenai motivasi Anda? Beri tanda (✓) pada satu kotak saja

No	Pernyataan	Sangat setuju	Setuju	Ragu-ragu	Tidak setuju	Sangat tidak setuju
1	Saat ini saya memiliki keinginan untuk bekerja sebaik mungkin di rumah sakit ini					
2	Saya bersedia bekerja di rumah sakit ini hanya agar mendapatkan gaji tiap akhir bulan					
3	Saya bersedia bekerja di rumah sakit ini karena memperoleh jaminan hari tua/pensiun					
4	Saya merasa emosi saya terkuras setiap pulang dari bekerja					
5	Saat saya bangun pagi, kadang-kadang saya merasa takut menghadapi hari di tempat kerja					
6	Saya merasa puas dengan pekerjaan saya					
7	Saya merasa tidak puas dengan hasil kerja rekan kerja saya pada unit yang sama					
8	Saya merasa puas dengan kebijakan atasan saya					
9	Saya merasa puas dengan kesempatan yang diberikan oleh rumah sakit ini untuk mengembangkan kemampuan saya					
10	Saya merasa puas karena saya telah menyelesaikan hal-hal yang berarti dalam pekerjaan saya					
11	Saya merasa hasil pekerjaan saya kurang berarti pada beberapa hari ini					
12	Saya bangga bekerja di rumah sakit ini					
13	Nilai yang saya anut sejalan dengan nilai pada rumah sakit ini					
14	Saya senang bekerja di rumah sakit ini daripada di rumah sakit lain					
15	Saya merasa kurang memiliki komitmen kepada rumah sakit					
16	Rumah sakit ini memberikan inspirasi sehingga saya bekerja sebaik mungkin					
17	Saya tidak tergantung pada rekan kerja dalam menyelesaikan pekerjaan saya					
18	Saya selalu menyelesaikan pekerjaan saya secara tepat dan efisien					
19	Saya seorang pekerja keras					

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Continued from previous page

No	Pernyataan	Sangat setuju	Setuju	Ragu-ragu	Tidak setuju	Sangat tidak setuju
20	Saya melakukan pekerjaan tanpa harus disuruh terlebih dahulu					
21	Saya tepat waktu datang ke tempat kerja					
22	Saya sering tidak masuk kerja					

Perihal Anda

30. Jenis kelamin Anda: laki-laki perempuan

31. Usia Anda saat ini: *Beri tanda (✓) pada satu kotak saja*

kurang dari/sama dengan 30 tahun

31 sampai 40 tahun

41 sampai 50 tahun

lebih dari 51 tahun

32. Status pernikahan Anda: *Beri tanda (✓) pada satu kotak saja*

Belum menikah

Menikah

Cerai hidup

Cerai mati

33. Berapa orang anak yang masih menjadi tanggungan Anda? Harap sebutkan jenis kelamin dan umur anak-anak Anda tersebut dalam tabel di bawah ini.

No.	Urutan anak	Jenis kelamin	Umur (tahun)
1	Pertama		
2	Kedua		
3	Ketiga		
4	Keempat		

34. Apakah Anda merawat atau membantu kerabat atau teman yang mengalami keterbatasan fisik/cacat tubuh, gangguan kejiwaan atau berusia lanjut? *Beri tanda (✓) pada satu kotak saja*

Tidak

Ya, 0-4 jam dalam seminggu

Ya, 5-9 jam dalam seminggu

Ya, 10-19 jam dalam seminggu

Ya, 20-34 jam dalam seminggu

Ya, 35 jam atau lebih dalam seminggu

35. Apakah kegiatan Anda sehari-hari terbatas karena mengalami gangguan kesehatan atau keterbatasan fisik yang telah berlangsung, atau akan berlangsung, paling tidak selama 12 bulan (termasuk jika Anda memiliki masalah kesehatan terkait dengan usia lanjut)? *Beri tanda (✓) pada satu kotak saja*

Tidak

Ya, sedikit terbatas

Ya, sangat terbatas

36. Bagaimana kesehatan Anda secara umum?

sangat baik

baik

cukup baik

buruk

sangat buruk

37. Tingkat pendidikan terakhir Anda: *Beri tanda (✓) pada satu kotak saja*

SLTP/SMP Umum/Kejuruan/Madrasah Tsanawiyah

SLTA/SMA/SMU/SMK/Madrasah Aliyah

Diploma

Sarjana (S1)/S1 Profesi

Pasca Sarjana (S2)/Spesialis

Doktoral (S3)/Sub Spesialis

Lainnya, sebutkan _____

38. Tuliskan apa yang Anda lakukan dalam pekerjaan Anda. Harap jelaskan selengkap mungkin.

39. Apakah Anda melakukan kegiatan supervisi atas karyawan lain? Seorang penyelia, mandor atau atasan bertanggungjawab atas pelaksanaan kerja karyawan lain dalam kesehariannya. *Beri tanda (✓) pada satu kotak saja*

Ya

Tidak

40. Jumlah pengeluaran/belanja rumah tangga Anda (rata-rata) setiap bulan adalah Rp _____

41. Jumlah uang yang ditabung (rata-rata) setiap bulan adalah Rp _____

42. Apa saja yang Anda terima sebagai komponen gaji bulanan Anda dari rumah sakit ini? *Beri tanda (✓) pada semua kotak yang relevan*

Gaji pokok/upah

Tunjangan

Penerimaan lain berdasarkan kinerja individual

Penerimaan lain berdasarkan keseluruhan kinerja grup atau tim

Penerimaan berdasarkan keseluruhan kinerja rumah sakit ini atau unit kerja (seperti: pembagian insentif/bonus kepada karyawan berdasarkan peningkatan penerimaan rumah sakit)

Penerimaan ekstra untuk kerja lembur

43. Agama Anda: *Beri tanda (✓) pada satu kotak saja*

Islam

Kristen Protestan

Katolik

Hindu

Budha

Khonghucu

Lainnya, sebutkan _____

44. Anda termasuk suku bangsa: *Beri tanda (✓) pada satu kotak saja*

- Jawa
- Madura
- Cina
- Batak
- Sulawesi(non Bugis)
- Minangkabau
- Sunda
- Bugis
- Melayu
- Betawi
- Lainnya, sebutkan _____

Terimakasih atas kesediaan Anda.

Appendix B

Participant consent form

The University of Manchester
Institute for Social Change

Lembar Persetujuan Responden

**Pengaruh korporatisasi dan modal sosial di tempat kerja
terhadap motivasi dan kepuasan karyawan
serta kinerja rumah sakit umum daerah di Jawa Timur**

Jika Anda bersedia berpartisipasi dalam penelitian ini, mohon membaca lembar persetujuan ini dan memberikan tanda ✓ atau inisial nama Anda pada kotak yang tersedia:

1. Saya telah membaca lembar informasi responden untuk penelitian ini dan telah berkesempatan untuk mempertimbangkan semua informasi yang tersedia dan memahaminya.
2. Saya mengerti bahwa partisipasi saya dalam penelitian ini bersifat sukarela dan saya bebas untuk mengundurkan diri kapanpun tanpa perlu memberikan alasan dan tanpa konsekuensi negatif apapun.

Saya setuju untuk berpartisipasi dalam penelitian ini.

Nama responden

Tanggal

Tandatangan

Nama pihak peneliti

Tanggal

Tandatangan

Appendix C

Districts and public hospitals surveyed in East Java

City/Regency	Public hospitals
Surabaya city	RS Dr. Soetomo RS Haji RS Dr. M. Soewandhi RS Bhakti Darma Husada
Malang city	RS Dr. Saiful Anwar
Malang regency	RS Kepanjen RS Jiwa Lawang
Batu city	RS Paru Batu
Jember regency	RS Dr. Soebandi RS Balung RS Kalisat RS Paru
Madiun city	RS Dr. Soedono RSU Kota Madiun
Madiun regency	RS Kabupaten Madiun RS Paru Dungus
Lamongan regency	RS Dr. Soegiri
Kediri city	RS Kusta
Kediri regency	RSUD Pare
Sidoarjo regency	RSUD Sidoarjo
Gresik regency	RSUD Ibnu Sina
Mojokerto city	RSUD Dr. Wahidin Sudiro Husodo
Mojokerto regency	RSUD Prof. Dr. Soekandar RSUD RA Basuni RS Kusta Sumber Glagah
Pasuruan city	RSUD Dr. R. Soedarsono
Pasuruan regency	RSUD Bangil
Bojonegoro regency	RSU Dr. Sosodoro RSU Sumberrejo

Continued on the next page

Table C.1 – continued from the previous page

City/Regency	Public hospitals
	RSU Padangan
Tuban regency	RSUD Dr. R. Koesma
Ngawi regency	RSUD Dr. Soeroto
Probolinggo city	RSUD Dr. Moh. Shaleh
Probolinggo regency	RSUD Waluyoajati Kraksaan
	RSUD Tongas
Lumajang regency	RSUD Dr. Haryoto
Bondowoso regency	RSUD Dr. H. Koesnadi
Situbondo regency	RSUD Abdurrahem
Banyuwangi regency	RSUD Blambangan
	RSUD Genteng
Magetan regency	RSUD Dr. Sayidiman
Ponorogo regency	RSUD Prof. Dr. Harjono, SpOG
Pacitan regency	RSUD Pacitan
Blitar city	RSUD Mardi Waluyo
Blitar regency	RSUD Ngudi Waluyo
Tulungagung regency	RSUD Dr. Iskak
Nganjuk regency	RSUD Nganjuk
	RSUD Kertosono
Jombang regency	RSUD Jombang
Bangkalan regency	RSUD Syarifata Rato Ebuh
Sampang regency	RSUD Sampang
Pamekasan regency	RS Slamet Martodirjo
Sumenep regency	RSUD Dr. Moh. Anwar
Trenggalek regency	RSUD Soedomo

Notes: RS = *rumah sakit* or hospital,
 RSU = *rumah sakit umum* or public hospitals,
 RSUD = *rumah sakit umum daerah* or district public hospitals.

Appendix D

Unimputed results of Chapter 4

Table D.1: Multilevel models predicting well-being of workers in Europe

	Model 1	Model 2	Model 3	Model 4	Model 5
Constant	16.256(0.224)‡	11.543(0.233)‡	3.380(0.542)‡	3.235(0.583)‡	3.967(0.995)‡
Social capital		1.209(0.028)‡	0.466(0.039)‡	0.464(0.039)‡	0.464(0.033)‡
<i>Activities outside work:</i>					
Voluntary activity			0.069(0.033)†	0.071(0.033)†	0.070(0.033)†
Caring for children			-0.001(0.015)	-0.000(0.015)	-0.001(0.015)
Cooking			-0.052(0.023)†	-0.050(0.023)†	-0.050(0.023)†
Caring for elderly			-0.060(0.021)‡	-0.061(0.021)‡	-0.061(0.021)‡
Taking a training			-0.020(0.034)	-0.020(0.034)	-0.020(0.034)
Sporting/cultural activity			0.153(0.022)‡	0.154(0.022)‡	0.153(0.022)‡
Gardening and repairs			0.083(0.022)‡	0.082(0.022)‡	0.084(0.022)‡
<i>Individual characteristics:</i>					
Age			-0.125(0.023)‡	-0.126(0.023)‡	-0.123(0.023)‡
Age-squared			0.001(0.000)‡	0.001(0.000)‡	0.001(0.000)‡
Male			0.564(0.082)‡	0.559(0.082)‡	0.568(0.082)‡
Health			2.294(0.068)‡	2.294(0.068)‡	2.294(0.068)‡
Education			-0.010(0.009)	-0.011(0.009)	-0.010(0.009)
Having a spouse/partner			0.331(0.077)‡	0.334(0.077)‡	0.332(0.077)‡
Being a main earner			-0.205(0.058)‡	-0.208(0.058)‡	-0.200(0.058)‡
Work schedule fits with family			1.116(0.081)‡	1.119(0.081)‡	1.116(0.081)‡
Income €4801 - €7200			-0.076(0.109)	-0.051(0.109)	-0.084(0.110)
Income €7201 - €12000			-0.058(0.132)	-0.012(0.133)	-0.101(0.136)
Income €12001 - €21000			-0.083(0.145)	-0.019(0.146)	-0.138(0.151)
Income €21001 - €48000			-0.394(0.169)†	-0.320(0.171)	-0.454(0.177)†
<i>Job aspects:</i>					
Well-paid job			0.340(0.033)‡	0.340(0.033)‡	0.341(0.033)‡
Career advancement			0.180(0.031)‡	0.178(0.031)‡	0.181(0.032)‡
Feel at home			0.582(0.040)‡	0.582(0.040)‡	0.579(0.040)‡
Ease to find other job			0.170(0.027)‡	0.173(0.027)‡	0.170(0.027)‡
Motivated to do the best			0.534(0.037)‡	0.534(0.036)‡	0.534(0.036)‡
Possibility to lose job			-0.172(0.029)‡	-0.174(0.029)‡	-0.171(0.029)‡
<i>Employment contract:</i>					
Temporary/apprenticeship			0.172(0.277)	0.170(0.276)	0.169(0.277)
Fixed contract			0.333(0.155)†	0.323(0.155)†	0.339(0.155)†
Indefinite contract			0.226(0.131)	0.215(0.130)	0.241(0.131)
<i>Work sectors:</i>					
Public			-0.019(0.073)	-0.024(0.073)	-0.018(0.073)
Joint			-0.111(0.155)	-0.111(0.155)	-0.103(0.155)
Non-profit			0.082(0.277)	0.087(0.277)	0.083(0.277)
Other			0.271(0.371)	0.272(0.371)	0.276(0.371)
<i>Regional factors:</i>					
Growth				-0.099(0.054)	-0.131(0.046)‡
Unemployment rate				0.030(0.016)	0.058(0.016)‡
<i>Country factors:</i>					
Gini index					-0.013(0.032)
Bismarckian					-0.208(0.407)
Anglo-Saxon					-0.648(0.571)
Southern Europe					-0.232(0.471)
Eastern Europe					-1.156(0.442)‡
Between-country variance	1.218(0.170)	1.104(0.157)	0.671(0.112)	0.580(0.106)	0.427(0.097)
Between-region variance	1.291(0.062)	1.228(0.062)	1.063(0.064)	1.065(0.064)	1.063(0.064)
Between-individual variance	5.021(0.018)	4.890(0.018)	4.370(0.022)	4.370(0.022)	4.370(0.022)
ρ country	0.162	0.153	0.110	0.096	0.073
ρ region	0.171	0.170	0.174	0.177	0.196
Individuals	39819	37160	20844	20844	20844
Regions	400	400	400	400	400
Countries	34	34	34	34	34

Note: Reported in coefficients (standard errors). Sig. 1%‡; 5%†.

Table D.2: Multilevel models predicting job satisfaction in Europe

	Model 1	Model 2	Model 3	Model 4	Model 5
Constant	2.968(0.039)‡	2.296(0.039)‡	1.028(0.068)‡	1.145(0.073)‡	1.003(0.131)‡
Social capital		0.172(0.004)‡	0.010(0.005)‡	0.010(0.005)‡	0.010(0.005)‡
<i>Activities outside work:</i>					
Voluntary activity			0.004(0.004)	0.004(0.004)	0.004(0.004)
Caring for children			0.003(0.002)	0.004(0.002)	0.004(0.002)
Cooking			0.001(0.003)	0.001(0.003)	0.001(0.003)
Caring for elderly			-0.005(0.003)	-0.005(0.003)	-0.005(0.003)
Taking a training			0.004(0.004)	0.005(0.004)	0.005(0.004)
Sporting/cultural activity			0.001(0.003)	0.001(0.003)	0.001(0.003)
Gardening and repairs			-0.008(0.003)‡	-0.008(0.003)‡	-0.008(0.003)‡
<i>Personal characteristics:</i>					
Age			-0.004(0.003)	-0.004(0.002)	-0.003(0.003)
Male			-0.010(0.010)	-0.009(0.010)	-0.009(0.010)
Health			0.151(0.009)‡	0.151(0.009)‡	0.151(0.009)‡
Education			0.004(0.001)‡	0.004(0.001)‡	0.004(0.001)‡
Having a spouse/partner			-0.005(0.010)	-0.005(0.010)	-0.005(0.010)
Being a main earner			-0.007(0.007)	0.008(0.007)	-0.007(0.007)
Work schedule fits with family			0.211(0.010)‡	0.212(0.010)‡	0.212(0.010)‡
Income €4801 - €7200			0.032(0.014)†	0.029(0.014)†	0.029(0.014)†
Income €7201 - €12000			0.051(0.017)‡	0.045(0.017)‡	0.043(0.017)†
Income €12001 - €21000			0.015(0.018)	0.008(0.018)	0.004(0.019)
Income €21001 - €48000			0.014(0.021)	0.006(0.021)	0.000(0.022)
<i>Job aspects:</i>					
Well-paid job			0.113(0.004)‡	0.114(0.004)‡	0.114(0.004)‡
Career advancement			0.037(0.004)‡	0.037(0.004)‡	0.037(0.004)‡
Feel at home			0.150(0.005)‡	0.150(0.005)‡	0.150(0.005)‡
Motivated to do the best			0.114(0.005)‡	0.114(0.005)‡	0.114(0.005)‡
Possibility to lose job			-0.063(0.004)‡	-0.063(0.004)‡	-0.063(0.004)‡
<i>Employment contract:</i>					
Temporary/apprenticeship			0.051(0.035)	0.050(0.035)	0.051(0.034)
Fixed contract			0.074(0.019)‡	0.075(0.019)‡	0.076(0.019)‡
Indefinite contract			0.032(0.016)†	0.032(0.016)†	0.034(0.016)†
<i>Work sectors:</i>					
Public			0.014(0.009)	0.015(0.009)	0.014(0.009)
Joint			-0.018(0.019)	-0.019(0.019)	-0.018(0.019)
Non-profit			-0.019(0.035)	-0.019(0.035)	-0.019(0.035)
Other			0.075(0.047)	0.075(0.047)	0.074(0.047)
<i>Regional factors:</i>					
Growth				-0.012(0.007)	-0.011(0.007)
Unemployment rate				-0.008(0.002)‡	-0.008(0.002)‡
<i>Country factors:</i>					
Gini index					0.005(0.004)
Bismarckian					-0.075(0.052)
Anglo-Saxon					-0.059(0.075)
Southern Europe					-0.093(0.059)
Eastern Europe					-0.102(0.055)
Between-country variance	0.224(0.028)	0.205(0.026)	0.106(0.015)	0.084(0.012)	0.069(0.011)
Between-region variance	0.126(0.007)	0.122(0.007)	0.071(0.007)	0.070(0.007)	0.071(0.007)
Between-individual variance	0.697(0.002)	0.672(0.002)	0.551(0.003)	0.551(0.003)	0.551(0.003)
ρ country	0.214	0.205	0.146	0.119	0.100
ρ region	0.120	0.122	0.098	0.099	0.114
Individuals	40089	37396	20877	20877	20877
Regions	400	400	400	400	400
Countries	34	34	34	34	34

Notes: Reported in coefficients (standard errors). Sig. 1%‡; 5%†.

Age-squared and easy to find job are not reported as the coefficients are zeros.

Appendix E

Regression models for Chapters 7 and 8

Table E.1: Workplace social capital*, job satisfaction* and workplace performance in Britain - regression models¹

	Productivity	Quality	Financial results	Absenteeism
Social capital	0.066(0.023)‡	0.058(0.027)†	0.130(0.022)‡	0.001(0.002)
Job satisfaction	0.014(0.026)	0.072(0.028)†	-0.069(0.026)‡	-0.004(0.002)†
<i>Workplace characteristics:</i>				
Female employees (%)	0.082(0.137)	-0.241(0.155)	0.001(0.139)	0.054(0.012)‡
Tenured employees (%)	-0.084(0.150)	-0.089(0.172)	-0.074(0.148)	0.024(0.014)
Matched skill with job (%)	-0.008(0.018)	-0.009(0.021)	-0.032(0.019)	-0.001(0.002)
Over-skilled for job (%)	0.010(0.048)	0.005(0.052)	-0.036(0.048)	-0.002(0.004)
Trained employees:				
<39%	-0.134(0.131)	-0.341(0.157)†	0.081(0.129)	0.030(0.014)†
40-59%	0.131(0.143)	-0.297(0.162)	0.065(0.136)	0.010(0.014)
60-79%	0.173(0.144)	-0.178(0.162)	0.254(0.135)	0.019(0.014)
>80%	0.154(0.101)	0.061(0.120)	0.323(0.099)‡	0.008(0.009)
Existence of performance-based system	0.136(0.070)	-0.027(0.080)	0.100(0.070)	-0.021(0.006)‡
Introduction of management changes	0.121(0.081)	-0.126(0.101)	0.154(0.080)	-0.004(0.009)
Size of workplace	-0.038(0.023)	-0.016(0.025)	0.059(0.023)†	0.005(0.001)‡
Public sector	-0.051(0.089)	-0.359(0.092)‡	0.000(0.085)	0.017(0.007)‡
Redundancy in workplace	-0.003(0.005)	-0.003(0.006)	-0.001(0.006)	-0.001(0.001)†
Dismissals in workplace	-0.024(0.011)†	-0.018(0.013)	-0.009(0.011)	0.006(0.002)‡
Impacted by recession	-0.178(0.083)†	-0.004(0.022)	-0.377(0.083)‡	-0.008(0.008)
Industrial unemployment	0.003(0.019)	-0.003(0.022)	0.039(0.020)	0.001(0.002)
Constant				0.187(0.038)†
/cut1	-0.598(0.417)	-0.650(0.476)	-0.475(0.440)	
/cut2	-0.957(0.414)	0.645(0.478)	0.950(0.441)	
Individuals	18099	19157	18428	17672
Workplaces	1615	1706	1642	1561

Notes: * summation of indicators based on CFA.

¹ Absenteeism uses linear regression; other performance measures use ordered probit.

Reported in standardised coefficients (robust standard errors) by workplace.

Sig.: 1%‡; 5%†; 10%

Table E.2: Workplace social capital*, job satisfaction* and workplace performance in British health-care industry - regression model²

	Productivity	Quality	Financial results	Absenteeism
Social capital	0.006(0.062)	0.032(0.081)	0.134(0.063)†	0.005(0.006)
Job satisfaction	0.039(0.078)	0.012(0.090)	-0.198(0.085)†	0.005(0.006)
<i>Workplace characteristics:</i>				
Female employees (%)	0.119(0.572)	0.735(0.696)	-1.279(0.667)	-0.047(0.085)
Tenured employees (%)	-0.171(0.396)	0.922(0.535)	-0.214(0.370)	-0.012(0.034)
Matched skill with job (%)	0.015(0.043)	-0.081(0.058)	0.049(0.045)	-0.002(0.003)
Over-skilled for job (%)	0.110(0.137)	-0.182(0.177)	0.299(0.141)†	-0.004(0.008)
Trained employees (%)	-0.006(0.079)	0.237(0.095)†	0.007(0.066)	-0.001(0.009)
Existence of performance-based system	0.287(0.201)	-0.184(0.265)	0.308(0.191)	-0.017(0.014)
Introduction of management changes	-0.147(0.210)	-0.755(0.326)†	-0.001(0.193)	-0.004(0.024)
Size of workplace	-0.010(0.053)	-0.051(0.068)	0.101(0.049)	0.002(0.005)
Public sector	-0.767(0.232)‡	-0.948(0.284)‡	-0.556(0.209)‡	0.017(0.021)
Redundancy in workplace	0.005(0.025)	-0.013(0.036)	0.029(0.039)	-0.001(0.003)
Impacted by recession	-0.126(0.231)	-0.359(0.254)	-0.226(0.224)	-0.002(0.021)
Constant				0.069(0.103)
/cut1	-1.748(1.226)	-1.118(1.510)	-4.661(1.386)	
/cut2	-0.067(1.198)		-2940(1.358)	
Individuals	2937	3098	2972	2832
Workplaces	258	271	259	248

Notes: * summation of indicators based on CFA.

² Absenteeism uses linear regression; other performance measures use ordered probit.

Reported in standardised coefficients (robust standard errors) by workplace

Sig.: 1%‡; 5%†.

Table E.3: Social capital*, job satisfaction and subjective workplace performance in Indonesia (1) - ordered probit regression model

	Financial performance	Quality	Productivity
Vertical social capital	0.038(0.082)	-0.055(0.071)	-0.021(0.074)
Horizontal social capital	-0.002(0.021)	0.010(0.020)	0.027(0.021)
Job satisfaction	-0.008(0.041)	-0.060(0.049)	-0.041(0.040)
Hospital class	0.741(0.404)	-0.027(0.372)	0.249(0.379)
Existence of performance-related pay	0.067(0.382)	-0.041(0.410)	-0.008(0.432)
Proportion of matched skill employees	0.029(0.113)	0.045(0.135)	-0.060(0.130)
Proportion of over-skilled employees	0.086(0.126)	0.047(0.136)	-0.000(0.133)
Having an experienced director	0.044(0.430)	0.447(0.426)	0.248(0.397)
/cut1	-0.639(0.564)	-0.964(0.499)	-0.604(0.499)
/cut2	0.906(0.571)	0.661(0.539)	0.442(0.498)
Individuals	860	997	943
Workplaces	37	43	41

Notes: * only horizontal social capital is a summation of indicators based on CFA.

Reported in standardised coefficients (robust standard errors) by workplace. Sig. 1%‡; 5%‡.

Table E.4: Social capital*, job satisfaction* and subjective workplace performance in Indonesia (1) - ordered probit regression model

	Financial performance	Quality	Productivity
Vertical social capital	0.004(0.032)	-0.019(0.027)	-0.009(0.027)
Horizontal social capital	-0.001(0.021)	0.013(0.019)	0.025(0.021)
Job satisfaction	0.007(0.024)	-0.024(0.024)	-0.010(0.023)
Hospital class	0.741(0.404)	-0.047(0.370)	0.231(0.379)
Existence of performance-related pay	0.076(0.382)	-0.038(0.412)	0.003(0.434)
Proportion of matched skill employees	0.040(0.119)	0.034(0.148)	-0.039(0.136)
Proportion of over-skilled employees	0.085(0.127)	0.027(0.144)	0.013(0.135)
Having an experienced director	0.041(0.429)	0.434(0.424)	0.240(0.395)
/cut1	-0.607(0.594)	-1.016(0.519)	-0.605(0.530)
/cut2	0.927(0.591)	0.609(0.547)	0.434(0.520)
Individuals	843	977	925
Workplaces	37	43	41

Notes: * summation of indicators based on CFA.

Reported in standardised coefficients (robust standard errors) by workplace. Sig. 1%‡; 5%‡.

Table E.5: Workplace social capital*, job satisfaction* and objective workplace performance in Indonesia (1) - linear regression model

	Revenue per bed	Expenditure per bed	BOR	LOS
Constant	21.008(0.356)‡	19.283(0.245)‡	0.325(0.065)‡	0.290(0.023)‡
Vertical social capital	0.008(0.021)	-0.044(0.021)†	0.007(0.004)	-0.001(0.002)
Horizontal social capital	-0.011(0.015)	0.020(0.010)	-0.007(0.003)‡	0.002(0.001)
Job satisfaction	-0.010(0.021)	-0.240(0.415)	0.004(0.012)	-0.001(0.002)
Hospital class	1.199(0.255)‡	0.337(0.195)	0.161(0.045)‡	-0.041(0.018)
Existence of performance-related pay	0.537(0.305)	-0.263(0.074)‡	0.068(0.055)	-0.044(0.024)
Proportion of matched skill employees	-0.046(0.112)	0.378(0.081)	0.011(0.017)	-0.004(0.007)
Proportion of over-skilled employees	-0.050(0.108)	0.061(0.078)	0.015(0.014)	-0.011(0.007)
Having an experienced director	-0.284(0.254)	0.090(0.206)	0.107(0.040)†	-0.013(0.018)
Individuals	1063	1104	1019	1019
Workplaces	47	44	45	45

Notes: * summation of indicators based on CFA.

Reported in standardised coefficients (robust standard errors) by workplace. Sig. 1%‡; 5%†

Table E.6: Workplace social capital*, job satisfaction and objective workplace performance in Indonesia (1) - linear regression model

	Revenue per bed	Expenditure per bed	BOR	LOS
Constant	20.980(0.041) ‡	19.319(0.239) ‡	0.326(0.060) ‡	0.286(0.021) ‡
Vertical social capital	0.045(0.041)	-0.093(0.049)	0.014(0.009)	-0.002(0.003)
Horizontal social capital	-0.018(0.015)	0.013(0.010)	0.005(0.002) †	0.002(0.001)
Job satisfaction	-0.014(0.033)	-0.008(0.021)	0.007(0.005)	-0.003(0.003)
Hospital class	1.192(0.255) ‡	0.341(0.198)	0.161(0.045) ‡	-0.041(0.018) ‡
Existence of performance-related pay	0.523(0.306)	0.145(0.174) ‡	0.067(0.055)	-0.044(0.024)
Proportion of matched skill employees	-0.032(0.103)	0.036(0.079)	0.013(0.015)	-0.004(0.007)
Proportion of over-skilled employees	-0.042(0.101)	0.066(0.077)	0.015(0.013)	-0.010(0.007)
Having an experienced director	-0.290(0.252)	0.085(0.209)	0.106(0.040) †	-0.012(0.018)
Individuals	1089	1026	1043	1043
Workplaces	47	44	45	45

Notes: * only horizontal social capital is a summation of indicators based on CFA.

Reported in standardised coefficients (robust standard errors) by workplace. Sig. 1% ‡; 5% †.

Appendix F

Codes for Chapter 4

F.1 Data preparation

```
use G:\Spare HDDF2011dec2014\HDDF2011\Europe\EWCS\  
ewcs2010_nmrg13.dta  
***to merge unemployment rate per region  
sort region  
drop _merge  
merge m:m region using G:\SpareHDDF2011dec2014\HDDF2011\Europe\EWCS\  
unemp2010_nuts2.dta  
save G:\SpareHDDF2011dec2014\HDDF2011\Europe\EWCS\  
ewcs2010_febmrg14.dta,replace  
*** to have work only respondents  
recode hh2d (1=1) (else=0), gen(respondent)  
keep if respondent==1  
***to generate age of respondent  
recode hh2b (999=.), gen(age)  
keep if age<=64  
gen agesq=age^2  
*** to generate gender  
gen gender=hh2a  
*** health  
recode q68 (1/2=1)(3/5=0)(8/9=.), gen(health)  
label variable health "reported health"  
*** to generate years of education  
recode q5(88/99=.)(77=0), gen(yrs1)  
tab yrs1 recode yrs1(0=1) (else=0), gen(yrs2) gen yrs3 = yrs2 * age  
***to generate starting age for education  
recode countid (1=6)(2=7)(3/5=6)(6=7)(7=5)(8/11=6)(12=4)(13=5)(14=7)  
(15=4)(16/18=5)(19/24=6)(25/26=7)(27=4)(28/34=6), gen(stedu)  
**to center education  
gen yrseduc = (yrs1 + yrs3)-stedu  
tab yrseduc  
***to differentiate type of employment contract  
recode q7 (1=4) (2=3)(3/4=2) (5/6=1)(8/9=.), gen(empcontr)
```

```

***to generate income
recode ef11_rec (22/23=.), gen(inc)
xtile qincome= inc, nq(5)
***to generate main earner in the household
recode ef5 (8/9=.) (1=1)(2/3=0), gen (mainearner)
***to generate size of household
recode hh1 (99=.),gen(sizehh)
***to generate marital status
recode hh3_2c (88/99=.) (1=1)(2/8=0), gen(married)
***to generate the fit of working hours with family/social commitments
recode q41 (1/2=1)(3/4=2)(8/9=.), gen(workfit)
***to generate variable friendship at work
recode q77e (7/9=.), gen(friendship)
****other variables related to job
***to generate variable possibility to lose job
recode q77a (7/9=.), gen(losejob)
***to generate variable wellpaid job
recode q77b (7/9=.), gen(wellpaid)
***to generate variable career advancement
recode q77c (7/9=.), gen(career)
***to generate variable feeling at home
recode q77d (7/9=.), gen(athome)
***to generate variable easy to find similar job
recode q77f (7/9=.), gen(easyfind)
***to generate variable encouraged to do my best
recode q77g (7/9=.), gen(mybest)
***to generate variable activities outside work
recode ef2a (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0) (8/9=.), gen(voluntary)
recode ef2b (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0) (8/9=.), gen(union)
recode ef2c (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0) (8/9=.), gen(children)
recode ef2d (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0) (8/9=.), gen(cooking)
recode ef2e (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0) (8/9=.), gen(elderly)
recode ef2f (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0)(8/9=.), gen(training)
recode ef2g (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0) (8/9=.), gen(leisure)
recode ef2h (1=6)(2=5)(3=4)(4=3)(5=2)(6=1)(7=0)(8/9=.), gen(gardening)
label var voluntary "voluntary"
label var union "union"
label var children "children"
label var cooking "cooking"
label var elderly "elderly"
label var training "training"
label var leisure "leisure"
label var gardening "gardening"
***to generate variable wellbeing
recode ef4a (1=5)(2=4)(3=3)(4=2)(5=1)(6=0)(8/9=.), gen(cheerful)
recode ef4b (1=5)(2=4)(3=3)(4=2)(5=1)(6=0)(8/9=.), gen(relax)
recode ef4c (1=5)(2=4)(3=3)(4=2)(5=1)(6=0)(8/9=.), gen(active)

```

```

recode ef4d (1=5)(2=4)(3=3)(4=2)(5=1)(6=0)(8/9=.), gen(fresh)
recode ef4e (1=5)(2=4)(3=3)(4=2)(5=1)(6=0)(8/9=.), gen(interest)
***to generate wellbeing index (revised)
gen webidx = (cheerful+relax+active+fresh+interest)
***to generate variable job satisfaction
recode q76 (1=4)(2=3)(3=2)(4=1)(8/9=.), gen(jobsat)
sum webidx
sum jobsat
***to generate working sectors
recode q10 (8/9=.), gen(wsector)
gen private = wsector==1 if !missing(wsector)
gen public = wsector==2 if !missing(wsector)
gen joint = wsector==3 if !missing(wsector)
gen ngo = wsector==4 if !missing(wsector)
gen othsector = wsector==5 if !missing(wsector)
*** to generate the welfare state regimes
gen labmar=countid
recode labmar (1=1)(2/3=5)(4=3)(5=1)(6=5)(7/8=4)(9=1) ///
(10=2)(11/12=4)(13=5) (14=5)(15=1)(16=5)(17=4)(18/19=1) ///
(20=5)(21=4) (22/24=5)(25/26=3)(27=2)(28/29=5) ///
(30=4)(31=3)(32/34=5), gen(regime)
gen conserve = regime==1 if !missing(regime)
gen liberal = regime==2 if !missing(regime)
gen socdem = regime==3 if !missing(regime)
gen southern = regime==4 if !missing(regime)
gen postcom = regime==5 if !missing(regime)
***to rename contextual factors
ren ue2010 regunp10
ren GINI10 gini10
save G:\Europe\EWCS\ewcs2010_WB2014.dta, replace

****dataset prepared to be imputed
keep p7 region countid id age agesq gender health yrseduc married ///
mainearner qincome wellidx jobsat ///
friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening workfit ///
empcontr wsector g2010 regunp10 gini10 regime

```

```

***to impute the dataset using Realcom
realcomImpute
gen cons=1
sort p7 id
realcomImpute
o.health yrseduc o.married o.maineerner o.qincome ///
o.wsector o.workfit o.empcontr webidx o.jobsat ///
o.friendship o.losejob o.wellpaid o.career o.athome ///
o.easyfind o.mybest o.voluntary o.children ///
o.cooking o.elderly o.training o.leisure o.gardening ///mis1
gender age agesq ///an1
g2010 regunp10 gini10 regime ///an2
using ewcs0515.text, numresponses(24) ///
level2id(p7) cons(cons)

```

```

***to load imputations to the data
realcomImputeLoad

```

F.2 Modelling

F.2.1 Unimputed models

```

***3 level models - null model

```

```

xtset p7
xtmixed webidx || countid: || p7:, mle
xtmixed jobsat || countid: || p7:, mle

```

```

***3 level models with social capital (friendship)

```

```

xtset p7
xtmixed webidx friendship|| countid: || p7:, mle
xtmixed jobsat friendship|| countid: || p7:, mle

```

```

***3 levels models with individual and workplace characteristics

```

```

xtmixed webidx friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector || countid: || p7:, mle

```

```

xtmixed jobsat friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector || countid: || p7:, mle

```

```

***3 levels models with individual and regional characteristics

```

```

xtmixed webidx friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening ///

```



```
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector ///
regunp10 g2010 || countid: || p7:, mle
```

```
xtmixed jobsat friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector regunp10 g2010|| countid: || p7: , mle
```

```
***3 levels models with individual and contextual characteristics (complete)
xtmixed webidx friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector ///
regunp10 g2010 gini10 ib3.regime|| countid: || p7:, mle
```

```
xtmixed jobsat friendship losejob wellpaid career athome easyfind mybest ///
voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector regunp10 g2010 gini10 ///
ib3.regime|| countid: || p7: , mle
```

F.2.2 Imputed models

```
***3 level models- null model
```

```
mi xtset p7
mi est: xtmixed webidx || countid: || p7:, mle
mi est: xtmixed jobsat || countid: || p7:, mle
```

```
***3 level models with social capital (friendship)
```

```
mi xtset p7
mi est: xtmixed webidx friendship|| countid: || p7:, mle
mi est: xtmixed jobsat friendship|| countid: || p7:, mle
```

```
***3 levels models with individual and workplace characteristics
```

```
mi xtset p7
mi est: xtmixed webidx friendship losejob wellpaid career athome easyfind ///
mybest voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector || countid: || p7:, mle
```

```
mi est: xtmixed jobsat friendship losejob wellpaid career athome easyfind ///
mybest voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector || countid: || p7: , mle
```

```
***3 levels models with individual and regional characteristics
```

```

mi xtset p7
mi est: xtmixed webidx friendship losejob wellpaid career athome easyfind ///
mybest voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector ///
regunp10 g2010 || countid: || p7:, mle

```

```

mi est: xtmixed jobsat friendship losejob wellpaid career athome easyfind ///
mybest voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector regunp10 g2010|| countid: || p7: , mle

```

***3 levels models with individual and contextual characteristics (complete)

```

mi xtset p7
mi est: xtmixed webidx friendship losejob wellpaid career athome easyfind ///
mybest voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector ///
regunp10 g2010 gini10 ib3.regime|| countid: || p7:, mle

```

```

mi est: xtmixed jobsat friendship losejob wellpaid career athome easyfind ///
mybest voluntary children cooking elderly training leisure gardening ///
age agesq ib2.gender health yrseduc married ib1.qincome ib2.workfit ///
mainearner ib1.empcontr ib1.wsector regunp10 g2010 gini10 ///
ib3.regime|| countid: || p7:, mle

```

F.3 Codes for graphs

F.3.1 Graphs for well-being, job satisfaction, social capital

***the well-being graph

```

gr bar webidx, over(gender) over(welfare) asyvars ///
yscale(r(100)) ///
bar(1, bcolor(gs15)) bar(2, bcolor(gs10)) ///
legend( label(1 "Male") label(2 "Female") ) ///
ytitle ("") ///
xlabel (1 "continental" 2 "liberal" 3 "social democratic" 4 "central/eastern")
title("Well-being")
graph save Graph "G:\Europe\EWCS\wellidx.gph"

```

***the job satisfaction graph

```

gr bar jobsat, over(gender) over(welfare)asyvars ///
yscale(r(4)) ///
bar(1, bcolor(gs15)) bar(2, bcolor(gs10)) ///
legend( label(1 "Male") label(2 "Female") ) ///
ytitle("") ///

```

```

title("Job satisfaction")
graph save Graph "G:\Europe\EWCS\jobsat.gph"

***the social capital graph
gr bar friendship, over(gender) over(welfare) asyvars ///
yscale(r(5)) ///
bar(1, bcolor(gs15)) bar(2, bcolor(gs10)) ///
legend( label(1 "Male") label(2 "Female") ) ///
ytitle("") ///
title("Social capital")
graph save Graph "G:\Europe\EWCS\socap.gph"
gr combine G:\Europe\EWCS\socap.gph G:\Europe\EWCS\jobsat.gph
G:\Europe\EWCS\wellidx.gph, xcommon

```

F.3.2 Europe map

```

***to make the job satisfaction map
by cdnuts2, sort : egen jsatisfy2=mean(jsatisfy)
by cdnuts2, sort : keep if _n==1
use ewcs_simul
mmerge NUTS_CODE using F:\df\eudb2.dta
drop if id==8 | id==55 | id==221 | id==21 | id==217 | id==169 |
id==102 | id==186
spmap jsatisfy2 using "F:\df\eucoord2.dta", ///
id(id) ndf(yellow) fcolor(Refs2) ocolor(none ..)

```

Note: To make the well-being map, variable jsatisfy2 is replaced by webidx.

Appendix G

Codes for Chapter 5

G.1 Stata codes

G.1.1 Data preparation for WERS2011

```
use G:\SpareHDDF2011dec2014\HDDF2011\WERS2011\
wers2011_4merged.dta,clear
***variable job satisfaction
***rename relevant variables of satisfaction - based on Jones et al.
recode qa8a (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(ach)
recode qa8b (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(init)
recode qa8c (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(infl)
recode qa8d (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(train)
recode qa8e (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(skill)
recode qa8f(-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(pay)
recode qa8g (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(secure)
recode qa8h(-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(workc)
***vertical social capital
recode qc2a (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(trust)
recode qc2b(-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(sincere)
recode qc2c (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(honest)
recode qc2d (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(torant)
recode qc2e (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(support)
recode qc2f (-9/-1=.) (5=1) (4=2) (3=3) (2=4) (1=5), gen(fair)
***CFA
sem (JOB -> ach init infl skill workc),cov(e.ach*e.workc)cov(e.init*e.infl)
cov(e.ach*e.init)method(mlmv)
estat gof, stats(all)
sem,stand
sem (SOC -> trust sincere honest), method(mlmv)
estat gof, stats(all)
sem, stand
***recode gender, age, status
recode qe1(-9/-1=.) (1=0)(2=1), gen(female)
recode qe2 (-9/-1=.) (1/3=1)(4/5=2)(6/7=3)(8/9=4), gen(age)
```

```

gen agesq=age2
recode qe3 (-9/-1=.) (1=0)(3=0) (2=1), gen(married)
recode qe6 (-9/-1=.) (1=1)(2/3=0), gen(health)
***income per week
recode qe11 (-9/-1=.), gen(income)
xtile qincome = income, nq(4)
gen inc1 = qincome==1 if !missing(qincome)
gen inc2 = qincome==2 if !missing(qincome)
gen inc3 = qincome==3 if !missing(qincome)
gen inc4 = qincome==4 if !missing(qincome)
***recode of tenure and skill match
recode qa1 (-9/-6=.) (1/3=0)(4/5=1), gen(workyr)
sort serno
by serno: gen nobs=_N
by serno: egen sumyear = sum(workyr)
gen yearpc = sumyear/nobs
recode qa2 (-9/-1=.) (1=1) (2/3=0), gen(job)
***recode of skill compatibility with the job, qualification and training received
recode qb3 (-9/-1=.) (1=0)(2/6=1), gen(traing)
recode qb4 (-9/-1=.) (1/2=1)(3=2)(4/5=3), gen(match)
gen match1 = match==1 if !missing(match)
gen match2 = match==2 if !missing(match)
gen match3 = match==3 if !missing(match)
sort serno
by serno: egen skmatch1 = sum(match1)
by serno: egen skmatch2 = sum(match2)
by serno: egen skmatch3 = sum(match3)
gen skm1 = skmatch1/nobs
gen skm2 = skmatch2/nobs
gen skm3 = skmatch3/nobs
***to generate highest academic
recode qe7mul1(-9=.) (1=2), gen(edu1)
recode qe7mul2(-9=.) (1=3), gen(edu2)
recode qe7mul3(-9=.) (1=4), gen(edu3)
recode qe7mul4(-9=.) (1=4), gen(edu4)
recode qe7mul5(-9=.) (1=6), gen(edu5)
recode qe7mul6(-9=.) (1=7), gen(edu6)
recode qe7mul7(-9=.) (1=4), gen(edu7)
recode qe7mul8(-9=.) (1=1), gen(edu8)
recode qe7mul9(-9=.) (1=2), gen(edu9)
recode qe7mul10(-9=.) (1=3), gen(edu10)
recode qe7mul11(-9=.) (1=4), gen(edu11)
recode qe7mul12(-9=.) (1=5), gen(edu12)
recode qe7mul13(-9=.) (1=6), gen(edu13)
recode qe7mul14(-9=.) (1=2), gen(edu14)
recode qe7mul15(-9=.) (1=2), gen(edu15)
recode qe7mul16(-9=.) (1=4), gen(edu16)

```

```

recode qe7mul17(-9=.) (1=1), gen(edu17)
by persid, sort: gen educ = _n
by persid, sort: gen hiedu=max(edu1,edu2,edu3,edu4,edu5,edu6,edu7,edu8,edu9,
edu10,edu11,edu12,edu13,edu14,edu15,edu16,edu17)
tab hiedu
gen hied1 = hiedu==1 if !missing(hiedu)
gen hied2 = hiedu==2 if !missing(hiedu)
gen hied3 = hiedu==3 if !missing(hiedu)
gen hied4 = hiedu==4 if !missing(hiedu)
gen hied5 = hiedu==5 if !missing(hiedu)
gen hied6 = hiedu==6 if !missing(hiedu)
gen hied7 = hiedu==7 if !missing(hiedu)
sort serno
by serno: egen hied6s = sum(hied6)
by serno: egen hied7s =sum(hied7)
gen hiedp = hied6s+hied7s
gen hiedpc = hiedp/nobs
***supervisory position
recode qe10(-9/-1=.) (1=1)(2=0), gen(spv)
***to generate formal status of workplace
recode astatus1 (1/7=0)(8/12=1), gen(wpstatus)
***to generate organisation size
gen orgsize = log(zallemps)
gladder orgsize
****to generate performance by result or merit pay
recode fperfl (-8=.) (1/2=1)(3=0), gen(perfp)
***number of trained employees in LOG
recode coffjob (-8=.) (1/2=5)(3=4)(4=3)(5=2)(6/7=1), gen(trainlog)
***to measure dismissal rate and redundancies in workplace
(divided by all employees 1 year ago)
recode zredund (-9/-1=.), gen(empredd)
recode zdismiss (-9/-1=.), gen(empdisms)
recode zemplago (-8/0=.), gen(emplago)
gen dismr=(empdisms/emplago)*100
gen redr=(empredd/emplago)*100
***to generate impact of recession
recode lrecimp (-8/-1=.) (1/3=1)(4/5=0), gen(impact)
***to generate industry
recode nsicod07 (3=4)(4/5=5) (6=1)(7=6)(8=7)(9=8)(10=9)(11/12=2) ///
(13=10)(14=11)(15=12)(16=13)(17=3)(18=14)(19=15), gen(indtr)
***to measure performance of workplace
recode kestper1 (-9/-1=.) (1/2=3)(3=2)(4/5=1)(6/7=.), gen(finance)
recode kestper2 (-9/-1=.) (1/2=3)(3=2)(4/5=1)(6/7=.), gen(prod)
recode kestper3 (-9/-1=.) (1/2=3)(3=2)(4/5=1)(6/7=.), gen(quality)
recode zabsnce (-9/-1=.), gen(absent)
gen absence = absent/100
gen absencesq = sqrt(absence)

```

```

***changes in the workplace (management changes and impact of recession)
recode limpchx (-8=.)(-1=0)(1/7=1), gen(wpch)
recode lreact01 (-8/-1=.) (1/14=1)(15=0), gen(wpact)

```

G.1.2 Analysis

Factor analysis

```

*** EFA for job satisfaction
factor ach init infl train skill pay secure workc, blank(.4)
rotate
***Cronbach' alpha-job satisfaction
alpha ach init infl skill workc, std item det
*** EFA for social capital
factor trust honest sincere support torant fair, blank(.4)
rotate
factor trust honest sincere fair, blank(.4)
rotate
***Cronbach' alpha-social capital
alpha trust honest sincere fair, std item det
sem (SOC -> trust honest sincere fair), cov(e.honest*e.sincere)
cov(e.honest*e.fair)method(mlmv)
estat gof, stats(all)
sem, stand
***CFA
sem (JOB -> ach init infl skill workc), cov(e.ach*e.workc)cov(e.init*e.infl) ///
cov(e.ach*e.init)method(mlmv)
estat gof, stats(all)
sem, stand
sem (SOC -> trust honest sincere support fair), cov(e.trust*e.sincere) ///
cov(e.honest*e.fair) method(mlmv)
estat gof, stats(all)
sem, stand

```

Modelling

```

***SEM model (M1) the baseline model
sem (JOB -> ach init infl skill workc)(SOC -> trust honest sincere fair) ///
(JOB <- SOC), cov(e.ach*e.workc)cov(e.init*e.infl) ///
cov(e.ach*e.init)cov(e.trust*e.sincere)cov(e.honest*e.fair)
sem, stand
estat gof, stats(all)
***SEM model (M2) with individual characteristics
(contract type is not included since most of employees are permanent)
sem (JOB -> ach init infl skill workc)(SOC -> trust sincere honest fair) ///
(JOB <- SOC female married health workyr match2 match3 hied2 hied3 ///
hied4 hied5 hied6 hied7 traing inc2 inc3 inc4 spv), ///

```



```

cov(e.ach*e.workc)cov(e.init*e.infl)cov(e.ach*e.init)cov(e.trust*e.sincere) ///
cov(e.honest*e.fair)
sem, stand
estat gof, stats(all)
***SEM model (M3) with workplace characteristics including recession impact ///
sem (JOB -> ach init infl skill workc)(SOC -> trust sincere honest fair) ///
(JOB <- SOC female married health workyr match2 match3 hied2 hied3 ///
hied4 hied5 hied6 hied7 inc2 inc3 inc4 traing spv ///
wpstatus orgsize redr dismr perfp impact avunemp), ///
cov(e.ach*e.workc)cov(e.init*e.infl)cov(e.ach*e.init)cov(e.trust*e.sincere) ///
cov(e.honest*e.fair)
sem, stand
estat gof, stats(all)
***SEM model (M4) - complete and clustered
sem (JOB -> ach init infl skill workc)(SOC -> trust sincere honest fair) ///
(JOB <- SOC female married health workyr match2 match3 hied2 hied3 ///
hied4 hied5 hied6 hied7 traing inc2 inc3 inc4 spv ///
wpstatus orgsize redr dismr perfp impact avunemp), ///
cov(e.ach*e.workc)cov(e.init*e.infl)cov(e.ach*e.init)cov(e.trust*e.sincere) ///
cov(e.honest*e.fair)vce(cluster serno)
sem, stand
estat gof, stats(all)

```

G.2 Mplus codes

Data:

```

File is G:\SpareHDDF2011dec2014\HDDF2011 \WERS2011\
wers2011JS_wers2011JS_180515.dta.dat;

```

Variable:

Names are

```

serno persid avunemp avrd ach init infl train skill pay secure workc
trust sincere honest torant support fair female married health inc1
inc2 inc3 inc4 workyr job traing match1 match2 match3 hied1 hied2
hied3 hied4 hied5 hied6 hied7 spv wpstatus wpage orgsize perfp dismr
redr impact indtr;

```

Usevariables are

```

ach init infl skill workc fair
trust sincere honest female married health traing spv
inc2 inc3 inc4 workyr match2 match3 hied2 hied3 hied4
hied5 hied6 hied7 wpstatus orgsize perfp dismr redr impact
avunemp;

```

Within are female married health inc2 inc3 inc4 workyr traing spv
match2 match3 hied2 hied3 hied4 hied5 hied6 hied7;

Between are wpstatus orgsize perfp dismr redr impact avunemp;

Cluster is serno;

Missing are all (-9999);

Analysis:

```
type=twolevel;
```

Model:

```
%within%
```

```
jobsat by ach init infl skill workc;
```

```
socap by trust sincere honest fair;
```

```
ach with init; init with infl; ach with workc;
```

```
trust with sincere; honest with fair;
```

```
jobsat on socap female married health inc2 inc3 inc4 workyr
```

```
match2 match3 hied2 hied3 hied4 hied5 hied6 hied7 traing spv;
```

```
%between%
```

```
jobsat2 by ach init infl skill workc trust sincere honest fair;
```

```
jobsat2 on wpstatus orgsize perfp dismr redr impact avunemp;
```

```
jobsat2@1;
```

Output: tech1 sampstat standardized cinterval;

Appendix H

Codes for Chapter 6

H.1 Stata codes

H.1.1 Data preparation for Indonesia

```
use G:\SpareHDDF2011dec2014\HDDF2011\Indonesia2013\IDN280914R.dta, replace
***Individual characteristics
recode var4 (1/3=0)(4/5=1), gen(workyr)
label var workyr "working years"
recode var40 (1/2=1)(3=2)(4/5=3), gen(match)
recode var40 (1/2=0)(3/5=1), gen(matches)
label var match "matched skill with job"
gen match1 = match==1 if !missing(match)
gen match2 = match==2 if !missing(match)
gen match3 = match==3 if !missing(match)
recode var131(1=0)(2=1), gen(female)
label var female "female"
recode var133 (1=0)(2=1)(3/4=0), gen(married)
label var married "marital status"
recode var144 (1/2=0)(3/5=1), gen(health)
label var health "general health" recode var145 (1/3=0)(4/6=1)(7=.), gen(edu)
label var edu "highest education"
recode var39 (1=0)(2/6=1), gen(rectrain)
label var retrain "received training in the last 12 months"
recode var146 (.=.)(1=1)(2=0), gen(spv)
label var spv "supervisor"
***to differentiate the jobs
recode var6 (.=.)(9=3)(1/2=1)(5=1)(7/8=1)(10=1)(11=2)(3/4=2)(6=2), gen(jobs)
gen admin =jobs==3 if !missing(jobs)
gen doctors = jobs==1 if !missing(jobs)
gen nurse =jobs==2 if !missing(jobs)
***job satisfaction aspects
recode var19 (1=.) (2=1)(3=2)(4=3)(5=4)(6=5),gen(ach)
label var ach "achievement"
recode var20 (1=.) (2=1)(3=2)(4=3)(5=4)(6=5),gen(init)
```

```

label var init "initiative"
recode var21 (1=.) (2=1) (3=2) (4=3) (5=4) (6=5), gen(infl)
label var infl "influence"
recode var22 (1=.) (2=1) (3=2) (4=3) (5=4) (6=5), gen(train)
label var train "training"
recode var23 (1=.) (2=1) (3=2) (4=3) (5=4) (6=5), gen(skill)
label var skill "skill development"
recode var24 (1=.) (2=1) (3=2) (4=3) (5=4) (6=5), gen(pay)
label var pay "pay received"
recode var25 (1=.) (2=1) (3=2) (4=3) (5=4) (6=5), gen(secure)
label var secure "job security"
recode var26 (1=.) (2=1) (3=2) (4=3) (5=4) (6=5), gen(workc)
label var workc "work itself"
***social capital following oksanen(2010)
recode var61 (1=1) (2=2) (3=3) (4=4) (5/6=5) (.=.), gen(kind)
label var kind "kind superior"
gen concern=var62
label var concern "concern for employees' right"
gen trust=var63
label var trust "trusted superior"
gen inform=var64
label var inform "information among employees"
gen accept=var65
label var accept "feeling accepted by other employees"
gen develop=var66
label var develop "developing new ideas"
gen best=var67
label var best "best results"
gen together=var68
label var together "togetherness among employees"
***vertical social capital (WERS2011)
recode var53 (.=.) (1=.) (6=5) (5=4) (4=3) (3=2) (2=1), gen(trusted)
recode var54 (.=.) (1=.) (6=5) (5=4) (4=3) (3=2) (2=1), gen(sincere)
recode var55 (.=.) (1=.) (6=5) (5=4) (4=3) (3=2) (2=1), gen(honest)
recode var56 (.=.) (1=.) (6=5) (5=4) (4=3) (3=2) (2=1), gen(torant)
recode var57 (.=.) (1=.) (6=5) (5=4) (4=3) (3=2) (2=1), gen(support)
recode var58 (.=.) (1=.) (6=5) (5=4) (4=3) (3=2) (2=1), gen(fair)
factor trust sincere honest torant support fair, ipf blank(.4)
alpha trust sincere honest, std det item
sem(WSOC -> trust sincere honest), method(mlmv)
estat gof, stats(all)
sem, stand
***Hospital characteristics
recode k14 (1/2=1) (3/4=0), gen (hclass)
label var hclass "hospital class"
***to generate training given to the largest occupational group in the last 12
months

```

```

label var p44 "percentage of trained employees from the largest occupational
group"
***additional variable
recode p169 (1=1)(2/8=0)(.=.), gen(change)
***existence of performance based salary
recode p79 (1=1)(2=0), gen(perfp)
label var perfp "existence of performance based pay system"
***gender of the hospital director
recode p15 (1=0)(2=1), gen(femdir)
***director with management degree
recode p17 (1=0)(3=1)(4/7=0), gen(edudir)
***leadership experience
recode p18 (1=1)(2/3=0), gen(exprdir)
***Hospital performance
gen revbed = k3/k15
label var revbed "hospital revenue per bed in rupiahs"
gladder revbed
**generate the log of revbed as suggested by the graph (gladder revbed)
gen lrevbed = log(revbed)
label var lrevbed "log revenue per bed in rupiahs"
gladder lrevbed
recode p165 (1/2=3)(3=2)(4/5=1)(6/7=.), gen(finance)
label var finance "Financial performance according to MOH"
sum finance
recode p166 (1/2=3)(3=2)(4/5=1)(6/7=.), gen(prod)
label var prod "Productivity according to MOH"
sum prod
recode p167 (1/2=3)(3=2)(4/5=1)(6/7=.), gen(quality)
label var quality "Quality according to MOH"
sum quality
gen bor=k21s1_2012/100
gladder bor
sum bor
gen borsq = bor2
label var bor "Bed occupancy rate 2012(square)"
gladder borsq
gen los=k21s2_2012
gladder los
sum los
gen ilos = loshat - 1
gladder ilos
label var los "Length of stay 2012"
label var ilos "Length of stay 2012 (inverse)"
gen totexp = k7+k8+k9
replace totexp=k21s11_2012 if missing(totexp)
label var totexp "total expenditure of hospital in 2012"
gen expbed = totexp/k15

```

```

label var expbed "expenditure per bed in 2012"
gladder expbed
gen lexpbed=log(expbed)
label var lexpbed "expenditure per bed (log)"
***proportion of employees
***for skills
sort serno
by serno: gen nobs=_N
by serno: egen m1=sum(match1)
gen skm1=m1/nobs
label var skm1 "proportion of employees with lower skills"
by serno: egen m2=sum(match2)
gen skm2=m2/nobs
label var skm2 "proportion of employees with matched skills"
by serno: egen m3=sum(match3)
gen skm3=m3/nobs
label var skm3 "proportion of overskilled employees"
***tenured employees
sort serno
by serno: egen sumyear = sum(workyr)
gen yearpc = sumyear/nobs
**receiving training in the past 12 months
sort serno
by serno: egen trained = sum(rectrain)
gen trainpc = trained/nobs
**for gender
sort serno
by serno: egen f1=sum(female)
gen fempc=f1/nobs
***for education
sort serno
by serno: egen educ=sum(edu)
gen edupc=educ/nobs

```

H.1.2 Analysis

factor analysis

```

***EFA for job satisfaction
factor ach init infl train skill pay secure workc, ipf blank(.4)
rotate
estat kmo
***CFA to be used
sem (JOBSAT -> ach init infl)
sem, stand
estat gof, stats(all)
***Cronbach alpha

```

```

alpha ach init infl, std item det
***EFA for social capital
factor kind concern trust accept together inform best together, pcf blank(.4)
rotate
estat kmo
***vertical social capital only
factor kind concern trust, ipf blank(.4)
rotate
estat kmo
***Cronbach alpha
alpha kind concern trust, std item det
***horizontal social capital (oksanen)
factor accept develop inform best together, ipf blank (.5)
rotate
estat kmo
***Cronbach's alpha
alpha accept together best develop, std det item
***CFA
sem(HSOC -> accept together best develop), cov(e.develop*e.together)stand
estat gof, stats(all)
sem(VSOC -> kind concern trust), stand
estat gof, stats(all)

```

Modelling

```

***Model 1 - null model
sem (JOBSAT -> ach init infl)(VSOC ->kind concern trust)
(HSOC -> accept together best develop) ///
(JOBSAT <- VSOC HSOC), cov(e.develop*e.together)stand
estat gof, stats(all)
***Model 2 - for job satisfaction and social capital with individual characteristics
sem (JOBSAT -> ach init infl)(VSOC ->kind concern trust)
(HSOC -> accept together best develop) ///
(JOBSAT <- VSOC HSOC female age edu match2 match3 retrain),
cov(e.develop*e.together) stand
estat gof, stats(all)
***Model 3 - for job satisfaction and social capital with individual
& hospital characteristics
sem (JOBSAT -> ach init infl)(VSOC ->kind concern trust)
(HSOC -> accept together best develop) ///
(JOBSAT <- VSOC HSOC female edu match2 match3 retrain hclass ),
cov(e.develop*e.together) stand
estat gof, stats(all)
***Model 4 - clustered
sem (JOBSAT -> ach init infl)(VSOC ->kind concern trust)
(HSOC -> accept together best develop) ///
(JOBSAT <- VSOC HSOC female edu match2 match3 retrain hclass),

```

```
cov(e.develop*e.together)vce(cluster serno)stand
estat gof, stats(all)
```

Data prepared for Mplus

```
keep distrik persid serno ach init infl skill train trusted sincere honest fair ///
accept best develop together kind concern trust female workyr age married ///
edu health income match1 match2 match3 spv restrain var39 ///
hclass owner nblu p6 p44 perfp pctheal healexp disadv gov change cls3 vip ///
edudir exprdir femdir hstatus doctors admin nurse yearpc fempc skm1 skm2 ///
skm3 edupc trainpc lrevbed ilos finance prod quality borsq lexpbed
save G:\SpareHDDF2011dec2014\HDDF2011\Indonesia2013\
WPJSIDNR2091214.dta,replace
***to convert to dataset in Mplus
stata2mplus using G:\SpareHDDF2011dec2014\HDDF2011\Indonesia2013\
WPJSIDNR2091214.dta, replace
```

H.2 Mplus codes

H.2.1 Factor analysis

CFA - 1 level

Data: File is G:\Indonesia2013\WPJSIDNR2091214.dta.dat;

Variable:

Names are

distrik serno persid var39 p6 p44 healexp pctheal workyr match1 match2
match3 female married health edu restrain income spv admin doctors
nurse ach init infl train skill kind concern trust accept develop
best together trusted sincere honest fair hstatus hclass nblu owner
cls3 vip change perfp femdir edudir exprdir lrevbed finance prod quality
borsq ilos lexpbed fempc edupc skm1 skm2 skm3 yearpc trainpc disadv
gov age;

Usevariables are

ach init infl kind concern trust accept best develop together;

Missing are all (-9999) ;

Analysis:

Type = general ;

Model:

jobsat by ach init infl;
vsoc by kind concern trust;
hsoc by accept develop best together;
develop with together;
jobsat with vsoc; hsoc with vsoc; hsoc with jobsat;

Output: sampstat standardized cinterval;

CFA - 2 levels

Data:

File is G:\Indonesia2013\WPJSIDNR2091214.dta.dat ;

Variable:

Names are

distrik serno persid var39 p6 p44 healexp pctheal workyr match1 match2
match3 female married health edu restrain income spv admin doctors
nurse ach init infl train skill kind concern trust accept develop
best together trusted sincere honest fair hstatus hclass nblu owner
cls3 vip change perfp femdir edudir exprdir lrevbed finance prod quality
borsq ilos lexpbed fempc edupc skm1 skm2 skm3 yearpc trainpc disadv
gov age;

Usevariables are

ach init infl kind concern trust accept best develop together;

Cluster is serno;

Missing are all (-9999) ;

Analysis:

Type = twolevel ;
algorithm=EM;
mconvergence=1000;

Model:

%within%

jobsat by ach init infl;
vsoc by kind concern trust;
hsoc by accept develop best together;
develop with together;
jobsat with vsoc; hsoc with vsoc; hsoc with jobsat;

%between%

jobsat2 by ach init infl kind concern trust accept develop
best together;
jobsat2@1;

Output: sampstat standardized cinterval;

H.2.2 Modelling

Multilevel SEM - Model 5

Data: File is G:\Indonesia2013\WPJSIDNR2091214R.dta.dat ;

Variable:

Names are

distrik serno persid var39 p6 p44 healexp pctheal workyr match1 match2
match3 female married health edu restrain income spv admin doctors
nurse ach init infl train skill kind concern trust accept develop
best together trusted sincere honest fair hstatus hclass nblu owner
cls3 vip change perfp femdir edudir exprdir lrevbed finance prod quality
borsq ilos lexpbed fempc edupc skm1 skm2 skm3 yearpc trainpc disadv
gov age;

Usevariables are

```
ach init infl kind concern trust accept best
```

```
develop together female edu match2 match3 retrain hclass;
```

Between are hclass;

Cluster is serno;

Missing are all (-9999);

Analysis:

```
Type = twolevel;
```

```
algorithm=EM;
```

```
mconvergence=1000;
```

Model:

```
%within%
```

```
jobsat by ach init infl;
```

```
vsoc by kind concern trust;
```

```
hsoc by accept develop best together;
```

```
develop with together;
```

```
hsoc with vsoc;
```

```
jobsat on vsoc hsoc female edu match2 match3 retrain;
```

```
%between%
```

```
jobsat2 by ach init infl kind concern trust accept develop best together;
```

```
jobsat2 on hclass;
```

```
jobsat2@1;
```

Output: sampstat standardized cinterval;

Appendix I

Codes for Chapter 7

I.1 The general industry

I.1.1 Financial performance

The baseline model

Data:

File is H:\WERS2011\wers2011NEW2_wp120914.dta.dat;

Variable:

Names are

serno persid avunemp ach init infl train skill pay secure worke trust
sincere honest fair yearpc skm1 skm2 skm3 wpstatus orgsize perfp
tr1 tr2 tr3 tr4 tr5 dismr redr dismsq redsq impact femalepc indtr
finance prod quality absencesq wpch;

Usevariables are

ach init infl skill worke trust sincere honest fair finance;

between are finance;

cluster is serno;

Missing are all (-9999) ;

Analysis:

Type = twolevel;

Model:

%within%

jobsat by ach init infl skill worke;
socap by trust sincere honest fair;
init with infl;init with ach; ach with worke;
trust with sincere; honest with fair;
jobsat with socap;

%between%

jobsat2 by ach init infl skill worke;
socap2 by trust sincere honest fair;
finance on jobsat2 socap2;

Output: sampstat standardized cinterval;

The complete model

Data:

File is H:\WERS2011\wers2011NEW2_wp120914.dta.dat;

Variable:

Names are

serno persid avunemp ach init infl train skill pay secure workc trust
sincere honest fair yearpc skm1 skm2 skm3 wpstatus orgsize perfp
tr1 tr2 tr3 tr4 tr5 dismr redr dismsq redsq impact femalepc indtr
finance prod quality absencesq wpch;

Usevariables are

ach init infl skill workc trust sincere honest fair
skm2 skm3 femalepc tr2 tr3 tr4 tr5 yearpc perfp impact redsq
dismsq orgsize wpstatus avunemp finance wpch;

Between are skm2 skm3 femalepc tr2 tr3 tr4 tr5 yearpc perfp impact
redsq dismsq orgsize wpstatus avunemp finance wpch;

Cluster is serno;

Missing are all (-9999) ;

Analysis:

Type = twolevel;

Model:

%within%

jobsat by ach init infl skill workc;
socap by trust sincere honest fair;
init with infl;init with ach; ach with workc;
trust with sincere; honest with fair;
jobsat with socap;

%between%

jobsat2 by ach init infl skill workc;
socap2 by trust sincere honest fair;
finance on jobsat2 socap2 femalepc skm2 skm3 tr2 tr3 tr4 tr5
yearpc perfp wpch impact redsq dismsq orgsize wpstatus avunemp;

Output: sampstat standardized cinterval;

Note: Similar codes are used for other workplace performance measures
(productivity, quality and absenteeism) by adjusting
the performance variables.

I.2 The healthcare industry

I.2.1 Productivity

The baseline model

Data: File is H:\WERS2011\wers2011HH2_120914.dta.dat ;

Variable:

Names are

serno persid avunemp ach init infl train skill pay secure workc trust
sincere honest fair yearpc trainpc skm1 skm2 skm3 wpstatus
orgsize perfp tr1 tr2 tr3 tr4 tr5 dismr redr redsq impact femalepc
indtr finance prod quality absencesq wpch;

Usevariables are

ach init infl skill workc trust sincere honest fair prod;

Between are prod;

Cluster is serno;

Missing are all (-9999) ;

Analysis:

Type = twolevel;

Model:

%within%

jobsat by ach init infl skill workc;
socap by trust sincere honest fair;
init with infl;init with ach; ach with workc;
trust with sincere; honest with fair;
jobsat with socap;

%between%

jobsat2 by ach init infl skill workc;
socap2 by trust sincere honest fair;
prod on jobsat2 socap2 ; Output: sampstat standardized cinterval;

The complete model

Data:

File is H:\WERS2011\wers2011HH2_120914.dta.dat;

Variable:

Names are

serno persid avunemp ach init infl train skill pay secure workc trust
sincere honest fair yearpc trainpc skm1 skm2 skm3 wpstatus
orgsize perfp tr1 tr2 tr3 tr4 tr5 dismr redr redsq impact femalepc
indtr finance prod quality absencesq wpch;

Usevariables are

ach init infl skill workc trust sincere honest fair
skm2 skm3 femalepc yearpc trainpc perfp impact redsq
orgsize wpstatus prod wpch;

Between are

skm2 skm3 femalepc perfp impact yearpc trainpc

```

    orgsize wpstatus prod wpch redsq;
Cluster is serno;
Missing are all (-9999);
Analysis:
    Type = twolevel;
Model:
    %within%
        jobsat by ach init infl skill workc;
        socap by trust sincere honest fair;
        init with infl;init with ach; ach with workc;
        trust with sincere; honest with fair;
        jobsat with socap;
    %between%
        jobsat2 by ach init infl skill workc;
        socap2 by trust sincere honest fair;
        prod on jobsat2 socap2 femalepc skm2 skm3 trainpc
        perfp wpch impact orgsize wpstatus yearpc redsq;
Output: sampstat standardized cinterval;

Note: Similar codes are used for other workplace performance measures
      (productivity, quality and absenteeism) by adjusting
      the performance variables.

```

Appendix J

Codes for Chapter 8

J.1 The subjective performance

J.1.1 Financial performance

The baseline model

Data:

```
File is H:\Indonesia2013\WPJSIDNR091214.dta.dat;
```

Variable:

Names are

```
distrik serno persid var39 p6 p44 pctheal workyr match1 match2  
match3 female married health edu retrain income spv ach init infl  
train skill kind concern trust accept develop best together trusted  
sincere honest fair hstatus hclass nblu owner cls3 vip change perfp  
femdir edudir exprdir lrevbed finance prod quality borsq ilos lexpbed  
fempc edupc skm1 skm2 skm3 yearpc trainpc admin doctors nurse;
```

Usevariables are

```
init concern finance accept develop best together;
```

Between are finance ;

Cluster is serno;

Missing are all (-9999);

Analysis:

```
Type = twolevel;  
algorithm=EM;  
mconvergence=1000;
```

Model:

```
%within%
```

```
hsoc by accept develop best together;  
develop with together;  
init with hsoc; hsoc with concern; init with concern;
```

```
%between%
    hsoc2 by accept develop best together;
    finance on init hsoc2 concern;
Output: standardized sampstat;
```

The complete model

Data:

```
File is G:\SpareHDDF2011dec2014\HDDF2011\Indonesia2013\
WPJSIDNR060215.dta.dat ;
```

Variable:

Names are

```
distrik serno persid var39 p6 p44 pctheal workyr match1 match2
match3 female married health edu restrain income spv ach init infl
train skill kind concern trust inform accept develop best together
hstatus hclass nblu owner cls3 vip change perfp femdir edudir
exprdir lrevbed finance prod quality borsq ilos lexpbed fempc edupc
skm1 skm2 skm3 yearpc trainpc;
```

Usevariables are

```
init best accept develop together concern
finance hclass perfp skm2 skm3 exprdir;
```

Between are finance hclass perfp skm2 skm3 exprdir;

Cluster is serno;

Missing are all (-9999);

Analysis:

```
Type = twolevel;
algorithm=EM;
mconvergence=500;
```

Model:

```
%within%
    hsoc by accept develop together best;
    develop with together;
    init with hsoc; init with concern; hsoc with concern;
```

```
%between%
```

```
hsoc2 by accept develop together best;
finance on init hsoc2 concern hclass perfp skm2 skm3 exprdir;
```

Output: standardized sampstat;

Note: for other workplace performance measures, similar codes are used adjusting the performance variable (productivity and quality).

J.2 The objective performance

J.2.1 Revenue per bed

The baseline model

Data:

File is H:\Indonesia2013\WPJSIDNR091214.dta.dat ;

Variable:

Names are

distrik serno persid var39 p6 p44 pctheal workyr match1 match2
match3 female married health edu rectrain income spv ach init infl
train skill kind concern trust accept develop best together trusted
sincere honest fair hstatus hclass nblu owner cls3 vip change perfp
femdir edudir exprdir lrevbed finance prod quality borsq ilos lexpbed
fempc edupc skm1 skm2 skm3 yearpc trainpc admin doctors nurse;

Usevariables are

init concern lrevbed accept develop best together;

Between are lrevbed ;

Cluster is serno;

Missing are all (-9999);

Analysis:

Type = twolevel;

algorithm=EM;

mconvergence=1000;

Model:

%within%

hsoc by accept develop best together;

develop with together;

init with hsoc; hsoc with concern; init with concern;

%between%

hsoc2 by accept develop best together;

lrevbed on init hsoc2 concern;

Output: standardized sampstat;

The complete model

Data:

File is G:\SpareHDDF2011dec2014\HDDF2011\Indonesia2013\
WPJSIDNR060215.dta.dat ;

Variable:

Names are

distrik serno persid var39 p6 p44 pctheal workyr match1 match2
match3 female married health edu rectrain income spv ach init infl
train skill kind concern trust inform accept develop best together
hstatus hclass nblu owner cls3 vip change perfp femdir edudir
exprdir lrevbed finance prod quality borsq ilos lexpbed fempc edupc
skm1 skm2 skm3 yearpc trainpc;

Usevariables are

```
init best accept develop together concern
```

```
lrevbed hclass perfp skm2 skm3 exprdir;
```

Between are lrevbed hclass perfp skm2 skm3 exprdir;

Cluster is serno;

Missing are all (-9999);

Analysis:

```
Type = twolevel;
```

```
algorithm=EM;
```

```
mconvergence=500;
```

Model:

```
%within%
```

```
hsoc by accept develop together best;
```

```
develop with together;
```

```
init with hsoc; init with concern; hsoc with concern;
```

```
%between%
```

```
hsoc2 by accept develop together best;
```

```
lrevbed on init hsoc2 concern hclass perfp skm2 skm3 exprdir;
```

Output: standardized sampstat;

Note: for other workplace performance measures, similar codes are used adjusting the performance variable(expenditure per bed, BOR and LOS).