Work-Life Balance Practices in the Healthcare Industry:
The Case of East Malaysia

A thesis submitted in fulfilment of the requirement for the degree of
Doctor of Philosophy

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DECLARATION

I certify that except where due acknowledgment has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics, procedures and guidelines have been followed.

Oscar Dousin
August 2017
LIST OF PUBLICATIONS


DEDICATION

To mum and dad,
For your unconditional love and unending prayers......
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<td>α</td>
<td>Alpha</td>
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<tr>
<td>CMV</td>
<td>Common Method Variance</td>
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<tr>
<td>EFA</td>
<td>Explanatory Factor Analysis</td>
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<tr>
<td>HPWPs</td>
<td>High Performance Work Practices</td>
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<td>HPWS</td>
<td>High Performance Work Systems</td>
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<td>HRM</td>
<td>Human Resource Management</td>
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<td>KMO</td>
<td>Kaiser-Meyer-Olkin</td>
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<td>MDR</td>
<td>Doctor</td>
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<td>MoH</td>
<td>Ministry of Health, Malaysia</td>
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<td>NKEAs</td>
<td>National Key Economic Areas</td>
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<td>NR</td>
<td>Nurse</td>
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<td>RM</td>
<td>Ringgit Malaysia</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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ABSTRACT

Work-life balance practices, an important dimension in contemporary human resource management, has received significant attention from academics, management, government and employees. This study investigates work-life balance practices in relation to the perceived value of money, employee outcomes (well-being and work behaviour), the meaning of work and life contentment for medical professionals (doctors and nurses) in the healthcare industry in East Malaysia. The thesis takes a pragmatic mixed-methods approach by adopting a two-phase, sequential explanatory research design to investigate the central research questions ‘how does the perceived value of money influence the relations between work-life balance practices and employee outcomes, and why?’ The quantitative study investigates the relations between work-life balance practices and employee well-being and work behaviour as well as the moderating impact of the perceived value of money. The qualitative study further investigates some key findings of the quantitative analysis and confirms the influence of the meaning of work and life contentment on employee work-life balance, the perceived value of money, well-being and work behaviour.

The thesis expands Western interpretations of work-life balance to include specific interactions between East-Malaysian collectivist culture and gender norms which mitigate the stress of high-intensity work for medical professionals. The study also extends the concept of the perceived value of money by suggesting that medical professionals value their permanent job status as a component of financial security. In addition, medical professionals perceived their professions as a ‘calling’ which conforms to their notion of the meaning of work. The study also suggests that life contentment is an important outcome of work-life balance practices. The HR contributions of the study are important, underscoring the significance of developing and cultivating work-life balance practices in the workplace to attract, motivate and retain talented employees.

Keywords: Work-life balance, perceived value of money, employee outcomes, meaning of work, life contentment, medical professionals, East Malaysia
CHAPTER 1: INTRODUCTION

In any organisation, human resources are the largest and most exclusive assets, but the most difficult to control (Pfeffer 1998). In this era of globalisation, human resources management (HRM) concepts have evolved from their initial focus on welfare and administration to an emphasis on employee motivation and job satisfaction (Shen 2011). One of the main reasons is due to modern social concerns with employee rights and their personal and developmental needs (Hartel et al. 2007). Over the past few decades, this has resulted in the rise of employee-oriented HRM (Greenwood 2002), such as high involvement HRM (Guthrie 2001), flexible employment (Guest 2001), family-friendly HRM (Bagraim & Sader 2007) and work-life balance (WLB) (Bardoel et al. 2008). There are new pressures for HR practitioners to design HR policies and practices to fulfill employee expectations (Zopiatis et al. 2012). This awareness leads to innovative HR practices and results in greater employee job satisfaction which helps increase organisational performance (Becker et al. 1997). The pressure to meet employee expectations has resulted in the need for new HRM initiatives in managing the modern workplace.

The role of work has moved simultaneously with a shift in globalisation that impacts economic conditions and social demands (Joshi et al. 2002). In the past, work was a matter of necessity and survival. However, over the years, the role of work has evolved and the composition of the workforce has changed. Work is still seen as a necessity, but also a source of personal satisfaction as well. One of the motivating factors that help the attainment of personal and professional goals is the introduction of work-life benefits and programs (Joshi et al. 2002).

The concept of WLB is popular today because of its potential value for both employers and employees. Employees can benefit by increasing their life satisfaction and general well-being as well as reducing work-family conflicts (Allen et al. 2000; Hammer et al. 2008). On the other hand, benefits for employers include increased productivity through improved employee outcomes such as commitment, motivation, talent retention and reduced turnover intentions (Carrasquer & Martin 2005; Hughes & Bozionelos 2007; Nelson et al. 1990; Scandura & Lankau 1997). A good balance of work and life provides the organisation with productive and innovative employees (Greenhaus et al. 2003).
WLB and its impact on various aspects of employment and employee well-being have been extensively studied and debated in western and advanced economies (Carrasquer & Martin 2005; Hartel et al. 2007; Joshi et al. 2002; Shen 2011). However, the notion of WLB remains theoretically vague and unclear, especially in the Asian context (Au 2009; Felstead et al. 2002). This study contributes to emergent literature by investigating the relation between WLB, the perceived value of money and employee outcomes among medical professionals in the state of Sabah and Sarawak in East Malaysia.

1.1 Research Rationale and Questions

Malaysia’s healthcare industry is one of the best in the region and comparable to developed countries such as Singapore. In recent years, Malaysia has also emerged as a popular medical tourism destination in the south-east Asia region (Allianz 2013). The industry is identified as one of the country’s main economic contributors and one of 12 National Key Economic Area (NKEAs) in the country’s Economic Transformation Programme (Jabatan Perdana Menteri 2012). Malaysia currently spends about 4.7 % of its gross domestic product (GDP) on healthcare (Dexter 2012; Health Informatics Centre Planning Division 2013). Therefore, due to the expansion of the healthcare industry to promote medical tourism in Malaysia, the sector is required to improve the quality of their services, manpower skills and to achieve certification for internationally recognised quality standards (Garcia-Altes 2005).

Even though the industry has been a priority for government manpower planning and resources, it has suffered a shortage of personnel as measured by international standards. This results in medical professionals working long hours with high pressure and less flexibility than other professions. The number of doctors is only 1:600 per head of population, far below the World Health Organization (WHO) standard (Ibrahim 2012). In 2015, there is an increase in the number of doctors and nurses to population ratio at the national level. The doctor to population ratio in 2014 and 2015 was 1:674 and 1:671, whereas the nurse to population was 1:331 (2014) and 1:312 (2015) (Department of Statistics Malaysia 2016). However, this ratio is worse in East Malaysia as 2012 statistics showed the doctor per population ratio in Sabah was 1:2248 and 1:1709 in Sarawak. The shortage of nurses is also critical, especially in the public healthcare sectors (Barnett et al. 2010; Manaf 2005). The nurse-to-patient ratio proposed by WHO is 1:200 while the country’s current nurse-to-patient ratio is 1:599
This situation is worsening with large numbers of nurses leaving the public sector to seek employment opportunities in the Middle East as it offers higher monetary benefits (BERNAMA 2008; myMetro 2014; Yazid 2010). The shortage of personnel has forced both professions to work under high pressure with long-working hours away from home which influences WLB, well-being and work behaviour.

Other factors adding to WLB pressures are the government’s generous compensation package and flexible work arrangement policies in the industry to maximise working hours. Doctors in public hospital have the option of locum practice in private clinics out of official working hours (Dahlui & Aziz 2012). The Ministry of Health (MoH) also issued a policy to encourage doctors working overseas to return by offering numerous attractive compensation and benefits packages.

Several scholars have studied the relation between WLB practices and employee outcomes (Aziz et al. 2011; Deery & Jago 2015; Jamieson et al. 2013; Md-Sidin et al. 2010; Noor 2011; Tanaka et al. 2011). Furthermore, some researchers investigated the influence of the perceived value of money and the relation between WLB practices and employee outcomes (Lee 2006; Paul & Guilbert 2013; Wang & Yang 2016). However, to date, studies on WLB conducted in the Malaysian context focused on industrial sectors such as agricultural and fisheries (Mahpul & Abdullah 2011), public higher-education institutions and manufacturing and telecommunication (Hassan et al. 2010). These studies are limited because they do not provide an in-depth explanation of how WLB affects individual employees and their families. They also do not provide sufficient perceptions of individual participant opinions towards the current situation of WLB, especially in high-demand workload environments with staff shortages.

Very little research on WLB has been conducted specifically in the context of the East Malaysian healthcare industry. The rigorous improvement in the national healthcare system and aggressive promotion of health tourism by the MoH has had a direct impact on the East Malaysia healthcare industry. This can be seen though the allocated budget of RM22.1 billion in 2014 (Ministry of Finance Malaysia 2013) to improve the medical facilities and staff well-being in these regions. Further, the rigorous development and establishment of several public and private medical facilities in recent years has increase the demand for adequate numbers
of medical professionals. However, the shortages of manpower which has led to heavy workloads, will affect their job motivation, satisfaction and performance. Therefore, it is important to evaluate the issue of WLB among medical professions to improve employee attraction, retention and motivation. Specifically, this study seeks to fill this gap by investigating the importance of the perceived value of money, WLB, well-being and work behaviour among doctors and nurses in the East Malaysian healthcare industry. This study also examines the effectiveness of government policies on promoting WLB for doctors and nurses.

The central research question of this study is ‘How does the perceived value of money influence the relation between WLB practices and employee outcomes, and why?’ There are three prominent sub-research questions that emerged from phase 1 and will be investigated in phase 2 of this study. First, this study attempted to identify some key factors such as the East Malaysian culture, gender and social norms to WLB, well-being and work behaviour which had led to this sub-question 1: ‘What are the key factors that influence employee WLB, well-being and work behaviour in the East Malaysian healthcare industry?’ This study also provided an in-depth explanation of the differences between doctors’ and nurses’ perceptions on the value of money. Since both professions are significantly different in terms of their medical certifications, compensation and benefits packages as well as employment conditions, it is important to thoroughly investigate their perceived value of money. This leads to the sub-question 2, ‘Why is there a difference between the perceptions of doctors and nurses on the value of money?’ Finally, this study expands the initial conceptual framework in understanding the WLB issues by further exploring some important and emerging issues that influence medical professionals’ WLB and their perceived value of money which leads to the sub-question 3, ‘What are other emerging issues that influence employee WLB and perceived value of money?’
1.2 Research Aims and Objectives

This study aims to extend the WLB concept to evaluate employee well-being and work behaviour as well as the impact of the perceived value of money among medical professionals in the East Malaysian context. To achieve these purposes, this study focuses to achieve three main objectives:

1. To examine the relations between work-life balance practices with employee outcomes (employee well-being and work behaviour)
2. To examine the moderating effect of the perceived value of money in the relations between work-life balance practices with employee outcomes (employee well-being and work behaviour)
3. To contribute to new knowledge about the salience of work-life concept in the context of the healthcare industry in East Malaysia.

By doing so, this study adopts a two-phase explanatory sequential mixed-method approach. Phase 1 is a quantitative study comprising 494 doctors and nurses recruited by selective and snowball sampling techniques. This phase aims to investigate the direct relation between WLB practices on employee outcomes. Specifically, it aims at examining the elements of flexibility and choice in working hours, supportive supervision and family-friendly programs and practices to employee outcomes (employee well-being and work behaviour). Moreover, the study also investigates the moderating effect of the perceived value of money on the relations between WLB practices and employee outcomes.

Phase 2 is a qualitative study based on the principal findings of Phase 1. It comprises interviews with 11 doctors and 8 nurses. The results and findings of Phase 1 are explained and explored by in-depth explorations of WLB issues and the perceived value of money and their influence on employee well-being and work behaviour. In addition, this phase also explores emerging factors of the meaning of work and life contentment which could influence employee WLB, the perceived value of money, well-being and work behaviour. In this phase, the study also aims to contribute to new knowledge and enrich the literature concerning the salience of the WLB concept in the context of the healthcare industry in East Malaysia.
1.3 Organisation of the Thesis

This thesis contains eight chapters. The first chapter provides an overview of the research, the research background and the central research questions. Chapter two describes the context of the study, which is the healthcare industry in East Malaysian states (Sabah and Sarawak). It highlights the current situations of doctors and nurses in both states as well as the culture and HRM practices in these professions. Chapter three reviews the literature, discusses studies on variables to be explored as a measure of WLB, the perceived value of money, employee well-being and work behaviour. The chapter also explores underpinning theories that support these relations. It then discusses current studies on WLB in Malaysia from medical professional’s perspectives. The chapter concludes with a description of the development of a conceptual framework and research hypotheses as the foundation for the enriched WLB model proposed for this study.

Chapter four outlines the research methodology which employs a pragmatic paradigm using a mixed-methods approach and the justification for the sequential explanatory approach adopted. It presents the research design and procedure, data collection and analysis methods, unit of analysis, research location, sample and sample recruitment methods and the approaches to data cleaning and screening. The chapter then explain in details the data collection methods in each phase of this study.

Chapter five sets out the Phase 1 study, including the pilot study, survey findings and analysis. The chapter presents the validity and reliability analysis, the descriptive and Pearson correlations (r) analysis and multiple regression analysis results for hypothesis testing. Chapter six presents findings of phase 2, qualitative study. It discusses the hypotheses testing results through in-depth interviews. It then provides in-depth analysis and discussion of the factors that influence employee WLB, well-being and work behaviour and explores differences between doctors and nurses in their perceptions of the value of money.

Chapter seven further investigates the analysis and discussion of two significant emerging themes of the meaning of work and life contentment. Chapter eight provides the conclusion as well as the contributions of this study to the current debates on WLB. It then will highlight key implications for HR practitioners and relevant government to design and implement
suitable HR policies that will beneficial for healthcare workforce, organisation and East Malaysia region. The chapter will conclude with limitations and recommendations for future research. Figure 1.1 below presents the organisation of the thesis.

Figure 1.1: Organisation of the Thesis
CHAPTER 2: THE HEALTHCARE INDUSTRY IN EAST MALAYSIA

2.1 Introduction

This chapter describes government plans for the development of the healthcare industry as one of the key economic contributors to Malaysia’s economic growth and discusses how these developments have affected employee perceptions of WLB.

In particular, the review explores the developmental history of the healthcare industry in Malaysia and highlights key government policies and strategies for the improvement. In addition, it highlights the culture in Malaysia, the current HRM issues related to doctors and nurses as well as several WLB policies available for the Malaysian workforce. Finally, the review outlines relevant situations in the healthcare sector of Sabah and Sarawak.

This chapter draws primarily on sources from ‘grey literature’ (Auger 1975; Schöpfel & Farace 2010) such as secondary data, newspaper reports and government documents. The researcher also conducted preliminary interviews to scope key issues in understanding issues of WLB, the perceived value of money, employee well-being and work behaviour among doctors and nurses in East Malaysia. In several sections, the researcher will describe both doctors and nurses as medical professionals.

2.2 Background and the Culture of Malaysia

Malaysia is a country located in Southeast Asia where it encompasses Peninsular and East Malaysia (Malaysian Borneo) separated by the South China Sea. The country consists of 13 states and 3 federal territories with a total landmass of 330,803 sq. kilometres. Both Sabah and Sarawak with Peninsular Malaya formed the Federation of Malaysia on 16 September 1963. In 2016, the total population of Malaysia was estimated at 31.7 million compared to 31.2 million in 2015. According to Department of Statistics Malaysia (2016), Malaysia’s GDP growth in 2016 was 4.2%, with all sectors showing positive growth led by construction (7.9%), services (5.1%) and manufacturing (4.5%). The labour participation rate as of April
2017 was 67.7% and the unemployment rate remained at 3.4% (Department of Statistics Malaysia 2016).

Sabah is the second largest state in Malaysia located in the Borneo Island, the 3rd largest island in the world. Sabah has an area covering 72,500 square kilometres, located in northern Borneo (Kerajaan Negeri Sabah 2015). The capital city of Sabah is Kota Kinabalu and major cities and towns include Sandakan, Tawau, Penampang, Lahad Datu and Papar. In 2016, the total population of Sabah was estimated at 3.81 million with an average 2.5% annual growth rate (Department of Statistics Malaysia 2016). Moreover, the GDP growth of Sabah in 2015 was 6.1% with a 70.8% labour force participation rate. However, in 2016, the state had one of the highest unemployment rates in the country (5.4%) (Department of Statistics Malaysia 2016). Sabah’s economy has always depended on primary industry exports and other commodities that are minimally processed. Apart from traditional wood manufacturing and agriculture, tourism and manufacturing are also increasing and fast becoming a major source of economic growth in Sabah. However, petroleum, palm oil and cocoa remained the three stable export commodities. As natural resources are rich in this country, nearly 14.2% of land around Sabah is assigned to the agricultural sector (Kerajaan Negeri Sabah 2015).

The state of Sarawak is the largest in Malaysia with a total area of 124,449 sq. kilometres (State Planning Unit 2012). The capital city of Sarawak is Kuching and major cities and towns include Miri, Sibu, Samarahan, Limbang, Mukah and Bintulu. In 2016, the total population of Sarawak was estimated at 2.74 million, with 1.4% average annual growth rate (Department of Statistics Malaysia 2016). In terms of economic development, the state of Sarawak recorded an estimated GDP growth of 3.7% in 2016 with a 41.9% labour participation rate. The unemployment rate was 3.3% (Department of Statistics Malaysia 2016). The main economic contributors for Sarawak include the service industry, manufacturing, mining and quarrying, agriculture and construction (State Planning Unit 2012). In addition, between 2006-2010, the economy in Sarawak vacillated in tandem with global economies, achieving an average growth of 3.3% per annum. Sarawak is still dependent on natural resources as the main economic driver.

Malaysia is a multi-ethnic country where 68.6% of the population consists of ethnic Bumiputera, followed by Chinese (23.4%), Indians (7.0%) and others (1.0%). About 10.3% out of the total are non-Malaysian citizens (Department of Statistics Malaysia 2016). In
Sabah and Sarawak, there are a numerous ethnic groups with their own unique cultures and heritages. In Sabah, the largest indigenous ethnic groups are the Kadazan Dusun, the Murut and the Bajau, whereas the Dayaks are the major ethnic group in Sarawak (Tourism Malaysia 2017). Most Malaysians retain their religion, customs and ways of life based on their ethnicities and consider family as the centre of the social structure. The official language of the country is ‘Bahasa Malaysia’ or ‘Bahasa Melayu’ introduced by the National Language Act 1967, but most Malaysians speak their own ethnic dialects as well (Commisceo Global 2017). The culture in Malaysia places a great emphasis on unity, loyalty and respect for the elderly, and strives to maintain the concept of maintaining face and avoiding shame in both public and private life. Hofstede (2017) describes Malaysian culture as a collectivist with high-power distance, low in masculinity and a moderate long-term orientation society. This is explained as follows. Employees in Malaysia have high tolerance of a bureaucratic management style with little or no challenges to direct supervisors. The concept of face could be extended to this attitude where individuals have the tendency to not challenge someone in the authority, especially in public, because this could lead to the ‘loss of face’ (Commisceo Global 2017). In addition, high-power distance also refers to an environment where employees expect to receive instruction from their supervisors and the concept of an ideal supervisor is a compassionate autocrat. Moreover, Malaysia scored low in masculinity, a feminine culture which refers to a society that values quality of life and compassion towards others. Achieving an adequate balance between personal life and career is perceived as a sign of success. A moderate long-term orientation society refers to a culture that has high respect for traditions, and a motivation to achieve immediate outcomes.

Furthermore, in a collective culture, societies are described as group-oriented and have high tendency to promote shared goals, emphasising collective uniqueness as well as the importance of external and public roles and relatives (Markus & Kitayama 1991; Triandis 1989, 1995). On the other hand, in a high-power distance culture, employees feel comfortable with a work hierarchy and the inadequate distribution of power in organisations despite valuing a concern with the needs of others. Malaysians also value religion. These cultural norms have a direct influence in shaping the characteristics of the Malaysian workforce that prioritises collaborative results, harmony, avoiding confrontations and having respect for the elders and authorities (Abdullah 1996).
2.3 The Role of the Healthcare Industry in the Malaysian National Economic Development

The history of the health service in Malaysia started before 1957, the year of the country’s independence. Before that time, the purpose of hospitals was to treat workers in the tin mining industry (Kementerian Kesihatan Malaysia 2014). At the end of the 19th century, the tin mining boom in the state of Perak led to a significant increase in the number of hospitals to a total of 15 in Malaysia. After 1957, there was a significant spike in the healthcare industry which led to a total of 65 hospitals (Kementerian Kesihatan Malaysia 2014). In the state of Sabah, health services were established by the North Borneo Chartered Company who ruled the country from 1881 until 1942 (Kementerian Kesihatan Malaysia 2014). In the state of Sarawak, the history of health services has been recorded since the Rajah Brooke era (1841–1946) where hospitals were built specifically for the treatment of European officials and their families. Before 1963, the colonial era brought medical services to the country to focus on medical treatment in urban areas (Kementerian Kesihatan Malaysia 2014).

Since 1957, the government made significant improvements in health care facilities. The development of national health care focused primarily on the development and upgrading of existing health services with a focus on general and small health centres, clinics and midwifery hospitals (Kementerian Kesihatan Malaysia 2014). In recent years, Malaysia has seen remarkable enhancements in its healthcare delivery system. The total expenditure on health was 4.4% of GDP in 2011 (MoH Malaysia, HIC, Planning Division 2013). Under the Tenth Malaysia Plan (10MP), one of the major initiatives was for quality healthcare and a healthy community with strategy geared towards the establishment of a comprehensive healthcare system and public recreational and sports infrastructure to support active lifestyles (MoH Malaysia, Health Informatics Centre Planning Division 2013). The healthcare industry is one of the National Key Economic Areas (NKEAs) expected to make a significant contribution to the country’s economic performance. The contribution of the health sector is primarily through the provision of services that will lead to improved health outcomes and, ultimately, an improved health status of the nation.

Currently, Malaysian healthcare is a dual practice delivery system which consists of public and private sectors. The government remains the main policymaking and regulatory body despite the healthcare provision being a dual system. The government’s goal is to provide
universal access to affordable and high-quality care for all Malaysians by ensuring that public health services are the dominant national services. The latter now comprises around 70% of all services. Public health services range from health promotion and illness prevention to curative and rehabilitative care. There are three types of public hospitals: general hospitals, district hospitals and specialised/referral medical institutes. In the public healthcare industry, the human resources division (HRD) is responsible for managing matters related to HR and the organisational structure of the MoH. HRD handles HR matters, schemes and remuneration, discipline, integrity and the Human Management Information System. The private healthcare sector is rapidly growing and offers mainly curative and rehabilitative services. It is financed strictly on a non-subsidised, fee-for-service basis. In terms of quality, all private medical centres are approved and licensed by the MoH and most medical facilities have achieved certifications for internationally recognised quality standards (Garcia-Altes 2005).

The government is committed to principles for universal high-quality healthcare, which the MoH offers through a network of nationwide clinics and hospitals. Malaysia, therefore, proves to be a formidable competitor for its regional rivals by providing superior healthcare services, English speaking staff, healthcare infrastructure, strict government rules on maintaining high standards of healthcare delivery and foreign-trained specialist doctor (Dexter 2012).

The concept of health tourism was initially introduced in 1998 by the Malaysian government. In recent years, Malaysia has become a popular destination for medical tourism as it provides one of the best services in the region (Allianz 2013). Currently, it is the second largest income earner for the national economy (Allianz 2013). The medical tourism industry has rapidly become one of the leading industries contributing to the nation’s economic development (Chaynee 2003). In 2013, the revenue from medical tourism in Malaysia was RM683 million, 9% above target (Pemandu 2013). Lee and Ramsay (2013) stated that the yearly double-digit growth of medical tourism is being used to attract overseas investment and joint ventures in the Malaysian healthcare industry.

With continued vigilance for providing quality healthcare, Malaysia has continuously attracted expatriates, tourists, migrants and visitors as its health patrons (Allianz 2013). The number of foreign patients seeking medical treatment in the country is increasing every year and, hence, the resulting revenue growth. Most of the private hospitals are enthusiastically
participating in the health tourism program and the prospects of this sector are even more optimistic. On the other hand, even though growing numbers of Malaysian healthcare facilities are enthusiastically promoting medical tourism, some 95% of private hospital clientele are Malaysian (Ormond et al. 2014). Medical tourism revenue from private and corporatised hospitals therefore sustains and upgrades these facilities for local users providing Malaysians with alternatives to the crowded public health care system (Ormond et al. 2014).

2.4 Human Resources Management in the Healthcare Industry

2.4.1 Compensation and Benefits Management

The basic salary for doctors in public healthcare industry in Malaysia is among the highest in the government service scheme. Table 2.1 below shows salary comparison between science officers, economic officers, engineers, legislative and judicial officers and medical and health officers/doctors.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Minimum Salary/ Per Month (RM)</th>
<th>Conversion to AUD (as of 19th October 2017)</th>
<th>Maximum Salary/ Per Month (RM)</th>
<th>Conversion to AUD (as of 19th October 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Health Officer</td>
<td>2,259.08</td>
<td>680.30</td>
<td>5,562.91</td>
<td>1675.22</td>
</tr>
<tr>
<td>Engineer</td>
<td>2,359.72</td>
<td>710.61</td>
<td>5,559.76</td>
<td>1674.27</td>
</tr>
<tr>
<td>Legislative and Judicial Officer</td>
<td>2,248.08</td>
<td>676.99</td>
<td>5,536.08</td>
<td>1667.14</td>
</tr>
<tr>
<td>Science Officer</td>
<td>1,939.89</td>
<td>584.18</td>
<td>5,555.05</td>
<td>1672.86</td>
</tr>
<tr>
<td>Economic Officer</td>
<td>1,913.16</td>
<td>576.13</td>
<td>5,471.66</td>
<td>1647.74</td>
</tr>
</tbody>
</table>

Source: *Pekeliling Perkhidmatan Bilangan 1 Tahun 2012* (Jabatan Perkhidmatan Awam Malaysia 2012)

In Malaysia, officers at level 41 must have a bachelor degree as prerequisite. Generally, during their first year of service, they receive the minimum basic salary. There are annual salary increments and officers only receive the maximum salary after several years in service. Salary increments will depend on seniority, job performance and performance appraisal
results. In addition, several other allowances will be added to the basic salary based on their level of employment and profession, such as cost of living allowances, housing allowances and fixed allowances for public service. The salary grades and stages apply to all officers in government service in Malaysia.

Apart from the high basic salary offered to doctors, the MoH was keen to improve the compensation and benefits schemes for all doctors across the country. Dahlui and Aziz (2012) reported that the government allows locum practice for doctors provided the locums are conducted at their workplace and out of official working hours. Thus, doctors working at public hospitals can earn extra income while still in government service. Additionally, public hospitals also invite specialists from private hospitals to practice at the public outpatient clinics or team with the public hospital clinicians in performing a complex operation or special procedures (Dahlui & Aziz 2012). The government also allowed university hospitals to open private wings, granting specialists the right to charge patients for elective operations, normally conducted during weekends (Dahlui & Aziz 2012). This provision helped increase the salary gap between specialists in the public and private sectors.

The ministry is also encouraging Malaysian doctors working abroad to return and work in the country. Dahlui and Aziz (2012) reported that the MoH offered numerous attractive compensation and benefits packages to ensure doctors return to Malaysia, including the offer of exempted houseman internship (provided doctors have worked in overseas hospitals as medical officers) and permanent resident status for spouses if they are expatriates. In addition, medical specialists with experience working as specialists overseas are waived the 3-year compulsory service requirement at public hospitals.

The human resource division of MoH has continued to improve existing benefits, allowances and remunerations systems to attract and retain excellent medical professionals. This includes extending payment for post-basic certificate holders of critical care and clinical specialisations who are entitled to receive the Incentive Payment post-basic (BIPB) at the rate of (RM) 100 per month for all qualified paramedics (MoH Malaysia 2014). The ministry conducted a study on methods of job promotions for doctors if they comply to job ministry secondments (Utusan Melayu 2013). Job promotion will become a pull factor for doctors to
work in rural and remote areas. Various incentives will also be provided to those currently working in these regions.

Therefore, in this context, it is assumed that the above factors created a significant improvement in government compensation and the benefit scale for doctors. They are perceived to be highly respected in the service scheme for this reason. These remuneration schemes could be expected to increase their perception of the value of money, since working in this profession helps grow doctor status in society. Monetary benefits have been largely implemented by MoH in their retention and attraction strategy which could improve employee job security and livelihood (Furnham & Argyle 1998; Tang 1992). Furthermore, this strategy also supports the previous study by Locke et al. (1980) which revealed that to improve organisational performance, one of the key strategies to improve employee motivation and attraction is remuneration.

2.4.2 Training and Career Development Programs

Training and development programs have been implemented by the training management division of the MoH with the main objective of developing the human capital to produce an effective and efficient health delivery system (Ministry of Health 2014). This department is fully aware and conscious of the changes and dynamism of the ever-increasing expectation of the public in seeking primary health services. Towards achieving this aim, the department’s activities are facilitated through various management training programs designed to produce a workforce that is knowledgeable, competent, disciplined and imbued with strong work ethics, values and commitment to excellence. In short, the focus of the division is to increase opportunities for quality training and education to strengthen its HR base (MoH Malaysia 2014).

The training program in the MoH is a continuous investment to produce trained and competent manpower in various health care fields. In ensuring the healthcare personnel of the MoH acquire the necessary skills and knowledge, the training department offers a diverse range of programs including basic training, post-basic training, masters level training for medical officers, dental officers, pharmacists, sub-speciality training for medical officers, doctoral programs and short-term in-service courses (MoH Malaysia 2014).
Significant efforts to improve the healthcare system and facilities in Malaysia have been made by the MoH over the past few years. The policies and support tools provided and developed by MoH aim to ensure there is an efficient and effective industry system as well as strategic HR practices and structures, competitive training programs and robust financial management. Besides offering the most competitive salaries to the medical professionals, the government also provides opportunities to practice their skills in private and public hospitals. The government, through the MoH and the Department of Health for both Sabah and Sarawak, have also implemented several medical and strategic policies to ensure medical professionals continue to practice in these states. Since the health tourism industry is growing and a key economic contributor, there is a high demand for competitive and skilled human resources. This will ensure the industry will maintain its competitive position as one of best in the region. Continuous improvements in almost all aspects of the medical professions aims to ensure doctors and nurses will become the best with satisfying jobs for personnel currently employed by the healthcare industry in Malaysia.

In Malaysia, nurses comprise 2-3% of the female workforce and a substantial proportion of the healthcare workforce. About two-thirds of nurses works full-time in public government hospitals and clinics. They are required to retire at age 55 or 56 years. In addition, very few nurses are male, though small numbers have been taught nursing skills and trained as medical assistants (MoH Malaysia 2007, 2008). Nurses train in colleges or universities by undertaking a 3-year Nursing Diploma or 4-year Bachelor of Nursing Degree. In general, graduates are bonded to the MoH for a period a time following their initial preparation in recognition of the employer’s contribution to the cost of their education. The entry requirement for a nursing course is usually restricted to high school graduates. For the Diploma in Nursing program, the entry level is the Sijil Pelajaran Malaysia (SPM), equivalent to O-levels, e.g. successful completion of the penultimate year of secondary schooling. The entry requirement for the Bachelor in Nursing program is the Sijil Tinggi Pelajaran Malaysia (STPM), equivalent to A-levels (Barnett et al. 2010), or the completion of the Diploma of Nursing course.

In Malaysia, the shortage of nurses has been identified as a critical problem for the public healthcare sector (Barnett et al. 2010; Manaf 2005). The WHO recommends a nurse-to-patient ratio of 1:200 while the Malaysian nurse ratio is 1:599 (MoH Malaysia 2009). Pillay (2008) and Barnett et al. (2010) suggest that at least 174,000 nurses need to be trained by
2020 to meet the WHO nurse-to-patient standard. However, this ratio is hard to achieve because 5000 nurses retire every year and only 1500 nurses are hired annually (BERNAMA 2008). In 2015, there is an increase in the number of nurse to population at the national level, it was 1:331 (2014) and 1:315 (2015) (Department of Statistics Malaysia 2016). However, this figure is still behind the WHO standard and as a result, nurse shortages lead to an uneven quality of care; a frequent topic in mainstream media (BERNAMA 2008).

Since 2003, the government has rigorously developed several policies and strategies to improve the retention of nurses in the country to increase supply, reduce demand and improve retention (Cowin & Jacobson 2003). Escalating the domestic supply of new graduates is one way to increase numbers. In Malaysia, a dramatic expansion in the number of schools and colleges of nursing, nursing students and subsequent increase in the proportion of new graduates within the workforce has been associated with some workplace challenges (Barnett et al. 2010). Demand can also be addressed by restructuring the workforce and substituting other types of workers in place of nurses, such as the midwives or medical assistants. Initiatives can also be taken to improve the working environment and support retention (Barnett et al. 2010).

2.4.3 Overseas Career Opportunities

Nurses show interest in leaving the public sector to seek employment in Singapore and Middle East (e.g. Saudi Arabia) as it offers them higher monetary benefits (BERNAMA 2008; FMT Reporters 2017; myMetro 2014; Yazid 2010). The drive for a higher salary as well as a fairer WLB is what causes these nurses to look for alternative employment (Kamaruzaman 2016). They are offered up to four-times the salary compared to Malaysia (myMetro 2014).

One of the nurses interviewed by Yazid (2010) stated that when working in Saudi Arabia in late 1990s, she was offered a salary of RM7,965 per month and other incentives, such as free accommodation and transportation. She further reported that, six-months after she passed her annual examination, her salary increased to RM9,865 per month. There is no doubt of the vast differences in her salary working abroad compared to Malaysia at approximately RM2,000 to RM3,000 per month. The high salary offers in Singapore and Saudi Arabia are
considered to be the main driver for nurses in Malaysia to consider migrating to those countries (Kamaruzaman 2016; Yazid 2010).

As well as the high salary range offered by the overseas hospitals, Malaysian nurses also equipped with suitable skills and competencies which help increase their market value. One of the advantages in employing Malaysian nurses in Saudi Arabia is their ability and competency in English. Since English is the ‘universal’ language, most patients feel comfortable consulting them (myMetro 2014). Another reason for employing Malaysian nurses is their medical skill (myMetro 2014).

2.4.4 Human Resource Policies that Promote Work-life Balance

The government sector in Malaysia is more generous than the private sector in the implementation of family-friendly policies (Ahmad 2007). Nevertheless, both public and private organisations are still at initial stages of policy development as there is a lack of organisational commitment. Interestingly, Ahmad’s (2007) study found out that organisations in Malaysia viewed the issue of synchronisation between families and working lives as unimportant. Thus, there is a lack of attention to policies that support WLB such as childcare and leave. Malaysia has developed several policies designed to improve female participation in employment, earnings and quality of employment over the past 25 years (Noor & Mahudin 2016). WLB policies and legislative initiatives in Malaysia can be classified into three types: (i) flexible work arrangements, (ii) childcare policies and (iii) leave policies.

*Flexible Working Arrangements*

Flexible working arrangements include staggered working hours, working from home, reduced work hours, compressed workweeks, job sharing as well as job exchanges which helps employees balance work and family obligations (Noor & Mahudin 2016). In Malaysia, three of these options were practised by public sector: (i) flexibility in starting and ending the working day (i.e. staggered hours), (ii) flexibility to work from home and (iii) part-time employment (Noor & Mahudin 2016).
The policy on flexibility in start and finish times was introduced to government sector employees in June 2007 (Pekeliling Perkhidmatan Bilangan 2 Tahun 2007). This working arrangement allows nurses and doctors in administration and management to choose three options of working hours: (i) 7.30 am to 4:30 pm, (ii) 8:00 am to 5:00 pm, and (iii) 8:30 am to 5:30 pm. A working from home policy was launched in October 2008 by the Ministry of Human Resources, allowing selected employees, especially the disabled or those with children, to work from home. The third form of flexible working arrangement is part-time, implemented after the amendment of the Employment Act 1955 in October 2010. This amendment provides that part-time employees are afforded similar benefits and protections as regular employees regarding pay, holidays, public holidays and paid sick leave.

*Childcare Policy*

Childcare policies are reinforced by the Childcare Act 1984 which sets out a framework for consultation on childcare provision. This policy forms the basis for the establishment of day care in the workplace. It also emphasises the importance of childcare support to enable parents, specifically mothers, to work.

There are several government initiatives closely related to this Act which include subsidies and fiscal incentives. The purpose of these initiatives is to support childcare facilities and work flexibility. From 2007, government employees who earn RM2,000 monthly receive RM180 per child subsidy for subsidised childcare (Pekeliling Perkhidmatan Bilangan 4 Tahun 2007). This policy was extended in 2009 to households that earn below RM3000 per month (United Nations Country Team 2011). Additionally, the Malaysian government has offered a fiscal incentive of 10% corporation tax exemption to encourage organisations, especially in the private sector, to set up their own childcare facilities.

*Parental Leave Policy*

Under the Employment Act 1955 (Section 37), women in the public sector are allowed a maximum of 60 days of paid maternity leave for their first 5 children. In 2010, 90 days maternity leave was introduced by the government (Pekeliling Perkhidmatan Bilangan 14 Tahun 2010). In the private sector, employees are entitled to 60 days paid maternity leave.
2003, paid paternity leave was introduced to give working fathers the right to extend leave from 3 to 7 days to share the responsibility of child care after birth (Pekeliling Perkhidmatan Bilangan 15 Tahun 2007). Government employees can also apply for up to 3 years of unpaid leave to accompany their spouse for an overseas posting (Pekeliling Perkhidmatan Bilangan 29 Tahun 2009).

However, there are some inconsistencies in these policies for both public and private sectors, especially in relations to the maternity leave. This inconsistency forced private sector employees to use annual or unpaid leave or even sick leave for caring for their babies after birth. There are very few private sector organisations implemented 90-day maternity leave. Those who wish to extend maternity leave are likely to take unpaid leave (Noor & Mahudin 2016).

2.5 Healthcare Professions in Sabah and Sarawak

The healthcare industry in Sabah and Sarawak is moderately less comprehensive compared to those in the peninsular states. One of the key issues faced in the Sabah and Sarawak healthcare industry is a lack of doctors and nurses frequently reported in mainstream media by several key personnel in the healthcare industry.

In 2012, Malaysian National News Agency (BERNAMA) quoted Datuk Rosnah Abdul Rashid Shirlin, former Deputy Minister of Health in Malaysia stating there was a significant increase in the ratio of doctors across Malaysia from 1:905 per head of population in 2000 to 1:940 in 2011 (Ibrahim 2012). However, in Sabah and Sarawak, employment rates in the medical professions are significantly lower. In fact, it is one of the worst rates in Malaysia due to the lack of attention to medical provision by the government (Ibrahim 2012). In 2012, the number of doctors in Sabah was 1:2,248 per head of population, whereas in Sarawak it was 1:1,709. The standard proposed by WHO is 1:600. Nevertheless, the MoH aimed to achieve the WHO standard by 2015 which is still unsuccessfully achieved. In 2009, Datuk Rosnah Abdul Rashid Shirlin claimed the lack of doctors in Sabah was due to the increase in population in recent years (Rahman 2009).
In 2014, the number of doctors and nurses required in the public service proposed by the Department of Health, Sabah was 2,570. However, only 2,182 filled position with 388 vacant positions. Besides, the state also required 7,460 nurses but only 6,644 positions filled in 2014 (Sabah State Department of Health 2014). For the state of Sarawak, the reported numbers of doctors in 2010 was 1,388 compared to 1,205 in 2009. For nurses, the state has 3,231 personnel in 2010 (State Planning Unit 2012).

In 2011, Sabah Health Director, Dr Mohd Yusof Ibrahim reported that there were approximately 2,000 vacancies, or more than a 60% vacancy rate for doctors in the state. (Borneo Post 2011). In the state of Sarawak, the Deputy Minister of Health, Datuk Seri Dr Hilmi Yahya also reported a similar problem. He highlighted that the problem was due to the desire of doctors to work interstate after their houseman officer tenure was completed, or after serving for approximately two or more years as medical officer. In 2013, The Borneo Post reported that several doctors from Peninsular Malaysia preferred to work in their hometowns after completing their attachment program and that the entire situation had rapidly declined when the local doctors in Sarawak chose to work in Peninsular Malaysia than their hometowns (Borneo Post 2013).

One factor that explains the lack of doctors in Sabah and Sarawak is the poor geographical conditions in these two states. In 2012, The Daily Express reported that due to the hospital not being in a centralised area in Kota Kinabalu, Sabah, it was a challenge for people to travel, and for the hospital to provide transport services. One key example of poor geographical planning is the scattering of the state capital hospital facilities, which comprise the Queen Elizabeth Hospital (QEH) 1, Queen Elizabeth Hospital (QEH) 2 and the Sabah Women and Children’s Hospital, Likas. The three hospitals are in different areas and their locality is a major inconvenience for patients. Doctors who are constantly rotated between hospitals find it to be a challenge to travel to and from these facilities situated at one end of the state to the other. The informant of this study reporting this problem was of the view that the inaccessibility to public clinics, all of which are located in rural areas of the state, creates a lack of motivation to find medical staff (Interview MDR 3, 6 January 2015). This issue also occurs in Sarawak which is facing similar problems. Utusan Melayu (2013) reported that there is a significant lack of surgeons and a shortage of medical officers in Kapit Hospital and Bleteh Polyclinic, both located in rural Sarawak. This issue has caused great inconvenience
for patients who undergo surgery at Sibu Hospital, because the only means of transport is express boat.

On the other hand, most medical staffs are constantly seeking job opportunities in the city and urban areas which leads to a high turnover rate of the professions in rural and remote hospitals and clinics (Malaysiakini 2016; Sinar Harian 2013). Some doctors reported that working in rural or remote areas could lead to high work-related stress and motivates them to leave the profession. These doctors prefer to work in the cities or inner city areas and there is evidence that they have a high tendency to resign if asked to transfer to rural clinics and hospitals (Malaysiakini 2016). The rapid growth and development of private hospitals and clinics around city areas in these states has created more opportunities for doctors to join the private healthcare sector. Since most private hospitals and clinics are being developed in the city areas, most medical professionals prefer to resign from the public sector and join the private sector. Most doctors interested in joining the private sector are young and believe that this sector gives them more opportunity for a balanced life with high salary (Malaysiakini 2016).

The federal MoH, as well as the Department of Health in Sabah and Sarawak, have implemented several ‘money attraction policies’ in the hope to retain existing medical professionals in the public sector (Malaysiakini 2016). For example, the Ministry offered several allowances and incentives to encourage doctors to locate to Sarawak. The Assistant Minister of Public Health, Dr Jerip Susil, said that the Sarawak state government would continue to offer these additional allowances exclusive of federal incentives. The aim of increasing monetary benefits is designed to retain local medical professionals in Sarawak. As a result, over the years, there has been an increase in the number of doctors working in the state and the Ministry is looking to attract more doctors in Sarawak (Borneo Post 2013). These incentives have also been implemented by the Department of Health, Sabah, whom offer special allowances to all medical professionals willing to work in rural clinics and hospitals (Malaysiakini 2016).

However, the outcome of these initiatives is that most doctors are still unwilling to be transferred to the rural clinics and hospitals and prefer to work in the city after they finish their attachment period in rural clinics. One of the key reasons is that amenities are not
readily available in rural areas, such as supermarkets, shopping centres and access to public transport. Doctors have the misconception that working in the city would provide a better WLB. They also believe that they would enjoy better working conditions (Personal Note, 6 January 2015).

Despite some issues with regard to medical facilities and staff in the two mentioned states, the government is keen on improving and developing facilities to deliver excellent healthcare services to the public. This effort was demonstrated in the 2014 budget tabled by the Prime Minister of Malaysia, where RM 22.1 billion was allocated towards the healthcare sector (Ministry of Finance Malaysia 2013).

Therefore, the current study attempts to better understand and examine the driving forces for shortages of doctors and nurses and the reluctance of doctors to travel to rural and remote areas. Furthermore, the study seeks to understand the extent to which WLB may be connected both to the shortage of medical professionals and the reluctance of staff to be transferred to rural and remote areas.

2.6 Summary

This chapter has identified several social elements that influence WLB for medical professionals in East Malaysia. These include economic conditions, the culture of Malaysia and the crucial role of the healthcare industry for the nation’s economic development. This chapter also discussed the HRM for medical professionals and the current situation of this industry in East Malaysia. The next chapter will review relevant WLB literature, the perceived value of money, employee well-being and work behaviour. It will also discuss the hypotheses development for the study and the conceptual framework.
CHAPTER 3: LITERATURE REVIEW AND DEVELOPMENT OF THE CONCEPTUAL FRAMEWORK

3.1 Introduction

This chapter will review key issues to provide a theoretical framework for the central thesis question: ‘How does the perceived value of money influence the relation between WLB practices and employee outcomes, and why?’

The discussion in this chapter begins by exploring the impact of globalisation on HRM practices specifically in the Asian context. This impact has resulted in several changes in HRM such as the implementation of high-performance work practices (HPWPs), one contemporary HRM area essential to promote employee WLB. This is important for an organisation to attract, retain and motivate valuable employees in a highly competitive labour market. The focus of the literature review is then narrowed to a discussion of the concept of WLB, the role of balance theory (Marks & MacDermid 1996) and the most recent empirical studies of WLB in Malaysia, including studies of medical professionals.

The concept of the perceived value of money will be then discussed based on Adam’s (1965) equity theory, including a review of the relevant literature. The chapter will then outline the concept of employee outcomes. This consists of employee well-being (job satisfaction and life satisfaction) and work behaviour (job performance). Other factors that influence WLB such as the Malaysian workplace culture, the meaning of work and life contentment are analysed. Finally, the conceptual framework and research hypotheses are developed, based on a review of the literature and considering common HR practices and healthcare industry policies in Malaysia.
3.2 The Impact of Globalisation on the Asian Human Resource Management

The impact of globalisation on business practices involves a shift of the traditional patterns of international production, investment and trade with the absence of borders and barriers to trade between nations (Cox 1994; Dicken 1992) and people are becoming more aware of cultural differences and diversity (Kahn 1995). The process of globalisation includes complex changes involving economic, social, political, cultural, religious and legal aspects, all interlinked in a complex situation (Santos 2002). The process defines a means through which events, decisions and activities in one part of the world can come to have a significant consequence for individuals and communities in quite distant regions of the globe (McGrew 1990).

Changes in organisation management are one of the impacts of globalisation (Park 2003). Management practices are shifting from the problem-based system of command and control approach to the shared visions and values approach. It focuses on the role of togetherness in achieving optimal organisation results, empowerment systems, stable performance and reward objectives (Park 2003). The impact of globalisation on HRM has raised several key issues on the causes of convergence, types of best practice, its suitability to all organisations and at which level are they transferable. Besides, several organisations were motivated to benchmark, adapt and transfer the best practices of HRM from other countries (Bae & Rowley 2001). Gennard and Judge (1999) defined the best HR practices as a fair and realistic management style that will improve the profitability of the organisation. These are practices that emphasise competitive advantages and a fit synergy among systems and holistic approaches (Delery & Doty 1996; Dyer & Reeves 1995; Pfeffer 1994).

There have been strong growths of another group of scholar who believe in individual nation’s power to influence the movement of globalisation. They argue that “western best practices” need to modify to fit with non-western business environment. For example in the context of collective culture, the western model of HRM maybe need to contextualize to be able to fit in this workforce (Zhu et al. 2007). This is essential to consider other contextual factors in investigating the impact of globalisation on HRM. Therefore, to understand the influence of globalisation on HRM practices, particularly on WLB, it is necessary to review these studies that were conducted in a similar social context, in Asian economies.
Globalisation has become a push convergence through the transfer of best practices which could change existing HRM practices. Bae and Rowley’s (2001) study supports this argument but revealed that individual acceptance and national systems of HRM may influence policy changes due to globalisation. A similar case was revealed by Zhu et al. (2008) in their investigation on the transformation of HRM practices in Vietnam. Their study revealed there is a difference in managing HR between organisations and some foreign enterprises adopt and incorporate local management practices. The process of globalisation will be influenced by both organisational strategic choices and a political-economic approach. In many cases, market competition will force organisation to adopt flexible management models by incorporating more HRM practices to improve organisational productivity and competitiveness. This study was consistent with the findings of Sitalaksmi and Zhu (2010). Their study discovered that the transformation of HRM in Indonesia forces organisations to adapt a hybrid HRM strategy as the ‘best-fit’ with competency improvement due to the impact of globalisation on society and organisations. The adoption of HRM ‘best practice’ is seen as a shift from a traditional personnel management. The study of Collins et al. (2013) and Collins et al. (2011) revealed that this phenomena occurs due to the privatisation and restructuring of Indonesian and Vietnamese companies to become modern organisations. Collins’ study also revealed that there is an evolution in trade unions in both countries from a ‘repressive to more democratic industrial relations’ (p.144). For example, trade unions in Vietnam remain totally involved in the process of economic and political reform and follow a more ‘management-driven’ model (Collins et al. 2013, 2011).

Zhu et al. (2007) investigated the influence of globalisation in East Asian countries and explored the similarity and differences of HRM practices. Their study reveals that HRM practices in several countries are typified by a reforming process towards a hybrid people-management system. The process of transformation incorporates several self-determined elements which relate to traditional cultural and value systems and historical evolution. These countries began to adopt modern HRM practices which value group-orientation, information sharing, training and development. In East Asian countries, organisations emphasise collectivism, harmony and a relationship based approach. However, there are several changes evident in HRM practices in these countries. The study revealed a strong foreign influence on the process of globalisation in HRM practices. Specifically, in Malaysia, Taiwan and
Thailand, organisations are rigorously adopting high-performance work systems (HPWS) and HRM practices due to globalisation.

Heffernan and Dundon (2016) conducted a study on the influence of HPWS to employee well-being (job satisfaction, affective commitment and work pressure) with the mediating effect of organisational justice (procedural, distributive and interactional justice) in three private companies in Ireland. Overall, this study suggested that an organisational justice framework can advance knowledge in clarifying why organisational-level HR practices can influence employee well-being. There were two significant theoretical implications from the Heffernan and Dundon (2016) study. First, employees who were very much involved with a frequent HPWS will experience low job satisfaction and effective commitment due to high work pressure. Then, organisational justice will potentially mediate the effects of HPWS on employee well-being. Interestingly, this study also revealed that the importance of interactional justice, which refers to the role of line manager through policy execution, will fully mediate the relationships between HPWS and employee outcomes (job satisfaction and affective commitment). This also partially mediate employee work pressure. Therefore, the roles of line managers in designing and implementing HPWS were crucial and have a direct influence on employee well-being.

Another study conducted by Van De Voorde and Beijer (2015) demonstrated the role of employee HR attributions in the relationship between HPWS and employee outcomes (employee well-being and performance) in the Netherlands. This study revealed that HPWS is seen as a valuable resource because it will increase employee expected performance. Adequate resources and support to HPWS is seen as positive by all employees but HPWS was found to increase levels of job strain when employees felt overwhelmed if the implemented system continuously ordered them to maximise their performance.

Overall, HPWS are an important concept in HR practices to be investigated in contemporary workplace research (Bartram & Rimmer 2007). These practices have also variously been referred to as innovation, flexible work practices, work reforms and new-work practices (Godard 2001). By perceiving employees as intellectual assets of the organisation, an organisation must design a system that could attract, develop and retain these assets (Becker & Huselid 1998). The new concepts of HR practices evolve over time. In the 1980s,
researchers such as Lawler (1986) used the term ‘high-involvement work systems’ (HIWs), while Walton (1985) and Wood and Albanese (1995) labelled this practice ‘high commitment management’. Lawler (1986) believes HIWs changes HR systems for production workers as a major shift in the degree to which production operators are involved in, or empowered to make decisions that affect their work quality and output. This also leads to changes in HR practices which enhance their skills (such as selective recruitment and better training) and commitment (such as team and company based compensations). The changes in HRM practices are designed to enhance employee involvement and operational performance.

However, Wood and Albanese (1995) revealed that the high commitment model is a complex practices which could no longer capable of attracting, retaining and motivating the kind of employees. The high uptake of the commitment model was also influenced by an increase in a well-educated workforce and improved perceptions about the importance of work (Tulgan 1966). Therefore, there is a need to shift from the top-down command and control practices to a high involvement and mutual commitment model (Walton 1985). This mutual commitment implies a new kind of psychological contract based on trust, the fairness of treatment and delivery of promises and, therefore, requires sophisticated HRM practices. HR practices within this approach are built around attempts to manage organisational culture and ensure workers operate effectively within it. The model relies on selection, training, communication, employment security, internal promotions, a range of involvement options quality improvement practices, teamwork and team-based job design. Studies on this approach suggested that employees display high commitment and motivation, high flexibility and high quality (Guest 1987; Trevor 1988; Wickens 1987).

In this era, organisations need to attract and retain valuable employees in a highly competitive labour market. Therefore, this motivates organisations to promote HR policies and practices that promote employee WLB. WLB is an important area in contemporary HRM that is receiving increasing attention from government, researchers, management employee representatives and the media (Nord et al. 2002; Pocock et al. 2001; Russell & Bowman 2000). WLB has emerged as a strategic issue for HRM and a key element of an organisation’s employee strategy (Cappelli 2000; Lewis & Cooper 1995; Nord et al. 2002). It has been argued that organisations need to be aware of the changing needs of employees and provide flexible WLB strategies to retain their employees (Bruck et al. 2002; Lambert, S
Organisations that seek to increase employee morale, commitment and satisfaction, and reduce stress and problems at work will improve their ability to recruit and retain talented and valued employees (Cappelli 2000). Building from this argument, this thesis intends to investigate WLB practices in organisations to gain a comprehensive understanding of these issues as a tool to attract, retain and motivate employees in the healthcare industry in East Malaysia.

3.3 Work-life Balance

This section identifies relevant WLB literature and its implications for employee well-being and work behaviour to establish and justify the context, background and importance of the topic. This section will also review several studies on WLB in the healthcare industry, specifically among nurses and doctors, as well as WLB studies in the Malaysian setting in general.

3.3.1 Key Concepts of Work-Life Balance

Various definitions of work-life balance have been expressed by numerous authors in recent years. Guest (2001) has provided definitions for each term in the WLB concept. Paid ‘work’ involves not simply contractual hours of employment but often includes additional unpaid activities such as extended and unpredictable journey times. At that time, ‘life’ was simply construed as ‘family life’. However, Evans et al. (2013) stated that recent reviewers included free and leisure time, irrespective of family commitments which are more comprehensive concept. The concept of ‘balance’ can have both objective and subjective meanings and measurement which varies according to settings and different individual perceptions. Several types of WLB approaches have attempted to define it by primarily focusing on a process of seeking to balance the multi-dimensions of work or career with other personal dimensions that include family, partners, other relationships or interests (Evans et al. 2013).

From an employee perspective, WLB is defined as the maintenance of a balance between responsibilities at work and home (De Cieri et al. 2005). Workers perceive the benefits or working conditions that assist them to balance the family and work domains as work-life benefits (Bardoel et al. 1998; Russell & Bowman 2000). WLB strategies emphasise the
enhancement of the autonomy of employees in the process of coordinating and integrating work and non-work aspects of their lives (Felstead et al. 2002).

In an organisational setting, WLB approaches include HR policies and strategies comprising flexible working arrangements, child and dependent care and family and parental leave (Bardoel et al. 1998; Kramar 1997). There is an increasing consciousness of benefits in providing more flexible HR strategies (Grover & Crooker 1995) and this reflects an increasing recognition that work and other life commitments cannot be easily separated. As organisations move towards a more participative and flat structure in which fewer employees are expected to manage increasing workloads (Hall & Richter 1988), maintaining the balance between career and life responsibilities becomes more difficult. Table 2.1 below indicates several definitions of WLB in the current literature.

Table 3.1: Key Definitions of Work-Life Balance

<table>
<thead>
<tr>
<th>No.</th>
<th>Author</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Lambert (1990)</td>
<td>Work-life balance is maintaining a particular balance between work and home</td>
</tr>
<tr>
<td>2</td>
<td>Kofodimos (1993)</td>
<td>The concept of work-life balance is the belief that it is in the individual’s best interest to live a balanced life</td>
</tr>
<tr>
<td>3</td>
<td>Clark (2000)</td>
<td>Work-life balance is the phenomenon of striking an ideal stability between the professional life of an individual and their personal life with all their individual associations</td>
</tr>
<tr>
<td>4</td>
<td>Guest (2002)</td>
<td>The concept of work-life balance has always been a focus of those interested in the quality of working life and its relation to wider quality of life</td>
</tr>
<tr>
<td>5</td>
<td>Greenhaus &amp; Allen (2006)</td>
<td>Work-life balance concept is the extent to which an individual’s effectiveness in work and family roles are compatible with the individual’s life-role priorities at a given point in time</td>
</tr>
<tr>
<td>6</td>
<td>Kalliath &amp; Brough (2008)</td>
<td>…the individual perception that work and non-work activities are compatible and promote growth by a person’s current life priorities</td>
</tr>
<tr>
<td>7</td>
<td>Chandra (2012)</td>
<td>Work-life balance is about paying attention to both work and family responsibilities. It indicates that individuals should take responsibility for managing personal fulfilment, work fulfilment, fulfilment of one’s role as spouse and parent, and fulfilment of one’s role as a responsible citizen</td>
</tr>
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</table>
In evaluating the work-life balance issues among doctors and nurses in East Malaysia, this study conceptualised work-life balance as maintaining a balance between work and family responsibilities. It recognises that individuals have the responsibility for managing and balancing their own personal fulfilment, work fulfilment and fulfilment of one’s role as spouse and parent, as well as being a responsible citizen. The concept of life also includes an individual’s leisure time, rest and community engagement (Chandra 2012; Lambert 1990).

3.3.2 Empirical Research and Debates on Work-Life Balance

A seminal theory in WLB research is the role balance theory proposed by Marks and MacDermid (1996). Marks and MacDermid proposed that individuals with more stable role systems will report less role strain, more role ease, greater well-being and more positive role-specific experience compared to those with a less balanced role system. Positive role balance is the tendency to become fully engaged in the performance of every role in one’s total role system, to approach every typical role and role partner with an attitude of attentiveness and care. In other words, it is the practice of that even-handed alertness which sometimes known as mindfulness. On the contrary, negative role balance is the tendency to become fully disengaged in the performance of any role which is the practice of apathy and cynicism.

There are several empirical studies on WLB developed since Marks and MacDermid’s (1996) work. In general, these highlight the main constructs of WLB and its outcomes and method of study in various sector and country settings. They suggest that organisations policies and support in providing WLB programs and options will enhance employee well-being, organisational commitment and job satisfaction (Cegarra-Leiva et al. 2012; Greenhaus et al. 2003; Haar 2013; Morganson et al. 2010; Noor 2011). Employees may experience personal conflicts if they cannot find a balance between work and personal life. Conflict is defined as ‘an interference of work and family roles that creates tension or problems for the individuals as the direct result of incompatible pressures from an individual’s work and family role’ (Moen et al. 2008). Organisations are encouraged to provide policies that will enhance employee WLB which provides for their well-being and eventually impacts firm performance (Haar 2013).
Pocock and Charlesworth (2015) studied the influence of workplace culture on quality employment that supports employees to resolve work and family over the life course in Australia. This study revealed three WLB interventions. Firstly, macro social and economic initiatives for employees that include provision for childcare, aged care, disability care, healthcare, transport, housing, education, social infrastructure, taxation and social security payments. Secondly, the regulation of work which consists of the nature of the employment contract, salary, working hours regulations and leave, and the opportunity for an individual and collective voice. Finally, critical interventions occur at the workplace where local enterprise and workplace culture and immediate supervision are the filters through which regulation takes or fails to take effect. This study also revealed that workplace cultures are essential as a determinant in ensuring employee quality that accommodates care. In regard to the flexibility in working hours, the study discovered that intense workloads and long working hours impedes flexibility. Employees with a higher level of skills and more senior positions are also challenged by this situation. Interestingly, this study also revealed that an organisational culture could assist employees to have flexible working hours. It requires organisational practices that carefully manage workloads, staffing levels and job design. A culture that supports flexibility is important because even when flexibility has been officially implemented, access is frequently obstructed when workloads become excessive.

The work of Chalmers et al. (2005) on WLB among part-time female employees in the care industry in Australia discovered several dimensions which contribute to the quality of work. Firstly, the working hours is a key determinant to establish a family-friendly working policy. Time is considered as a major restriction in everyone’s life. For part-timers, the reduction in working hours allows them to spend more time with family, friends, non-work activities and leisure while still retaining several employment benefits such as stable income, career development opportunity and the exercise of skills in the job. This study also revealed that most participants preferred flexible working hours. Moreover, they also favoured conventional leave arrangements such as parental, sickness and bereavement leave. The study also revealed the importance of salary, employment benefits and security. Stability of salary and access to standard employment benefits is critical in ensuring life stability. Part-time employees perceived themselves as ‘secondary earners’ and rely on their spouse or partner. On-going employment status provides employees with a sense of job security which ensures they can provide for their children and family. Finally, career development opportunities and
job responsibilities is another essential criterion for determining work quality. Training, career progression and job promotion opportunities are favoured by most employees. On the other hand, skills, work demands, task autonomy, social relations and work burden also influence employee work quality.

Deery and Jago (2015) studied the concepts of talent management, WLB and retention strategies in the hospitality industry. It revealed that WLB practices in organisations are a significant predictor in effectively managing and retaining employees. High workload intensity and role overload can lead to emotional imbalance, stress, exhaustion, burnout as well as work and family conflict. A culture that promotes WLB could increase job commitment, job satisfaction and decrease turnover intentions. Several retention strategies also discovered include, the image of the organisation and industry, pay level, as well as career development and management opportunities. In regard to gender preferences in employment opportunity: women prefer to work in an organisation with less work-life conflict and higher job promotion opportunities, whereas men prefer a career with higher job clarity.

Furthermore, Lawson et al. (2013) examined the work-family spill over among hotel managers in the US. The study revealed that work conditions which demanded employees to work longer hours with higher organisational expectations resulted in engaging a highly intense emotional labour and put employees at risk of experiencing more negative work-family spill over. Moreover, the study also found that women, employees with children at home and younger adults reported less stressful work conditions. This suggested that these groups of employees may be choosing work with minimal demands to balance time work and non-work activities. It also suggested that parents with children at home preferred to work in a department with standard working hours and women preferred work with less contact with clients to reduce emotional burden. Fujimoto et al. (2012) also studied gender issues and argued that men and women need to make different WLB choices. There are major differences in gender non-work activities. Women prefer a narrower range of sports activities such as regular gym attendance and significantly more home-oriented activities. Men prefer non-work activities which involve a broader range of social activities such as golf, cycling, football, gym and sailing. Furthermore, women have a greater preference for non-standard forms of employment than men.
Most studies demonstrate that western and eastern cultures have different demands and views of WLB issues (Adya 2008; Chandra 2012; Lu et al. 2006). For example, Chandra (2012) revealed that in the Asian context, working for long hours is always seen as high commitment to the job. The request for shorter work hours could be interpreted as a sign of weakness, and employees prefer not to mention it unless their supervisors or colleagues query them. On the contrary, most western cultures prefer shorter working hours. They tend to negotiate for trade-offs between salary and working hours as well as for the average amount of salary rates during economic crisis. Another dimension studied by Chandra (2012) was household responsibilities. In Asian cultures, women are expected to have total responsibility for household duties even though they have full-time jobs and contribute to household income. However, in western cultures, household responsibilities are shared equally between spouses. Based on a study by Hassan (2010), these differences exist due to cultural traditions, family structures and societal conventions. Despite these cultural differences between eastern and western cultures, WLB remains an issue for both.

It is clear that over the past 20 years, the importance of managing employee WLB has increased significantly and impacted several areas of HRM practice (De-Bruin & Dupuis 2004). Wickham et al. (2006) identified the main shifts in this area. Firstly, jobs have become more complex which put employees under pressure to produce quality results in tight timeframes with fewer resources (Hosie et al. 2004) and this has led to the redefinition of normal work hours. Secondly, changes in the demographic characteristic of the labour force (e.g. gender, ethnicity, dual-career couples, religion, multigenerational workplaces and several other factors) and thirdly, the very nature of employment contracts have demanded that organisations effectively manage employee well-being, stress and job satisfaction (Greenhaus & Powell 2006).

Ideally, HR policies in organisations can provide flexibility and enhance ‘choice’ in promoting WLB concepts. Several organisations have adopted a limited set of policies such as on-site childcare facilities and gymnasiums, telecommuting opportunities, and even on-site sleeping quarters for employees and their families (Hacker & Doolen 2003; Hyman & Summers 2004). Deery (2008) also suggested a list of practices which assist employees in balancing work and family life: (i) providing flexible working hours such as rostered days off and family friendly starting and finishing times; (ii) allowing flexible work arrangements
such as job sharing and working at home; (iii) providing training opportunities during work hours; (iv) providing adequate resources for staff so that they can undertake their jobs properly; (v) determining correct staffing levels so that staff are not overloaded; (vi) allowing adequate breaks during the working day; (vii) having provision for various types of leave, such as career leave and ‘time-out’ sabbaticals; (viii) rewarding staff for completing their tasks, note merely for presenteeism; (ix) staff functions that involve families; (x) providing, if possible, health and well-being opportunities such as access to a gymnasium or at least time to exercise; (xi) encouraging sound management practices. Current studies also argue that WLB issues also increase employee turnover intentions (Mahpul & Abdullah 2011) due to the struggle between work and personal life which lead to work and family-related conflicts and stress (Fujimoto et al. 2012). Even though work is a necessity for all individuals, it should be a source of personal satisfaction as well. Essentially, WLB is a ‘choice’ and personal responsibility (Lewis 2003). As stated by Chandra (2012), some people may be happy by working hard and for long hours, but others may prefer the opposite. Hence, individuals should decide what will make them happy and drive their behaviour. However, to balance a successful career with a personal and family life can be challenging and impacts individual satisfaction regarding work and personal life roles (Broers 2005).

3.3.3 Empirical Studies on Work-Life Balance in Malaysian Context

Over the past few decades, most WLB research has been conducted in western settings. The extensive research in this field has most benefited western governments and corporations to develop policies that support individual employees in their aspirations to be successful in both career and family lives (Sim & Bujang 2012). The debate and interest in WLB in Malaysia has increased in recent years.

Irwan and Azaian (2011) conducted research on the prevalence of work-family conflict in working mothers with at least one child in Peninsular Malaysia. The study reveals that ethnicity, age and employment are the main factors contributing to the prevalence of work-family conflict. Regarding ethnic origin, Chinese and Indians mothers are more likely to have work-family conflict than Malay mothers. Irwan and Nor Azaian (2011) concluded that work-family conflict is prevalent today mainly due to the increased participation of women in the labour market. The increase in the female labour force is largely a result of educational
improvement as better educated women are more likely to be in the workforce. Moreover, as married women participate in the workforce, they tend to experience conflict as they must occupy work and family roles simultaneously. Sim and Bujang (2012) suggested that role of religion could moderate employee WLB with job and family satisfaction. Religious involvement is associated with their parental roles in their families as a husband and a wife in addition to how they invest their time in these roles.

Another study on work-family conflict and facilitation conducted by Nasurdin et al. (2013) compared male and female SME entrepreneurs in Malaysia. The study revealed that there are no differences between genders in relation to work-family conflict and facilitation. The study also revealed that there is a transformation in cultural and religious norms in Malaysian society from strong traditional values towards more contemporary values regarding women (Koshal et al. 1998; Nasurdin et al. 2013). Since entrepreneurship is one of the country’s growing economic areas, women are encouraged to participate in the labour market (Nasurdin et al. 2013; Sum 2012).

Furthermore, another study on the quality of work life in relation to career related factors (career satisfaction, achievement and balance) was conducted by Rose et al. (2006). The study suggested that career achievement is the most important determinant of quality of work life followed by career satisfactions and career balance. Participants in this study stated that income, job position, personal growth and career opportunity are key indicators for accomplishment besides valuing spousal and family support. The results of this study were supported by Aziz et al. (2011) and Md-Sidin et al. (2010), who revealed that work-related factors such as supervisor support, job involvement, working time and schedule inflexibility as well as non-work factors such as, spousal support, family involvement and family conflicts influence employee quality of work life. The results of these studies are consistent with studies conducted in western settings. Most employees required various support roles (e.g. supervisor and spouse support) as a coping mechanism which could mitigate the negative impact of work-family conflicts and improve quality of life (Frone et al. 1992; Frone et al. 1997; Greenhaus et al. 1997; Higgins et al. 1992; Parasuraman et al. 1992).

On the other hand, Noor (2011) studied the relation between WLB and intention to leave among academics which revealed that job satisfaction and organisational commitment
influence employee WLB and turnover intentions. The outcome suggested that employees ‘feel happy in a working environment that helps them to balance the needs of their personal life with the needs of the workplace’ (Noor 2011). The results of are similar a study conducted in the western setting by Villanueva and Djurkovic (2009) revealed that job satisfaction and commitment had a strong effect on the intention to leave the organisation.

In summary, the discussion above reviewed studies on WLB in Malaysian context, but those conducted focused on agricultural and fisheries (Mahpul & Abdullah 2011), SMEs (Nasurdin et al. 2013; Rose et al. 2006), multi-national corporations (MNCs) (Rose et al. 2006), public sector organisations (Aziz et al. 2011; Md-Sidin et al. 2010), hospitality (Sim & Bujang 2012), public higher-education institutions (Noor 2011), manufacturing, telecommunication and service industries (Hassan et al. 2010). In assessing the WLB issues in Malaysia, several key areas have been highlighted by these researchers. Work-related factors, such as supervisor support job involvement, working time and schedule inflexibility, and non-work factors, such as spousal support, family involvement and family conflicts influence employee WLB and are crucial in reducing work-life conflict. Current studies show that employee WLB also will be indirectly influenced by gender, parental duties and religious beliefs.

3.3.4 Empirical Studies of Work-Life Balance Studies in Asian Pacific’ Healthcare Industry

Research on work-life balance in the healthcare industry in western countries is widespread but rarely focuses on Asia or particularly Malaysia. Understanding the important factors of WLB that contribute to employee well-being and work behaviour is necessary to refine HR policies and WLB in the Malaysian healthcare industry.

The current research project explores the relations between WLB, the perceived value of money and employee outcomes among medical professionals in Malaysia. There is limited research on these issues in Malaysia, most of which focuses on West Malaysia rather than the East. One of the drivers for the current study is to enhance understanding of WLB in this particular geographical and cultural context.

The shortage of nurses is a serious global issue (Barnett et al. 2010; Tanaka et al. 2011). Barnett et al. (2010) state that in Japan, the shortage is due to the decreasing number of
nursing students and this forces nurses to work longer hours increasing their turnover intentions. In addition, their turnover intentions are also influenced by child-raising, difficulties in balancing careers with household responsibilities, the excessive burden of night shifts and overtime (Japanese Nursing Association 2007). Nurses in Japan demanded flexible working styles, quality of life benefits and lifelong learning as the key to WLB (Tanaka et al. 2011), but these practices are rarely established in organisations.

A similar result was revealed by Jamieson et al. (2013), who studied nurse perceptions of WLB in New Zealand. The study suggested that work shifts and rosters are needed for nurses to establish and maintain balanced lifestyles. Most respondents to the study stated that high workloads sometimes caused exhaustion and they need non-work days to recover before returning to work. They also identified the importance of both work and life, balanced time with family and friends and time for leisure activities and study. The nurses further stated that fulfilling family responsibilities and accomplishing work goals at the same time was the key for job satisfaction and overall happiness.

Skinner and Chapman (2013) also revealed flexible shifts as well sensitivity to personal needs and preferences influences WLB among shift workers in the health sector. The authors also highlighted the issue of labour shortages and this required a win-win situation between individual and organisations with supportive management to establish family-friendly policies such as flexible and part-time work arrangements. Even though there was some degree of input from employees to their work schedules, negotiations and arrangements still needed to meet their circumstances and preferences.

Additionally, Skinner et al. (2011) explored the perspective of work-life in relation to retention and well-being in Australian nurses and midwives. They found that nurses and midwives described work as a vocation or ‘calling’ which provided opportunities for personal and professional growth and had a positive effect on many aspects of life domains. In terms of WLB facilitation, the work itself has been identified as a key source of meaning, purpose and personal satisfaction (Greenhaus & Powell 2006; Reiter 2007; Voydanoff 2005). Work-life balance is about assisting people to live out to their values (Reiter 2007). An important part of maintaining a good work-life relation is minimising negative spillover between work and personal life by maintaining clear boundaries (Skinner et al. 2011).
In Malaysia, nurses comprise 2–3% of the female workforce and a significant proportion of the healthcare workforce. Around two-thirds of full-time nurses’ work in the government public sector with small numbers of male nurses in the service as well (MoH Malaysia 2007, 2008). The problem of nurse shortages in Malaysia (Barnett et al. 2010; Manaf 2005) has led to strategies aimed at increasing supply, reducing demand and/or improving the retention of nurses (Cowin & Jacobson 2003). Kingma (2007) states that supply may be increased by encouraging more school graduates to enter the profession or by the active recruitment of nurses from other countries. In Malaysia, the dilemma of nurses seeking opportunities in the Middle East (e.g. Saudi Arabia) is a popular topic in mainstream media (myMetro 2014; Yazid 2010). myMetro (2014) stated that by 22 September 2014, more than 600 Malaysian nurses were working in hospitals in Jeddah.

Barnett et al. (2010) proposed several important steps to be taken into consideration when addressing nurse shortages in Malaysia. In order to reduce turnover intentions of nurses in Malaysia, strategic measures included: (i) improve the mentorship and support provided to new graduates and experienced clinicians; (ii) improve rewards, benefits and working conditions, including workloads and staffing levels; (iii) create the conditions for greater flexibility and participation in the workforce (allow part-time work and better support for re-entry to the workforce); (iv) increase worker control over work (improving professional autonomy and equivalence by reducing hierarchical control); (v) improve the clinical career structure and career mobility; and (vi) reduce occupational hazards, provide adequate compensation for accidents and injury and to improve Occupational Health and Safety. In addition, Barnett et al. also proposed the inclusion of several strategies in reducing occupational related accident and the introduction of flexible employment options such as part-time work, family friendly practices; also, extending the retirement age may increase attraction and retention of nurses in the workforce.

Lee et al. (2011) revealed that nurse professional status, autonomy, interaction, task requirements and work experience influence nurse organisational commitment in Malaysia. A high organisational commitment was determined by the working culture in the hospital. Since Malaysian culture upholds the core values of shared values and community orientation, nurses have a tendency to help each other, whereby others’ or team needs are put first. This creates a strong bond, encourages teamwork and increases the sense of belonging to the
A healthy work-relationship is based on trust, mutual respect and open communications, and those who have these experiences will have a high organisational commitment (Manion 2004; Sikorska-Simmons 2005).

The exploration of the issue of quality of work life among nurses in public hospitals in Malaysia has been explored by Mohamed and Mohamad (2012). Their study emphasised different aspects of quality of work life due to the current shortage of nurses in Malaysia. Their study recommended two strategies: (i) open communication and opportunities for career growth and (ii) work-family life balance. Organisations should provide a conducive work environment that promotes participatory decision-making with a transparent opportunity for career advancement to create the sense of ‘work-family’ belonging among employees. The study also revealed the importance of the ‘voluntary alternate scheduling’ practices which could potentially reduce work-life time imbalance and allow nurses some choice and control over their working hours and working days (Mohamed & Mohamad 2012).

Rashid et al. (2012) evaluated the influence of social support to work-family enrichment and life satisfaction among nurses in Malaysia. Social support was an important element in improving employee satisfaction, well-being, job satisfaction and enhanced work-family enrichment. An individual with a higher level of work-family enrichment is more likely to experience a greater level of satisfaction towards well-being, job and family (Greenhaus & Powell 2006; Rashid et al. 2012). Therefore, WLB and retention issues among nurses in Malaysia are an on-going concern for HR and policy makers at the national level.

In the modern medical workplace, the evolution of the healthcare system from clinician centred to patient centred has challenged medical professionals to uphold integrity in providing quality service and patient satisfaction (Sibbald et al. 2000). The reformation of the healthcare system places rising pressure on doctors because it is affects their autonomy, prestige, personality and income, resulting in higher work stress and burnout (Sibbald et al. 2000). The daily routine of doctors has been associated with long working hours, working under time pressure with a significant amount of administration and paperwork and taking work home (Cooper et al. 1989). In Malaysia, in addition to the issue of shortages of medical doctors, the expansion of the healthcare services and increasing number of patients seeking
treatment at government clinics and hospitals have resulted in greater work burdens for doctor, especially juniors (New Straits Times 2009) and some junior doctors experience emotional distress (Sidi & Maniam 1997).

Razak et al. (2011) examined the issues of work overload, spouse support and job involvement on work-family conflict among medical doctors in Peninsular Malaysia by focusing on the two dimensions of work-family conflict and work interference with family life. Their study revealed that work overload has a negative influence on work involvement with family and the influence of family obligations with work responsibility. Work overload results in exhaustion and fatigue and could potentially decrease doctor motivation to respond to other demands, such as family involvement. Surprisingly, Razak’s study revealed that job involvement will not influence work-family conflict due to the nature of the professions which required doctors to be dedicated and committed to their job. These expectations and perceptions of the profession are likely to enhance their motivational level and more likely to increase spousal understanding. Another study conducted by Razak et al. (2010) revealed the significant influence of spousal support, parental demands and family involvement to work-family conflict. The results of this study suggested that parental demand and family involvement will be positively related to work interference and family and spouse support and parental demand have a significant impact on interference with work.

In investigating the issues of emotional burnout, job stress, professional fulfilment and engagement, Al-Dubai et al. (2013) conducted a study of medical residents in Malaysia. This study suggested that working hours influence doctor emotional burnout due to long hours which leads to inadequate rest days per week for leisure activities. Their study also emphasises the significance of other factors such as resident-supervisor relationships, work overload, work environment, remuneration and incentives to emotional burnout and motivation to work. This study proposed several keys to prevention, such as appropriate mentorship, sufficient motivation and fair assessment during attachment.

The review above suggested several key elements to establish employee WLB such as work overload, supervisor support, compensation and benefits packages, flexibility in working hours, mentorship and spousal support. While it is obvious that the research on WLB in relation to employee well-being and work behaviour is a common phenomenon among
medical professions, at present, little research has been conducted specifically in the healthcare sector of East Malaysia.

3.4 Perceived Value of Money

3.4.1 Concepts of the Perceived Value of Money

The perceived importance of money has evolved owning to the changes in modern living standards and needs. In the early days, the meaning of money was more personal and used as an instrument to measure value (McClelland 1967; Smith 1937). Money was perceived as the instrument of commerce, the measure of value and it differed from one individual to another (McClelland 1967; Smith 1937). At an organisational level, individual employment status reflects their attitude to money and work-related beliefs (Staw et al. 1980) and most organisations still use money to attract, retain and motivate employees (Gomez-Mejia & Balkin 1992; Milkovich & Newman 2002). In a material-oriented society, most employees work hard to earn more money to improve individual satisfaction (Tang & Baumeister 1984). Individual attitudes towards the value of money are seen as the frame of reference which influences the evaluation of everyday life as represented by life experiences (Furnham 1984b; Lawler 1981; Tang 1992).

The conceptualisation of individual perceptions towards the value of money has evolved in recent years. Several groups of employees see money as a tool to obtain some physical rewards which will satisfy their needs (Lea & Webley 2006) and money motivates them to reach higher power and status (Durvasula & Lysonski 2010). An individual’s satisfaction with monetary rewards could provide short-term happiness but not guarantee long-term happiness (Rahman & Vairamuthu 2014).

One of the most prominent models used to investigate individual perceived value of money is the love of money scales (LOMS) established by Tang and his fellow researchers (Tang & Chiu 2003; Tang et al. 2003). Tang et al. state that the construct of the love of money has widespread discussion in the literature but has not been empirically-operationalised as no solid measurement exists in management literature. This concept is an important topic in management and business studies and the development of the construct for the LOMS is
stimulated by a western and religious perspectives. From a biblical perspective, the love of money is the root of evil (1 Timothy 6: 10) and individuals who aspire to be rich will fall into temptation (1 Timothy 6: 9). In the western perspective, individual love for money measures the meaning of money in peoples’ lives (Barber & Bretz 2000), the importance of money (Mitchell & Mickel 1999) and individual personal approaches towards it. The developed LOMS construct consists of several multidimensional aspects such as, factor rich, factor motivator, factor importance, factor success (Tang et al. 2003).

Since the East Malaysian culture is heavily influenced by the Islamic and traditional values, it will influence individual perceptions of the value of money. The Islamic Holy Qur’an refers to money as the blessings of Allah Almighty. Ad-Duha, 93:6-8 stated that “Did he not find you (O Muhammad, Peace be upon him) and orphan and gave you a refuge? And he found you unaware (of the Qur’an, its legal laws and prophethood) and guide you? And he found you poor and made you rich (self-sufficient with self-contentment)?” Furthermore, An-Nur, 24:33 also stated that money refers to the wealth of Allah Almighty. The Islamic religion also emphasizes moderation in affluence (Al-Furqan, 25: 67) “… and those, who, when they spend, are neither extravagant nor niggardly, but hold a medium way between those extremes”. Money is also viewed as being attributed to man as benefits and burdens (Al-Imran, 3: 186) but the Holy Qur’an also highlights money as something good. Allah Almighty says that: “It is prescribed for you, when death approaches any of you, if he leaves wealth (that which is good), that he make a bequest to parents and next of kin, according to reasonable manners. This is a duty upon Al-Mutaqun” (Al-Baqarah 2:180).

In assessing the concept of individual attitude and love of money in East Malaysian context, the researcher employs the term ‘the perceived value of money’. This is defined as individual medical professional’s frame of reference, symbol of success and how they evaluate their everyday lives. Their perceived value of money will be influenced by employment status, the amount of compensation and benefit package (Tang 1995; Tang et al. 2003). This study adopts three dimensions of the LOMS (Tang et al. 2003), factor rich, motivator and importance.

‘Factor rich’ refers to the affective component of one’s love of money which includes their love and hate orientations and feelings and emotions regarding money. It assumes that most
people love money and very few hate money; therefore, if one loves money, one wants to have a lot of it and this will lead to a desire to get rich (Tang 1992; Tang et al. 2003). Individuals who have gone through financial hardships also tend to be obsessed with money (Lim & Teo 1997; Tang & Chiu 2003). In the context of doctors and nurses in East Malaysia, this concept is reflected by the nature of the compensation and benefit scheme. Medical professions are one of the highest paid and this could increase their obsession with money and love of it.

‘Factor motivation’ refers to the behavioural component on how one intends or expects to act towards money. One may consider how one makes, budgets and spends money, as well as contributions to churches, charities and societies (Furnham & Argyle 1998; Tang 1992). Individuals with a high ‘love of money’ will be highly motivated to value it (Locke et al. 1980) which leads them to take action to make more money. In improving organisational performance, monetary incentives have been used as an effective motivational tool (Locke et al. 1980). However, as an exception money may not motivate several groups of employees. In the context of East Malaysia, factor motivation could be related to the work ethic of doctors and nurses by earning more money through on-call and locum practices after hours. These extra employment benefits will motivate them to work to earn more money.

The ‘factor important’ concept reflects the cognitive component of money which comprises beliefs and ideas about money. This factor assumes that, if an individual considers money as the most important part of their life, it indicates that the individual has a high-level love of money. In addition, those who have a high-level love of money perceive money as a source of power, freedom, respect and security (Furnham & Argyle 1998; Tang 1992) (Furnham & Argyle 1998; Tang 1992). Doctors and nurses in East Malaysia believe their salary and other employment benefits are significant in improving economic stability. Therefore, reaching a seniority position with some generous extra-benefit policies (e.g. on-call and locum earnings) allows them to earn extra salary.
3.4.2 Empirical Research and Current Debates on the Perceived Value of Money’s Concept

Although studies on the perceived value of money have increased in recent years, there are only a few that focus on the correlation between the relations of the perceived value of money, WLB practices, employee well-being and work behaviour.

One of the earliest theories that explain individual perceived value of money is the Adams Equity theory (1965) cited in Sweeney (1990) and Ismail et al. (2005). This theory predicted that one’s inputs and outcomes are evaluated in relation to the inputs and outcomes of others. Inequity can result from getting fewer outcomes or more outcomes than relevant others. In the context of East Malaysia, employees who perceive that the adequacy of compensation and benefits packages is about or close to their entitlements and work effort influences their job satisfaction and performance. For those employees who perceive that, if the organisation does not meet their expectations, they will be relatively dissatisfied with their work. Equity issues are an important concept in a work setting. From an employee perspective, the perception of inequity could be associated with a variety of important behaviours, including dissatisfaction with rewards, reduced effort on-the-job and willingness to leave the organisation (Mowday 1987).

In regard to the relation between income and quality of life, Tang (2007b) revealed that income levels do not influence quality of life. Furthermore, individual ‘love of money’ could reduce job satisfaction. In contrast, individual job satisfaction will improve perceptions of salary increments and quality of life. Tang’s study also discovered that the love of money for male, full-time and high-income employees decreases perceived quality of life. This finding was supported by a previous study by Solberg et al. (2004) which suggested that pursuing extrinsic goals (e.g. employees with a high love of money orientation) may distract individuals from achieving meaningful life satisfaction. One’s high love of money may create a high expectation (desire) for money that leads to dissatisfaction with pay (Tang et al. 2005). However, low pay satisfaction will contribute to a decrease in employee level of job satisfaction since it attributes for satisfaction with work, pay, promotions, supervision and co-workers (Tang et al. 2005). Therefore, in the context of East Malaysia, an adequate income level with employment benefits will increase job satisfaction and performance which eventually improves employee life satisfaction and quality of life.
Another study conducted by Tang et al. (2002) suggested that demographic factors such as employment status, level of income, age and gender influences job satisfaction. For full-time, high-income, older and male employees, these groups will have higher satisfaction levels with their work, pay, co-workers and promotions, but may have a low work ethic. Tang et al. suggests they may work hard to earn money because of the belief that the amount of money they have symbolises their success. In a situation where both extrinsic and intrinsic rewards are presented, extrinsic rewards may become more prominent for full-time employees compared to intrinsic rewards. They will focus more on the positive aspects of the money in their employment because it reflects a sign of employment success.

Another study conducted in Australia by Paul and Guilbert (2013) revealed that an increase of income will not influence and, in fact, may decrease happiness in life. In addition, this study also suggested that working hours will impact employee life satisfaction. Paul and Guilbert also proposed that gender, health status, living standards, martial and employment status, spouse health conditions as well as charity and volunteer work have a significant influence on life satisfaction. Lee (2006) previously supported this claim by proposing that an individual’s pursuit of money could become addictive and resulted in reduced time for family and friends, community service, intellectual pursuits, exercise and other activities that result in ‘genuine’ happiness. Lee’s study concludes that the value of money will not provide long and lasting happiness, but it is the nature of individuals who perceive that money could improve their lives and bring additional happiness. Individual happiness derives from striving for improvements and the sense of achievement gained by overcoming personal life challenges we face along the way (Mill 1989). On the other hand, happiness will improve by taking a little time out from our struggles each day to appreciate how much we have already achieved and by being grateful for the blessings that we received for being alive and living a more comfortable life than others. Also, it also includes other elements in life, such as comfort, health, the meaning of life and loved ones (Lee 2006).

Wang and Yang (2016) examined the concept of the love of money, ethical leadership, happiness and turnover intentions at an organisational level in Taiwan. Ethical leadership significantly influences turnover intention, but the love of money has no impact at all. Leadership influences employee loyalty to the organisation and consequently impacts happiness level and ethical behaviour at work. While monetary rewards appear to be an
attraction and retention strategy, their study revealed that in a high pressure and responsible work environment, employee desires are not solely based on the amount of salary they receive but also value organisational support and career progression. That being transparent in regard to reward and compensation would motivate people to work harder is the conventional wisdom of our society and particularly among compensation specialists (Kohn 1998). Kohn pointed out that new evidence suggests that the more people are driven by a desire for wealth, the poorer their psychological health on a range of measures. Money motivates, but this could signal a motivational orientation that is not associated with high quality of work or quality of life (Kohn 1998).

Even though the above studies have explored these three elements of the perceived value of money, WLB, employee well-being and work behaviours, they have not provided an in-depth explanation of the interrelations between those elements and how they influence each other to impact employee performance. This current study aims to explore and investigate the impact of these three elements for doctors and nurses the healthcare industry of East Malaysia.

### 3.5 Employee Well-Being and Work Behaviour

In the WLB literature, there are two main agendas of consequences studied, namely employee well-being and work behaviour. The following section reviews these key concepts. The dimensions of employee well-being adapted in this study are job satisfaction and life satisfaction and employee work behaviour refers to job performance. This review will focus on the concepts of these variables and the rationale and significance for WLB and the perceived value of money.

#### 3.5.1 Concepts of Employee Well-Being and Work Behaviour

Whenever an individual experiences conflicting demands between two roles (e.g. work and non-work roles), they tend to experience psychological discomfort (Huffman et al. 2008). Previous studies suggest that contradictory strains between work and non-work roles can lead to negative effects on the psychological and physical well-being of employees (Aryee & Hoon 2005; Greenhaus et al. 2003; Haar 2013; Mesmer-Magnus & Viswesvaran 2005;
The current study investigates two main concepts of employee well-being: job satisfaction and life satisfaction.

Job satisfaction is defined as the pleasurable emotional state resulting from the appraisal of one’s job as achieving or facilitating the achievement of one’s job values (Locke 1969). It is basically a general attitude of employees and their approach towards wages, working conditions, control, promotion related with the job, social relations in the workplace, recognition of talent and similar variables, personal characteristics, and group relations apart from their work life (Blum & Naylor 1968). A general view from previous studies on WLB stated that work-life conflict is negatively related to job satisfaction. Employee job satisfaction levels decrease with an increase in work-life conflict (Aryee, Srinivas & Hoon 2005; Mesmer-Magnus & Viswesvaran 2005).

On the other hand, life satisfaction is defined as the degree to which individuals evaluate their quality of lives favourably and, therefore, their subjective well-being (Diener 1984). Previous studies have also defined life satisfaction as a global assessment of a person’s quality of life. Shin and Johnson (1978) and Tatarkiewicz (1976) state that happiness requires total satisfaction, that is satisfaction with life. Whenever an individual is regularly struggling to meet demands at work because of interference from non-work, or vice versa, that individual is more likely to experience a decrease in terms of quality of their work and non-work life which is closely related to overall life satisfaction (Kinnunen & Mauno 1998). A constructive balance between work and non-work would lead to overall life satisfaction (Babin & Boles 1998).

The concept of employee work behaviour refers to the way individual employees behave in responding to some unresolved work-life conflicts, circumstances or situations in the organisations (Pitt-Catsoupes et al. 2007). The consequences of work behaviour would affect organisational commitment (Greenhaus et al. 2003), turnover intention (Anderson et al. 2002; Boyar et al. 2003; Noor 2011) and job performance (Frone & Russell 1997; Netemeyer et al. 2004). In the current study, the element of employee work behaviour examined is job performance.
Job performance is defined by Babin and Boles (1998) as the level of productivity of an individual employee relative to their colleagues on numerous job-related behaviours and outcomes. Previous research reveals that work-life conflict has a detrimental effect on job performance of employees (Frone & Russell 1997; Netemeyer et al. 2004). Therefore, to increase employee job performance, work-life conflict levels should be reduced (Madsen 2006).

3.6 Other Factors that Influence Employee Work-Life Balance, Perceived Value of Money, Well-Being and Work Behaviour

3.6.1 Meaning of Work

With an increase in the complexity and industrialisation of humanity, work is seen as an important aspect of life to ensure stability (Morse & Weiss 1955). Furthermore, work could be seen as the means to provide finances for people to enjoy their time away from work to pursue hobbies and other interests (Wrzesniewski 2003; Wrzesniewski et al. 1997). Work has a significant role in everyone’s life, and ‘could be a source of pain, drudgery boredom or joy, energy and fulfilment or a complex mix of all these elements’ (Wrzesniewski 2003, p. 297). Furthermore, the type or amount of meaning an employee experiences in their job has a direct influence on their feelings, thoughts and behaviour at work (Rosso et al. 2010). This area has been widely explored from many perspectives. Research has focused on questions of where employees find ‘meaningfulness in their work, how different meanings are made of similar jobs, how work meanings have changed over time and across cultures, and the personal and organisational implications of holding different beliefs about the meaning of work’ (Rosso et al. 2010, p. 92). Building on this claim by Wrzesniewski (2003) and Rosso et al. (2010), it is necessary to explore the role of work in individual lives and the influence on individual needs for WLB, attitudes towards the value of money, well-being and work behaviour.

In defining the meaning of work, scholars have focused on exploring employee expectations, values, job characteristics, tasks and social relationships at work (Dubin 1956; Hackman & Oldham 1980; Wrzesniewski 2003). Rosso et al. (2010) identified four dimensions of this concept. Firstly, individual values, motivations and beliefs about work that influence perceptions of the meaning of work. These elements are flexible and could change over time.
depending on various job contexts and experiences (Ashforth & Mael 1989). Secondly, this concept could be explored based on the interactions and relations of employees with others or teams both inside and outside the organisation (Grant 2008; Kahn, WA 1990; Rosso et al. 2010; Wrzesniewski 2003). These interactions include employee relationships with their managers, colleagues, teams and communities as well as with their families. Thirdly, the context of work is also an important influence in shaping employees’ meaning of work. It includes job responsibilities and tasks, organisational mission, financial status, non-work areas and the national culture in which the work is conducted. Finally, the role of spiritual life will influence the meaning of work for employees which incorporates their spirituality and sacred calling to a specific vocation (Rosso et al. 2010).

Concept of the meaning of work also could be understood by reflecting on the individual perceptions of the job as a calling or career. In the past, perceptions of work as a calling, could be related to being ‘called’ by God to do morally and socially significant work (Weber 1963). In recent times, this concept could be related to individual perceptions about their job in making an important contribution to the wider society (Davidson & Caddell 1994). Those employees with a career work orientation will be motivated by the compensation and benefits package as well as by career advancement and development opportunities. These individuals perceived advancement would increase their self-esteem, power and social status (Bellah et al. 1985). Those with a calling orientation will not work only for financial rewards and advancement opportunities, but to fulfil the meaning doing the work brings. For those motivated by a calling, work is perceived as their contribution in serving to make the world a better place to live (Wrzesniewski 2003).

In this study, the concept of the meaning of work follows a definition proposed by Colby et al. (2002). The meaning of work is related to individual perceptions about their job and contributing to family’s economic maintenance and allowing them to have a positive impact on the organisation and as self-expression. This study will also attempt to understand the concept of a calling and career in individual medical professionals in East Malaysia.
3.6.2 Malaysian Workplace Culture

The cultural dimension of organisational practices has been much debated (Zawawi 2008). Tayeb (1994) outlines three key arguments on the importance of incorporating the elements of culture in organisational study. Firstly, cultural values and norms are at least, if not in total terms, different from one society to another. Secondly, the behaviour of different cultures will differ from others in dealing with similar situations due to diverse fundamental values and attitudes. Thirdly, workplace culture is a crucial element in shaping the work environment and other social organisations.

Over the past two or three decades, several studies have examined the influence of cultural values and norms in relation to WLB issues in the Asian context. Previous literature and studies suggest that there is similarity among the Asian cultures, norms and values (Sim & Bujang 2012). In general, Asian culture is referred to as a collectivistic culture (Hofstede 2001; Yang et al. 2000). As previously mentioned, Malaysia is a collectivist culture (Hofstede 2017) and Malaysians are described as group-oriented with a high tendency to promote shared goals, emphasising collective uniqueness as well as the importance of external and public roles and family relatives (Markus & Kitayama 1991; Triandis 1989, 1995). These cultural norms have a direct influence in shaping the characteristics of the Malaysian workforce that prioritise collaborative results, harmony, avoiding confrontations and great respect for elders and authorities (Abdullah 1996).

Similar to affluent western countries, in Malaysia, there has been an increasing number of dual-earner families and numbers of women in paid work which has a direct impact on work-family interface (Hassan et al. 2010). However, unlike western developed countries, flexible work options and childcare are not common initiatives offered by Malaysian organisations (Hassan & Dollard 2007). In 2005, the Department of Statistics Malaysia reported that the average working hours per week in 2004 was 47.4 hours. In addition, the Malaysian Trades Union Congress (2007) reported that nearly 100,000 local workers were terminated from their jobs from 2002–2006. Evidence has shown that terminations lead to an increase job insecurity. Increasing working hours and job insecurity have led to work stress in the Malaysian workforce (Edimansyah et al. 2008; Manshor et al. 2003).
In regard to the different perceptions and acceptance of WLB between different generational groups, Cheng (2013) revealed that Malaysians were similar to other nations. His study found that the baby boomer generation seek job security and are achievement-oriented, dedicated and career focused. This generation feels satisfied with what they have (e.g. stable income and comfortable in their life for those still working). Generation X is described as workaholic, but also seeking job security as well as moderately pursuing a balance between professional work and personal life. This generation is very ambitious, independent, resourceful and self-sufficient. They value leisure time and quality time spent with family. Additionally, they have a clear and long-term vision towards life and yet, are willing to adapt to change. Generation Y shows a high demand for WLB and displays a trend in changing jobs, which indicates that job security, is not their main concern. This generation shows high flexibility and adaptation to change. They search for more meaningful and challenging careers.

Some studies on the influence of WLB in relation to cultural values, beliefs and norms revealed the strong influence of religious belief among Malaysians (Lobel 1991; Schein 1984; Sim & Bujang 2012). In a more recent study on married Malay Muslim women, found that Islam, like all other religions, is associated with well-being because it provides guidelines on how to live and is positively related to satisfaction in life and a negative association with psychological distress (Noor 2008). Those who are more religious tend to experience less work conflict than those who are less religious (Noor 1999). Abdullah (1994) supports this argument stating that Malaysians identified with a particular religion and that among Malay, there is a need to interpret work according to the Muslim faith.

3.6.3 *Life Contentment*

In using the concept of life contentment, this study discusses the concepts of happiness and contentment. Happiness is an emotion that involves a mood or feelings, but much like other emotions, it also involves physical characteristics such as physical desire or stimulations (Turner 2009). It also refers to secondary emotions which include individual experiences of guilt, pride or nostalgia (Kemper 1987). For example, happiness is an individual feeling of pleasure by getting a compliment or positive feedback from a friend (McKenzie 2015).
The concept of contentment can be related to finding fulfilment in aspects of work and leisure, pleasure or pain, reward and sacrifice. This feeling is long-lasting and involves a form of selfhood or self-understanding that eventually becomes and source of fulfilment and satisfaction (McKenzie 2015). Contentment could be observed in two ways: (i) to feel that something is acceptable or merely sufficient and (ii) that something is satisfying or pleasing. It includes a positive effect and both happiness and contentment have reciprocal relations (McKenzie 2015). Carson (1981) incorporated the concepts of social and cultural values in defining contentment. The feeling of contentment is about appreciating and valuing relationships, status and autonomy.

Building from McKenzie’s (2015) work, this study investigates the concept of contentment by incorporating a spiritual well-being element. In this study, life contentment refers to the individual feeling of acceptance and sufficiency of the outcome of their job including salary, increments, job security and other benefits. In addition, it also reflects individual perceptions about their personal life that is satisfying and pleasing which includes relationships with family, children and close friends, personal time and personal sacrifice for a fair balance between work and personal life.

The study makes the proposition that meaning of work, workplace culture and life contentment will have an individual influence on WLB, the perceived value of money, well-being and work behaviour. Since, these concepts should be investigated at an individual level, it will be explored and investigated in Phase 2 of this study, through a qualitative method since there is a lack of established measurement and its accessibility. There, the study adapts McKenzie’s (2015) work by asking participants two contentment questions: ‘how fulfilling or rewarding is your work?’ and ‘are you satisfied with your work defining you as a person?’

### 3.7 Development of Conceptual Framework and Research Hypotheses

Conceptual framework for this study has been developed from above literature review. Figure 2.1 presents the relations between perceived value of money, WLB, employee well-being and work behaviour. This conceptual framework, with associated factors and their theoretical relations were developed based on the previous literature and empirical studies as well as considering common HRM practices and policies in Malaysian healthcare industry. By
considering HRM practices and policies to refine some factors and the measurement of WLB practice items, it is crucial to ensure relevancy and suitability of the measurement in a setting of the Malaysian healthcare industry.

Figure 3.1: Conceptual Framework: The Relations between WLB Practices, the Perceived Value of Money, Employee Well-being and Work Behaviour

3.7.1 The Relation between Work-Life Balance Practices and Employee Outcomes (Employee Well-Being and Work Behaviour)

Over the past 20 years, the importance of managing employee WLB has become a concern by most organisation besides the concept has developed over time (De-Bruin & Dupuis 2004). This is due to the nature of job which has become more complex and forces employee to work under pressure to increase productivity in a tight time-frame with fewer resources (Hosie et al. 2004; Wickham et al. 2006). This situation has led to the redefinition of normal working hours. In recent years, numerous studies on WLB practices have been conducted in organisational settings. The concept of WLB has become popular because of its potential
value for both employers and employees. Employees benefit by increasing their life satisfaction and general well-being as well as reducing work-family conflicts (Allen et al. 2000; Kossek & Ozeki 1998). Furthermore, organisational policies and support in providing WLB programs and practices will enhance employee well-being, organisational commitment and job satisfaction (Cegarra-Leiva et al. 2012; Greenhaus et al. 2003; Haar 2013; Morganson et al. 2010; Noor 2011). These suggestions have been seconded by several researchers which suggested that organisations should developed HR policies that provide working-flexibility which enhances employee WLB (Hacker & Doolen 2003; Hyman & Summers 2004). The benefits for employers include the increase of organisational results through improved employee outcomes, such as commitment, motivation, talent retention and reduced turnover intentions (Carrasquer & Martin 2005; Hughes & Bozionelos 2007; Nelson et al. 1990; Scandura & Lankau 1997). Eventually, positive well-being will enhanced firm performance benefits (Haar 2013).

In this thesis, the constructs of WLB practices adopted are: (i) flexibility and choice in working hours (Clark 2000; Mohamed & Mohamad 2012; Skinner & Chapman 2013; White et al. 2003); (ii) supportive supervision (Al-Dubai et al. 2013; Clark 2000; Rashid et al. 2012); and (iii) family-friendly programs and practices (Chalmers et al. 2005; Lee et al. 2011; Saltzstein et al. 2001). The rationale behind the selection of these variables is to ensure they align with the work practices of medical professionals in Malaysia as well as the general human resource management practices and policies relevant to Malaysia.

This study aims to explore flexibility and choice in working hours and family-friendly programs and practices in the context of the shortages of medical professionals (doctors and nurses) which impacts well-being and work behaviour. As noted, in Sabah and Sarawak, the employment rate of doctors and nurses is significantly lower than the other states due to lack of attention from the government (BERNAMA 2008; Ibrahim 2012). This research explores the influence of flexibility in working hours and family-friendly programs on employee well-being (job satisfaction and life satisfaction) and work behaviour (job performance). These topics lead to the following hypotheses:

H1: There is a significant relation between flexibility and choice in working hours and employee well-being
H3: There is a significant relation between family-friendly programs and practices and employee well-being

H4: There is a significant relation between flexibility and choice in working hours and employee work behaviour

H6: There is a significant relation between family-friendly programs and practices and employee work behaviour

Supportive supervision concept explores the issues of HRM practices which support WLB practices in the healthcare industry in Malaysia. The fundamental goal of various enhancements in HRM policies is to attract and retain medical professionals to continue working in Sabah and Sarawak. Supportive HRM practices include rigorous job promotions and career advancement as well as the excellent service awards (Yazid 2010) plus the option for locum practice by doctors that allows them extra income while still working in the government sector (Dahlui & Aziz 2012). Since the healthcare industry is a key economic area in Malaysia, it is crucial for the federal and state health departments to continually improve strategic HRM policies and practices. This supportive supervision is postulated to have a significant impact on employee well-being and work behaviour. The following hypotheses are therefore posed:

H2: There is a significant relation between supportive supervision and employee well-being

H5: There is a significant relation between supportive supervision and employee work behaviour
3.7.2 Moderating Effect of the Perceived Value of Money in the Relations between Work-Life Balance Practices and Employee Outcomes (Employee Well-Being and Work Behaviour)

People’s attitude towards money can be perceived as their frame of reference through which they evaluate their everyday life (Tang 1992). In organisational settings, money is used to attract, retain and motivate employees by most managers and employers (Gomez-Mejia & Balkin 1992; Milkovich & Newman 2002). The meaning of money has also been associated with individual success (Rubenstein 1981) and an individual’s employment status is related to their attitudes to money and work-related beliefs (Staw et al. 1980).

Since medical professionals in Malaysia are the highest paid professions in the public and private sectors, it is assumed this situation will increase their perception towards the value of money. For example, the salary schedule in chapter 2 shows the basic salary for medical and health officers (doctor) is higher than other A-rank professions, such as engineers, legislative and judicial officers. Since Staw et al. (1980) stated that one’s employment status is related to the attitude to money, it is predicted that an individual’s perceptions about the value of money will act as a moderator in the relation between work-life balance practices and employee outcomes (employee well-being and work behaviour). In this study, a high perceived value of money is reflected by medical professionals to take more locum hours and on-call duties. These individuals are keen on making money and wanting to make more money and they would feel that the extensive working hours which leads to higher pay and allowance does not influence their concern of well-being and work behaviours. This situation can be seen as a trade-off for family life and vice-versa. Therefore, the following moderating hypotheses were developed based on this postulation, ‘If the individual perceived value of money is high, the effect of WLB and employee outcomes (well-being and work behaviour) will be weakened’

H7: Perceived value of money significantly moderates the effect of work-life balance practices and employee well-being

H8: Perceived value of money significantly moderates the effect of work-life balance practices and employee work behaviour
Given the emphasis in this chapter on the influence of the perceived value of money in relation to WLB, employee well-being and work behaviours, a desire to fill these gaps in knowledge have prompted this research into investigating these hypotheses and exploring in-depth the outcomes of the hypotheses testing. The next chapter will examine the research design and methodology adopted to conduct the study.
CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

This chapter presents the research methodology employed for this study to explore the research questions and objectives. The study adopts a pragmatic research paradigm by utilising a sequential explanatory mixed-method research model to cover the two phases of study. In Phase 1, a quantitative approach is used to explain the relations between WLB practices and employee outcomes (employee well-being and work behaviour) as well as the moderating effect of the perceived value of money in these relations. Phase 2 implements a qualitative approach to gain a better understanding of the results from the first phase and explore the concept of WLB in the context of the healthcare industry in East Malaysia.

4.2 Research Design and Strategy

4.2.1 Pragmatic Research Paradigm

A basic set of beliefs and philosophical view is needed to guide research actions and arguments and these philosophical ideas are characterised as a research paradigm or worldview (Creswell 2009; Guba 1990; Lincoln & Guba 2000). A research paradigm is important because it influences the approach to studying and interpreting research data and can be interpreted extensively as a research methodology (Mackenzie & Knipe 2006; Newman 2000). Given this research employs a mixed-methodology approach, the pragmatic research paradigm chosen to guide the research work is widely recommended by academic scholars (Creswell 2009; Tashakkori, Abbas & Teddlie 2010). Pragmatic paradigm is not devoted to any one system of philosophy or reality besides the researcher will focus on the 'what' and 'how' elements in the research problem (Creswell 2009).

In pragmatic research, the research problem is the central focus to understand the issues and it attempts to apply all approaches to explore related issues (Creswell 2009). By keeping the research question in focus, data collection and analysis methods chosen will most likely provide insights into the issue. This research paradigm is flexible compared to other
paradigms because it combines two methods of research, namely quantitative and qualitative. A pragmatic research paradigm provides opportunity to achieve an in-depth understanding of the research issues using multiple research methods simultaneously. The research paradigm provides various procedures in data collection and analysis through a mixed-method research approach (Creswell 2009).

4.2.2 Research Design: Mixed-Method Research Approach

The research design is a framework that identifies the detail and procedures to obtain information to structure and/or solve the problems and issues identified in the study (Malhotra 2004). Malhotra (2004) further stated that research design could be categorised into (i) exploratory and (ii) conclusive research. Exploratory research aims to provide insight and understanding of the research rationale whereas conclusive research seeks to test specific hypotheses to examine the relations between several investigated factors.

A mixed-methodology research approach refers to the ‘type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis and interference techniques) for the broad purposes of breadth and depth of understanding and corroboration’ (Johnson et al. 2007, p.123). Tashakkori and Teddlie (1998) and Creswell (2005) define this method as a procedure for collecting, analysing and mixing or integrating quantitative and qualitative data at some stage of the research process within a single study for the determination of a better understanding of the research rationales. The reasoning behind mixing both kinds of data in one study is grounded in the fact that neither method is sufficient in itself to capture the trends and details of the research agenda (Ivankova et al. 2006).

A mixed-methodology approach is believed to provide valuable insights and enhance the validity of the study (Rugg & Petre 2007; Welter & Lasch 2008). Applying this research method is useful to (i) generalise the finding to a population and (ii) develop a detailed view of the meaning of a phenomenon or concept for individuals (Morse 1991). This combined methodology is also able to overcome the flaws of each method, strengthening theory development, hypothesis testing and generalising results (Creswell 2009; Morell & Tan 2009; Rugg & Petre 2007). Indeed, the merging of results stemming from two or more methods
‘enhances our beliefs that the results are valid and not methodological artefact’ (Bouchard 1976, p.268). Additionally, other advantages of the triangulation method discussed by Jick (1979) are that: (i) it allows the researcher to be more confident of outcomes; (ii) it encourages the development of resourceful data collection methods; (iii) it can lead to a more affluent data; (iv) it may result in the synthesis or incorporation of theories; and (v) it can discover inconsistencies.

4.2.3 Principles of Designing a Mixed-Methods Study

There are several key principles that need to be considered in assisting the researcher conduct a mixed-methods research project. This include: ‘(i) using a fixed and/ or emergent design, (ii) identifying a design approach to use, (iii) matching a design to the study’s problem, purpose and questions, (iv) being explicit about the reason for mixing methods’ (Creswell & Clark 2011, p.54).

Fixed mixed-methods designs are mixed-methods where the researcher has predetermined the use of both the quantitative and qualitative methods at the beginning of the research process and followed the planned procedures. Emergent mixed-methods designs are determined during the process of conducting the research due to emerging issues related to the study. The second phase is required to increase the adequacy of the analysis and results in solving the research rationales (Creswell & Clark 2011; Morse & Niehaus 2009). In this study, an emergent research design was implemented due to the key reason for the lack of research on investigating WLB issues in medical professionals in East Malaysia states.

Secondly, a dynamic approach has been selected in designing the process of this research. This is ‘a design process that considers and interrelates multiple components of research design rather than placing emphasis on selecting an appropriate design from an existing typology’ (Creswell & Clark 2011, p.59). It is an interactive, system-based approach where the researcher should consider five interrelated elements when designing a mixed-methods study, including (i) the objective of the research, (ii) the conceptual framework, (iii) research questions (iv) research methods and (v) validity considerations (Maxwell & Loomis 2003).
Thus, the researcher needs to match the research design with the research problems, objectives and questions. Most mixed-methods scholars agree that the research question plays a vital role in the process of crafting any mixed-method study. This approach places the research rationales and questions as the key principles in design. This standpoint stems from the pragmatic basis in conducting mixed-methods research where the notion of ‘what works’ applies well to choosing the best approaches that address the study rationales and questions (Creswell & Clark 2011).

Finally, a complementarity approach seeks to elaborate, enhance, illustrate and clarify the results from one method (quantitative) with the results from the other method (qualitative) (Greene et al. 1989). It also seeks extensiveness in explaining the individual perceptions among doctors and nurses concerning WLB issues in East Malaysia. This approach helps the researcher to build a more comprehensive explanation of the issues by employing both quantitative and qualitative research approach (Bryman 2006).

4.2.4 Mixed-Methods Research: Explanatory Sequential Design and Unit of Analysis

As mentioned earlier, this study adopts a mixed-methods, explanatory sequential research design. It consists of two phases: quantitative followed by qualitative methods (Creswell 2003). First, the researcher collects and analyses the quantitative (numeric) data followed by the qualitative (text) data. The qualitative method helps the researcher to explain or elaborate on the quantitative results obtained in the first stage. The second, qualitative, phase builds on the first, quantitative phase and the two are connected in the intermediate stage of the study (Ivankova et al. 2006). The rationale for this approach is that the quantitative data and their subsequent analysis provide a general understanding of the research problem. The qualitative data and their analysis refine and explain those statistical results by exploring individual participant views in more depth (Creswell 2003; Rossman & Wilson 1985; Tashakkori & Teddlie 2003).

In addition, Creswell and Clark (2011) argue this research design is beneficial to access trends and relations in quantitative data and explain the reasons behind its analysis. It emphasises the following issues in considering the explanatory sequential research design: (i) the researcher and the research problems are more quantitatively oriented; (ii) the researcher
knows the important variables and has access to quantitative instruments for measuring the constructs of primary interest; (iii) the researcher has the ability to return to participants for a second round of qualitative data collection; (iv) the researcher has the time to conduct the research in two phases and (v) the researcher has limited resources and needs a design where only one type of data is being collected and analysed at a time (Creswell & Clark 2011, p.82).

To determine the best predictors of outcomes or classify factors influencing the outcome, a quantitative approach is the most appropriate method, while to understand a concept or phenomenon where little research has been conducted, the qualitative method is more suitable (Harrison 2012). Also, another advantage of the qualitative approach includes straightforwardness and opportunities for in-depth investigation and exploration of the quantitative result. Furthermore, this research design can be especially useful when unexpected results arise from a quantitative study (Morse 1991).

Several advantages of explanatory design have been further highlighted by Creswell and Clark (2011) including: (i) the research design is the most straightforward of the mixed-method designs because it requires only a single researcher and the data collection will be implemented during a different period which allows the researcher to collect only one type of data at a time; (ii) the final report can be written with a quantitative section followed by a qualitative section, making it straightforward to write and providing a clear delineation for readers; and (iii) the designs lends itself to emergent approaches where the second phase can be designed based on what is learned from the initial quantitative phase (2011, p.83).

Phase 1 of the current study employed a survey to test the relations between WLB practices, the perceived value of money and employee outcomes. The perceptions and views of doctors and nurses about WLB practices in their organisations as well as their perceptions about the value of money are tested. A quantitative methodology is employed to answer two research objectives:

1. To examine the relations between work-life balance practices with employee outcomes (employee well-being and work behaviour)
2. To examine the moderating effect of the perceived value of money in the relations between work-life balance practices with employee outcomes (employee well-being and work behaviour)

The results and findings from the Phase 1 are explained and explored in Phase 2 where a semi-structured and in-depth interview are employed to explore the relations between WLB practices, the perceived value of money and employee outcomes in a deeper context and thus, answer the third research objective:

3. To contribute to new knowledge about the salience of work-life concept in the context of the healthcare industry in East Malaysia.

The unit of analysis defines the level of analysis of the study and describes the collection of data. It can be categorised as organisations, departments, workgroups, individuals or objects. It is necessary to be determine the unit of analysis at the beginning of the study especially during the process of defining research rationale because this influences the process of identifying variables in the conceptual framework, data collection methods and sample size (Zickmund 2003). This study focuses on the individual unit of analysis in both Phase 1 and 2. It is represented by two medical professions: (i) doctors and (ii) nurses working in the healthcare industry of East Malaysian states of Sabah and Sarawak.

This thesis it adapts and modifies the basic procedures in implementing an explanatory sequential research design by Creswell and Clark (2011). Figure 4.1 below shows the details of activity for each phase of the study.
Figure 4.1: Procedures for Explanatory Sequential Research Design (Creswell & Clark 2011)

**Phase 1 Quantitative Research Design and Implementation**
- To state quantitative research questions and determine the quantitative approach
- To obtain permission to conduct research (Phase 1 and 2)
- To identify the quantitative sample
- To collect closed-ended data with instruments
- To analyse the quantitative data to answer the quantitative research questions and facilitate the selection of participants for phase 2

**Phase 1 Follow-up Strategies from the Analysis Results**
- To determine which results will be explained from quantitative analysis:
  - Significant results
  - Non-significant results
  - Group differences (i.e. medical doctors and nurses)
- The results from quantitative analysis:
  - Determine which participants will be selected for the qualitative sample
  - Design qualitative data collection protocols

**Phase 2 Qualitative Research Design and Implementation**
- To state qualitative research questions that follow from the quantitative results and to determine the qualitative approach
- To select a qualitative sample that can help to explain the quantitative results
- To collect qualitative data
- To analyse the qualitative data using procedures of theme development and those specific to the qualitative approach to answer the qualitative and mixed-methods research questions

**Connection and Interpretation of Phase 1 and Phase 2 Results**
- To summarise and interpret the quantitative results
- To summarise and interpret the qualitative results
- To discuss to what extent and in what ways the qualitative results help to explain the quantitative results
- To analyse emerging themes from qualitative results

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4.2.5 Research Locations and Participant Selection

Phase 1 of the study was conducted in the districts of Penampang, Putatan, Inanam and Kota Kinabalu city in Sabah. In Sarawak, the study was carried out in Kuching city. The public hospitals and clinics which participated in the study included Queen Elizabeth Hospital Kota Kinabalu, Queen Elizabeth Hospital II, Women and Children Hospital Likas, Sarawak General Hospital Kuching, Penampang District Health Clinic, Putatan District Health Clinic, Tebobon Inaman Health Clinic and Sabah Department of Health. The private hospital and clinics that participated included: Damai Specialist Hospital, Permai Polyclinics (HQ) Gaya St. Kota Kinabalu, Permai Polyclinics Kepayan, Permai Polyclinics Penampang, Permai Polyclinics Asia City Kota Kinabalu, Permai Polyclinics Kingfisher Sulaman, Permai Polyclinics Indah Permai Sulaman, Sentosa Polyclinics Sulaman Central and all three branches of the Hiltop Clinics and Surgery.

Participants for the research were selected based on purposive and snowball sampling techniques. The main advantages of these sampling techniques are: (i) it can avoid bias in selecting a sample and (ii) a sampling frame may identify the proper individuals to be selected and this may facilitate the participant selection process. Snowball sampling starts with the researcher identifying a few respondents that match the criteria for inclusion in the study and ask them to recommend others who meet the selection criteria (Bhattacherjee 2012). The selection criteria for this study included: (i) participants must be working as doctors or nurses and (ii) participants must be working in the state of Sabah and Sarawak, East Malaysia for at least one year. Bhattacherjee (2012) further stated that this method might sometimes be the only way to recruit hard-to-reach populations.

Phase 2 took place in four different settings in East Malaysia. The rationale for selecting these settings emerged during the pilot study conducted in December 2014 with two interviews that highlighted differences in job roles and responsibilities among medical professionals (doctors and nurses) in different job settings. The four settings are: (i) medical professionals in city/urban hospitals and clinics; (ii) medical professionals in the district hospitals and clinics—located in rural/remote areas; (iii) medical professionals with management and administrative positions—non-practicing clinical physicians; and (iv) medical professionals in private city hospitals. By means of these sample clusters, the study
aims to cover all key categories of medical professionals working in East Malaysia. Participants in this phase were selected from participants of Phase 1. In Phase 2, the researcher used semi-structured, in-depth interviews with each participant selected for this research.

The researcher received approval from the HR department, Head of Clinical Wards/ Clinics or Clinical Research Centres from each location to facilitate access of volunteers for the survey and the in-depth interviews. Then, the survey and the lists of interview questions were sent to the potential participants. After obtaining agreement and consent, the researcher approached them to schedule the face-to-face interviews for Phase 2 of the study.

This study conforms to standard ethical procedures and participants were not at risk in participating in the study. Ethics clearance was obtained from RMIT Human Research Ethics Committee: Application No: 18853. A consent letter was provided to all participants before the survey and interview. Participants were required to sign the consent form before participating in the study. Moreover, before the interview, participants were given explanations pertinent to the research purpose, procedure, and assurance of confidentiality and anonymity. The ethics approval is attached in Appendix 1 of the thesis.

4.3 Phase 1: Quantitative Research Design

4.3.1 Research Instrument

In Phase 1, a structured set of survey questions was used to gather the relevant data for this study. This was chosen as the main instrument with the questionnaire developed based on adapting and modifying established questionnaires from scholarly literature. The instrument can collect accurate and reliable data and satisfy research problems (Creswell 1998). All questions in the survey were closed-ended and divided into five (5) sections, namely: (i) demographic information, (ii) the perceived value of money, (iii) work-life balance practices, (iv) employee well-being and (v) employee work behaviour.

WLB practices were measured by three components namely: (i) flexibility and choice in working hours, (ii) supportive supervision and (iii) family-friendly programs and practices
(Clark 2000; Saltzstein et al. 2001; White et al. 2003). The perceived value of money was measured by the love of money scale (LOMS) developed by Tang and Chiu (2003). Three factors of this scale were adapted for this study: factor success, factor rich and factor important. Employee outcomes are measured by two elements of employee well-being: job satisfaction and life satisfaction. The questions for job satisfaction were adapted from Ismail et al. (2006, 2007 & 2008) in which life satisfaction was measured by adapting the Satisfaction with Life Scale (SWLS) by Diener et al. (1985). The second variable in employee outcomes is employee work behaviour, made up by two elements. The elements of job performance adapt the study by Ismail et al. (2009). The demographic variables used in this study, namely, respondent age, gender, marital status, education level, job position, job sector and job locations are used as controlling variables.

**Document Analysis**

Although the survey was developed by adapting and modifying established questionnaires, document analysis was crucial to ensure these measurements were suitable and relevant to the context of the study. Since this research was conducted in the healthcare industry in Malaysia, human resources policies and practices from the hospitals and the MoH relevant to the elements of WLB measured in this study were analysed.

Document analysis is a systematic procedure for reviewing or evaluating printed (computer based) or electronic (internet transmitted) materials (Bowen 2009). Similar to other analytical, qualitative research, this procedure requires that data be examined and interpreted in order to elicit meaning, gain understanding and develop empirical knowledge (Corbin & Strauss 2008, Rapley 2007). Bowen (2009) further states that documents that may be used for systematic evaluation as part of research include: manuals, background papers, books, maps and charts, newspapers articles, press releases, organisational or institutional reports, survey data and various public records. As a research method, document analysis is particularly applicable to qualitative studies, that is, intensive studies producing rich descriptions of a single phenomenon, event, organisation or program (Stake 1995; Yin 1994). Non-technical literature, such as reports and internal correspondence, is a potential source of empirical data for case studies; for example, data on the context within which the participant operates (Mills et al. 2006).
To ensure the suitability and relevance of the questionnaire, a document analysis was conducted especially to confirm the rationales of the elements of WLB practices in the healthcare industry in Malaysia. Several documents were analysed and reviewed, including the Budget 2013–2014, the National Key Economic Areas (NKEAs) Report 2013 and 2014, the MoH Malaysia Strategic Plan Report 2006-2010, MoH, Health Facts Report 2007 as well as several healthcare industry related articles published in Malaysia national newspapers. The final version of the survey items is set out in Table 4.1 below

Table 4.1: Survey Items

<table>
<thead>
<tr>
<th>Variables</th>
<th>Items</th>
<th>Source of References</th>
</tr>
</thead>
</table>
| **Perceived Value of Money** | Money is important for people working in your field  
Money is valuable for people working in your field  
Money is good for people working in your field  
Money is an important factor in the lives of people working in your field  
Money is attractive for people working in your field  
Money represents the achievement for people working in your field  
Money is a symbol of success for people working in your field  
Money reflects the accomplishments for people working in your field  
Money is how the people in your industry compare each other  
I am motivated to work hard for money  
Money reinforces my motivation to work harder  
I am highly motivated by money  
Money is a motivator for people working in your field  
It would be nice to be rich  
I want to be rich  
My life will be more enjoyable, if I was rich and have more money | (Tang & Chiu 2003) |
| **Work-Life Balance Practices**  
**Flexibility and Choice in Working Hours** | I have personal discretion over my starting and finishing time  
I can finish work within my contracted hours (e.g. 8 hours per shift)  
I can schedule my preferred days off supported by my team  
I can change my roster if daily working hours are not consistent | (Clark 2000; Saltzstein et al. 2001; White et al. 2003) |
<table>
<thead>
<tr>
<th><strong>Work-Life Balance</strong></th>
<th><strong>Supportive Supervision</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>My co-workers are supportive when I talk about personal and family issues that affect my work.</td>
<td></td>
</tr>
<tr>
<td>My supervisor is understanding when I talk about personal or family issues that affect my work.</td>
<td></td>
</tr>
<tr>
<td>I accept working overtime each day because I am committed to my job.</td>
<td></td>
</tr>
<tr>
<td>Employees in my department have good relationships with other departments in the organisation.</td>
<td></td>
</tr>
<tr>
<td>Training sessions provided and conducted by my organisation help in improving my current and future job performance.</td>
<td></td>
</tr>
<tr>
<td>Teams in my organisation have the freedom to adapt their goals as needed.</td>
<td></td>
</tr>
<tr>
<td>Teams in my organisation are confident that the organisation will act on their recommendations.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Work-Life Practices</strong></th>
<th><strong>Family-Friendly Programs and Practices</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I have enough time for my family.</td>
<td></td>
</tr>
<tr>
<td>I have enough time for my friends.</td>
<td></td>
</tr>
<tr>
<td>I have enough time after work to carry out personal matters.</td>
<td></td>
</tr>
<tr>
<td>I look forward to being with the people I work with each day.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Employee Well-Being</strong></th>
<th><strong>Employee Work Behaviour</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The physical working condition.</td>
<td></td>
</tr>
<tr>
<td>Relationship with management.</td>
<td></td>
</tr>
<tr>
<td>Relationship with immediate supervisor.</td>
<td></td>
</tr>
<tr>
<td>Relationship with fellow colleagues.</td>
<td></td>
</tr>
<tr>
<td>Your working hours.</td>
<td></td>
</tr>
<tr>
<td>Your job security (insurance, pension plan, career development).</td>
<td></td>
</tr>
<tr>
<td>Recognition for good work.</td>
<td></td>
</tr>
<tr>
<td>Chance of promotion.</td>
<td></td>
</tr>
<tr>
<td>Opportunity to use abilities and attention paid to suggestions you make.</td>
<td></td>
</tr>
<tr>
<td>Freedom to choose own method of work.</td>
<td></td>
</tr>
<tr>
<td>Amount of job responsibility you are given.</td>
<td></td>
</tr>
<tr>
<td>In most ways, my life is close to ideal.</td>
<td></td>
</tr>
<tr>
<td>The conditions of my life are excellent.</td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my life.</td>
<td></td>
</tr>
<tr>
<td>The quantity of work I produce meets or occasionally exceeds job expectations.</td>
<td></td>
</tr>
<tr>
<td>I constantly discuss career interests, provide advice and feedback to my fellow subordinates and inspire them.</td>
<td></td>
</tr>
<tr>
<td>I lead, motivate and work closely with subordinates under me.</td>
<td></td>
</tr>
<tr>
<td>I effectively delegate to subordinates with clear directives and guidelines.</td>
<td></td>
</tr>
<tr>
<td>I served competently in completing all departmental and unit responsibilities.</td>
<td></td>
</tr>
<tr>
<td>I demonstrate a strong sense of work ethic.</td>
<td></td>
</tr>
</tbody>
</table>

I am motivated, dedicated and demonstrate a strong sense of responsibility when a task is assigned.
I devote adequate time and thought to work assignments and resource allocations.
I am frequently successful in reaching a common understanding with others through verbal and non-verbal communication.

4.3.2 Scaling of Measurement

Scaling is the technique to assign numbers or other symbols to objects to convey how numbers are assigned to establish a scale value (Cooper & Schindler 2006). The scale is the outcome of this process, ‘which is an empirical structure for measuring items or indicators of a given construct’ (Bhattacherjee 2012, p.49). The Likert (1932) scale is one of the most popular used instruments in evaluating opinion, attitude and preference (Leung 2011). The 7-point Likert scale can achieve higher levels of reliability in research (Allen & Seaman 2007). Further, Likert (1932) and other researchers suggest that social sciences researcher could use the scale as widely as possible but the final decision will be subject to the empirical study setting (Leung 2011). Because this study investigates individual opinions and preferences on WLB and the perceived value of money, as well as attitudes towards perceived well-being and work behaviour, all items in the survey were measured with a 7-point Likert scale comprising: strongly disagree / dissatisfied (1) to strongly agree / satisfied (7). The detail of the scale used in the study is shown in Table 4.2 below.

Table 4.2: 7-point Likert Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strongly Disagree / Strongly Dissatisfied</td>
</tr>
<tr>
<td>2</td>
<td>Disagree / Dissatisfied</td>
</tr>
<tr>
<td>3</td>
<td>Somewhat Disagree / Somewhat Dissatisfied</td>
</tr>
<tr>
<td>4</td>
<td>Neutral</td>
</tr>
<tr>
<td>5</td>
<td>Somewhat Agree / Somewhat Satisfied</td>
</tr>
<tr>
<td>6</td>
<td>Agree / Satisfied</td>
</tr>
<tr>
<td>7</td>
<td>Strongly Agree / Strongly Dissatisfied</td>
</tr>
</tbody>
</table>
4.3.3 Pre-testing

Pre-testing is carried out to identify any items in the survey that may be difficult to comprehend and revise before distributing the survey for data collection. This process is useful to attain valid, reliable and unbiased outcomes. Expert opinions and focus group discussions to detect any problems in the survey are the most common technique implemented at the early stage of the study (Hughes 1996). This study utilises (i) expert review (ii) focus group discussion and (iii) a pilot study.

At the initial stage of examining the survey, the measurement scales and rational flow of the items representing each variable, expert analysis of the survey was conducted with one senior doctor (private clinic), two doctors, two senior nurses and one senior officer in the Sabah Health Department. They were selected based on their knowledge and experience in the healthcare industry in East Malaysia. This in-depth discussion is important to determine the suitability and applicability of the survey regarding the language and jargon used, format and the content of the survey. The feedback and suggestions from the expert panel were helpful in designing the precise terms and words of survey items as well as the layout and structure of the survey.

After amendments to the survey, a focus group was conducted with potential respondents to ensure they could understand the questions. In this session, participants were asked to evaluate the relevance of the survey to better understand participant internal cognitive processes in attempting to answer a question, the likeliness of answering a question and the level of knowledge needed to provide an accurate answer (Hughes 1996). The most important outcome of this process was to change a few of the ‘academic’ terms to more commonly used words, to reorder the structure and scale of the questionnaire and include the option of ‘no opinion’ for respondents not interested in commenting on an item.
4.3.4 Data Collection Method and Response Rate

Phase 1 data was collected from participants using a structured survey and this method proved to be reliable (Malhotra & Galletta 1999). The survey was of a structured question design which allowed participants to select an answer from a given set of choices (scale) (Bhattacherjee 2012). The survey was distributed by the HR department, Head of Clinical Wards/Clinics and the Clinical Research Centre of the hospitals and clinics. The researcher administered the distribution and collection process after being granted approvals from these departments. The survey was answered by all participants by freely giving their consent. The sample size exceeded the minimum of 66 participants as required by the probability sample technique to analyse data using inferential statistics (Leedy & Ormrod 2005).

The Phase 1 study began in December 2014 and was completed in February 2015. A total of 610 surveys were distributed to several public and private hospitals and clinics in Sabah and Sarawak. The response was 501 surveys which indicate an 82.1% response rate. After the data screening process, a total of 494 surveys were usable for data analysis and hypotheses testing, indicating an 81.0% response rate. Table 4.3 below shows details of the response rate.

Table 4.3: Response Rate

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>N</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total questionnaires distributed</td>
<td>Target participants:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Doctors</td>
<td>610</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>• Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total questionnaires received</td>
<td>Public hospitals</td>
<td>337</td>
<td>55.2</td>
</tr>
<tr>
<td></td>
<td>Public clinics</td>
<td>33</td>
<td>5.4</td>
</tr>
<tr>
<td></td>
<td>Private hospitals</td>
<td>45</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>Private clinics</td>
<td>60</td>
<td>9.8</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>19</td>
<td>3.1</td>
</tr>
<tr>
<td>Non-Responses</td>
<td></td>
<td>116</td>
<td>19.0</td>
</tr>
<tr>
<td>Total usable responses</td>
<td>(after data cleaning and screening)</td>
<td>494</td>
<td>81.0</td>
</tr>
</tbody>
</table>
4.3.5 Data Cleaning: Detecting Missing Data and Outliers

Missing data is an unavoidable part of empirical data collection and occurs in a situation where respondents may not answer questions if they are vaguely worded or too sensitive (Bhattacherjee 2012). This potential problem should be detected at the early stage by manually checking all surveys continually. The ‘9’ value was used to indicate a missing data value. Since this research used Statistical Package for Social Sciences (SPSS) version 22.0 as its main tool for data analysis and all data had been manually entered before any analyses were conducted, missing values were checked manually. This indicated that there was no missing data in the data set study.

Outliers are the observations with single combinations of features recognisable as noticeably different from other observations (Hair et al. 1998). Outliers that require deletion are incorrect data entry, recorded missing values that have been read as real value and data from respondents who are not members of the intended population (Tabachnick et al. 2001). In this study, a small number of outliers were expected in the usual pattern of distribution. Multiple Linear Regression assumptions and outlier tests for assessing data for the regression were conducted. Outliers were examined by box plots as well as measures of the mean and standard deviation. Seven outliers found and were removed from each analysis to ensure the assumption of linearity was not violated and no influential outliers remained in the analysis.

4.3.6 Data Analysis

In Phase 1, the SPSS version 22.0 was used to analyse the survey data. The data collected can be analysed using inferential statistics (Leedy & Ormrod 2005; Sekaran 2000). The nature of the sample was examined using descriptive statistical analysis. Descriptive statistics and Pearson correlations were used to develop a correlational matrix table that consisted of mean, standard deviation, and correlations between the same and different variables. The correlations provided further evidence of validity and reliability for measurement scales in research (Hair et al. 2006). Additionally, coefficient alpha and factor analysis with varimax rotation were used to cleanse the data and examine the reliability and validity of the measures. A Harman single factor analysis (Podsakoff et al. 2003) was conducted to test the common method variance for this study.
Hypothesis Testing (Pearson Correlation and Multiple Regression Analysis)

The relation that exists between two variables can be examined by using the Pearson Correlation ‘r’ (Mohd, 1993). The positive ‘r’ value shows that the relation between two variables is positive while the negative ‘r’ value refers to the negative relation between two variables. The ‘r’ value must be between positive one and a negative one (-1 ≤ r ≤ 1). The closer the ‘r’ values towards the value ‘r’, the stronger the relation between the two variables.

In analysing how an independent variable affects a dependent variable, linear regression analysis is recommended (Sekaran & Bougie 2003). This linear regression analysis is used to analyse the direct relations in this research.

Moderating effects are a type of interaction where the strength of the relation between an independent variable and a dependent variable is changed when other variables are present (Jaccard et al. 1990; Kleinbaum et al. 1988). Proof of interaction is evident when the relation between interacting terms (i.e. product terms) and the dependent variable is significant. The fact that the important main effects of predictor variables and moderator variables simultaneously exist in analysis does not affect the moderator hypothesis and was significant to interpret the interaction term (Baron & Kenny 1986). According to Cohen et al. (1983), moderating effects are a type of interaction where the strength of the relation between an independent and a dependent variable is changed when other variables are present.

In order to test the interaction hypotheses, Cohen et al. (1983) suggested using a hierarchical moderated regression analysis. The process of hierarchical regression analysis stresses the development of a multiplicative term. The purpose of the multiplicative term is to encompass the interaction effect, by calculating two $R^2$s, one for the equation which includes only main effects (main-effect model) and the other for a three-term equation (product-term model) which includes both the main and interaction effects. The technique may separate the part of the product term from the term itself to account for the complex combination of variance due to main and interaction effects. Interaction is considered present if the difference between the two $R^2$s is statistically significant. An examination of the difference between the squared multiple correlations for the product-term model and the main-effects model reflects the strength of the interaction effect in the sample data. An examination of the change in slope of
the dependent variable on the independence variable may show a one-unit change in the moderator variable, specifying the nature of the interaction.

The result of interaction is proved when the relation between interacting terms and the dependent variable is significant. The fact that the significant main effects of predictor variables and moderating variables simultaneously exist in the analysis did not affect the moderator hypothesis and will be significant in interpreting the interaction term (Baron & Kenny, 1986).

4.4 Phase 2: Qualitative Research Design

4.4.1 The Qualitative Research Design

Phase 2 of this study uses a generic qualitative research design. A key part of Phase 2 study consists of in-depth interviews, observations and documentation from the MoH, State Health Department and National and State news reports (Hesse-Bieber & Leafy 2011; Yin 2015). A qualitative methodology allows the researcher to explore, identify and clarify important elements that require in-depth exploration. Fraenkel and Wallen (2000) state that ‘researchers are likely to observe how people interact with each other; how certain kinds of questions are answered; the meanings that people give to certain words and action and how people’s attitude are translated into action’ (p.503). In addition, qualitative research provides a comprehensive description of the phenomena of interest using participant opinions (Tharenou et al. 2007). This research approach can be employed ‘to obtain the intricate details about phenomena such as feelings, thought process and emotions that are difficult to extract or learn about through more conventional research’ (Strauss & Corbin 1998, p.11). It is important to further explore the specific human resources policies and strategies that underpin with WLB practices in the healthcare industry in East Malaysia. This research design allows the researcher to better understand the relations between employee perceived value of money, the adequacy of WLB programs and efforts by organisations to influence on well-being and work behaviour.

In constructing the interview protocol, this study adopted a case study process (Yin 2011) to understand the nature of the research problem as well as interpreting and contextualizing
meanings from individual beliefs and practices (Denzin & Lincoln 2011; Strauss & Corbin 1994). There are six interdependent stages; planning, designing, preparing, collecting analysing and sharing. The planning stage focuses on identifying the emerging research questions based on the result of phase 1. It attempts to answer the ‘why’ from the central research question, ‘how does the perceived value of money influence the relation between WLB practices and employee outcomes, and why?’ Therefore, three sub-research questions was identified to be further investigated in phase 2, namely,

1. What are the key factors that influence employee WLB, well-being and work behaviour in the East Malaysian healthcare industry?
2. Why is there a difference between the perceptions of doctors and nurses on the value of money?
3. What are other emerging issues that influence employee WLB and perceived value of money?

The design stage focuses on defining the unit of analysis and identifying issues underlying the study. As previously stated, this study focuses on the individual unit of analysis in both phases, which is being represented by two medical professions: (i) doctors and (ii) nurses. Since this is study intended to provide a thorough explanation on the WLB issues among medical professionals in East Malaysia, it adopts a single case study method (Yin 2009) by implementing semi-structured and in-depth interviews. The preparation stages involved the development of an interview protocol, conducting a pilot case and gaining ethics approval (Yin 2009). The interview protocols were developed based on the results of phase 1 which reflects the lists of items in the survey questionnaire to ensure consistencies for both phases. In the data collection stage, qualitative data was collected through government reports and documents, interviews and direct observations. Finally, in the analysis and sharing stage, this research adopted the theoretical thematic analysis (Braun & Clarke 2006) to identify, analyse and report themes and patterns within the interview data as an academic, PhD research.
4.4.2 Semi-structured and In-depth Interviews

Interviews were conducted to explore and understand in-depth explanations of the relations between employees’ perceived value of money, the adequacy of WLB programs and efforts by organisations to influence well-being and work behaviour. This study applied in-depth, face-to-face interviews with doctors and nurses in a semi-structured format (Fontana & Frey 2000; Sarantakos 2005).

In order to encourage participants to freely and openly engage and respond with the interview, the researcher conducted the interviews at the convenience of the participants in a secure, comfortable and private area (Crabtree & Miller 1999). In-depth interviews were conducted to allow the researcher to ask participants information about facts and their opinions on and the adequacy of WLB programs. This included efforts by organisations, their perceptions on the value of money (compensation and benefits packages) and WLB influence on well-being and work behaviour (Kongchan 2013).

There are several advantages of semi-structured interviews as a sequential method in data collection (Creswell 2009). Firstly, they have the potential to overcome poor response rates of surveys (Austin 1981). Secondly, interviews are well suited to the exploration of attitudes, values, belief and motives (Richardson et al. 1965; Smith 1975). Finally, interviews ensure that the respondent is unable to receive assistance from others while formulating their response (Bailey 1987). Semi-structured interviews combine the advantages of both structured and unstructured interview techniques which may reduce bias. Asking predetermined questions or open-ended questions encourages participants to disclose their feelings, opinions and experiences (Fortune et al. 2012).
4.4.3 Observation

Observation is an essential approach to understanding a culture in qualitative research (Silverman 2000). It is a suitable method that allows the researcher first-hand information and exposure about the new study background and understands an unfolding event (Taylor-Powell & Steele 1996). For the method of participation, observation and documentation, the role of the researcher in this approach is to become an active participant observer. Observation can provide rich qualitative data, sometimes described as an in-depth description (Geertz 1973).

This study adapted the observation technique by Collins (2009). Observation of the activities in clinics and hospitals assisted the researcher in understanding their HR practices. Observation in clinical departments helped the researcher understand the role of both doctors and nurses at work, together with other important issues such as teamwork, multi-tasking, working hours and number of patients in the clinical wards. By observing the administration department, the researcher could obtain information on crucial roles in clinical departments, State health departments and the administration and management departments. These observation sessions were conducted for a total of 30 hours with some simple interviews conducted with several random healthcare personnel. The researcher recorded the relevant phenomena to better understand HR practices and workplace culture in relation to employee WLB, well-being and work behaviour. However, considering the ethics procedure, photographs and video-documents were not allowed during the sessions because of the nature of the industry which is respects patients and employee privacy and confidentiality.

4.4.4 Participant Profiles and Selection Criteria

There were two steps involved in determining the sample for Phase 2 of the study. Firstly, as mentioned earlier, the development of the interview setting emerged from two pilot study interviews which lead to the realisation that job locations of potential interviewees were crucial as they resulted in differences in job roles and responsibilities. This was followed by determining the minimum sample per sector. The nature of work for doctors in Malaysia allows for a flexible working arrangement in both public and private sectors. While working in public hospitals or clinics, doctors are legally permitted to work as locum doctors in
private clinics/hospitals outside official working hours. Thus, doctor opinions for the study could represent both public and private sector views. However, this practice and policy is not applicable to the nursing profession. A minimum of two participants were selected to represent each sector. Based on Allen and Ng’s (1999) sample precisions, the study included four selection criteria in participation selection: (i) gender, (ii) age (iii) marital status, and (iv) sector.

In order to recruit participants, the study adopted Lincoln and Guba’s (1986) purposeful sampling technique with a non-probability sampling strategy. Even though there is a possibility of unrepresentative sampling in this technique (Marshall & Rossman 2011), Patton (2002) suggests that the sampling strategy for qualitative study should be determined by the purpose and foundation of the research (Zikmund-Fisher et al. 2007). This technique ensures that the responses from participants are meaningful and significant to research rationales (Mason 2002). This method is an appropriate strategy to collect robust information in relation to WLB practices, the perceived value of money and well-being and work behaviour.

Since large numbers of participants are not necessary in a qualitative study, the numbers of interviews conducted were based on both redundancy and the theoretical saturation of significant data from additional informants (Dibley & Baker 2001; Lincoln et al. 2011). Overall, there were eighteen (18) medical professionals interviewed in this phase. Interviews were conducted with eleven (11) doctors, ranging from the position of Medical Officer (UD44) to Senior Medical Specialist (UD54). There were eight (8) interviews conducted with nurses, ranging from Nurse (UD29), Sister (Senior Nurses) (UD32), Matron (UD41) as well as Senior Nurses in private hospitals. The interviews lasted approximately 45–60 minutes and were audio recorded with notes transcribed for data coding. Table 4.4 shows the interviewee profiles and selection criteria.
Table 4.4: Interviewees Profiles

<table>
<thead>
<tr>
<th>Code</th>
<th>Age</th>
<th>Gender</th>
<th>Profession</th>
<th>Marital Status</th>
<th>Sector</th>
<th>Interview Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDR 1</td>
<td>30</td>
<td>Male</td>
<td>Medical Officer</td>
<td>Single</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 2</td>
<td>29</td>
<td>Male</td>
<td>Medical Officer</td>
<td>Single</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 3</td>
<td>34</td>
<td>Male</td>
<td>Senior Medical Specialist</td>
<td>Married</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 4</td>
<td>32</td>
<td>Male</td>
<td>Medical Specialist</td>
<td>Married</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 5</td>
<td>27</td>
<td>Female</td>
<td>Medical Officer</td>
<td>Single</td>
<td>District Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 6</td>
<td>28</td>
<td>Female</td>
<td>Medical Officer</td>
<td>Single</td>
<td>District Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 7</td>
<td>28</td>
<td>Male</td>
<td>Medical Officer</td>
<td>Single</td>
<td>District Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 8</td>
<td>32</td>
<td>Male</td>
<td>Medical Officer</td>
<td>Single</td>
<td>District Clinic</td>
<td>45 minutes</td>
</tr>
<tr>
<td>MDR 9</td>
<td>31</td>
<td>Female</td>
<td>Medical Officer</td>
<td>Married</td>
<td>Management &amp; Administration</td>
<td>60 minutes</td>
</tr>
<tr>
<td>MDR 10</td>
<td>28</td>
<td>Female</td>
<td>Medical Officer</td>
<td>Single</td>
<td>Management &amp; Administration</td>
<td>45 minutes</td>
</tr>
<tr>
<td>MDR 11</td>
<td>30</td>
<td>Male</td>
<td>Medical Officer</td>
<td>Single</td>
<td>Management &amp; Administration</td>
<td>60 minutes</td>
</tr>
<tr>
<td>NR 1</td>
<td>29</td>
<td>Male</td>
<td>Nurse</td>
<td>Single</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>NR 2</td>
<td>31</td>
<td>Female</td>
<td>Nurse</td>
<td>Married</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>NR 3</td>
<td>26</td>
<td>Female</td>
<td>Nurse</td>
<td>Single</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>NR 4</td>
<td>42</td>
<td>Female</td>
<td>Senior Nurse (Sister)</td>
<td>Married</td>
<td>City Hospital</td>
<td>60 minutes</td>
</tr>
<tr>
<td>NR 5</td>
<td>41</td>
<td>Female</td>
<td>Senior Nurse (Sister)</td>
<td>Married</td>
<td>Management &amp; Administration</td>
<td>45 minutes</td>
</tr>
<tr>
<td>NR 6</td>
<td>33</td>
<td>Female</td>
<td>Senior Nurse</td>
<td>Single</td>
<td>Private City Hospital</td>
<td>45 minutes</td>
</tr>
<tr>
<td>NR 7</td>
<td>34</td>
<td>Female</td>
<td>Senior Nurse</td>
<td>Single</td>
<td>Private City Hospital</td>
<td>45 minutes</td>
</tr>
<tr>
<td>NR 8</td>
<td>49</td>
<td>Female</td>
<td>Head Nurse (Matron)</td>
<td>Married</td>
<td>City Hospital</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

N = 19
4.4.5 Interview Analysis and Trustworthiness of the Qualitative Research

The data collected from observations and interviews was analysed qualitatively using coding techniques recommended by Corbin and Strauss (2008). The data were examined using microanalysis, open coding, axial coding, and selective coding methods. Microanalysis was used to begin the coding process, which is line-by-line analysis with lines, phrases, sentences and paragraphs analysed. The field notes from the observation sessions and interview transcripts were examined line-by-line in search of the unique emergence of value-in-use themes of perceptions of WLB practices, the perceived value of money and well-being and work behaviour.

Theoretical thematic analysis (Braun & Clarke 2006) was conducted to identify, analyse and report themes and patterns within the interview data. This analysis would tend to be motivated by the ‘researcher’s theoretical or analytical interest in the area and is thus more explicitly analyst-driven’ (Braun & Clarke 2006, p. 12). Theoretical or deductive thematic analysis can provide a more comprehensive analysis of the specific characteristics of the data. Thus, the researcher will code for a specific research question which maps onto the more theoretical approach. In this study, the analysis adapts Braun and Clarke’s (2006) six phase thematic analysis process:

1. Familiarisation with the data. This phase involved reading and re-reading the interview data to understand and to be familiar with its subject.
2. Coding. This phase generates the concise codes which have similarity with the elements of work-life balance, the perceived value of money, well-being and work behaviour as well as the emerging themes of the meaning of work and life contentment.
3. Searching for themes. This phase examined the codes and ordered data to identify significant broader patterns of meaning or potential themes. The researcher then organised relevant data for individual themes.
4. Reviewing themes. This phase examined individual themes. Some themes were redefined and compared to the data set to check substantial relations to the data, which answer the research questions.
5. Defining and naming themes. This phase established the detailed analysis of each theme and specified its scope and focus for determining the ‘story’ of each theme. It also involved classifying the data according to themes such as employee perceptions on the work-life balance practices, perceived value of money, influence on well-being and work behaviour and the meaning of work and life contentment.

6. Writing up. This final phase involved synthesising the analytic narrative and data extracts and contextualising the analysis in relation to existing literature.

Golafshani (2003) stated that quality in a qualitative study refers to the increase in its trustworthiness or the lessening of bias within the research. Since the nature of the qualitative research is different from quantitative studies, the aspect validity and reliability of qualitative research should be different (Krefting 1991). Since the qualitative research process involved non-standardised data analysis, reliability was considered irrelevant (Stenbacka 2001). A triangulation strategy is one way to increase the trustworthiness and quality of the qualitative study (Krefting 1991). Several types of triangulation include (i) triangulation of data sources, (ii) triangulation of the participant informants and (iii) triangulation of working sites to enhance trustworthiness.

In this phase, the research applied two triangulation strategies to increase the trustworthiness and quality during the qualitative data collection phase. Firstly, it adopted the triangulation of informants. As suggested by Shenton (2004), it is important to consider the opinions of different types of people involved in the interview process. Their opinions and experiences bring a constructive base for verifying a rich picture of attitudes, needs or behaviours. In this study, several factor criteria were selected to ensure diverse participants were involved: (i) gender, (ii) profession (job level, working experiences), (iii) age and (iv) marital status.

The study also applied a triangulation of working sites. Recruiting potential participants from several organisations and work locations may help to increase the trustworthiness and credibility of the study (Shenton 2004). In this study, participants were selected from four (4) major sectors, namely: (i) public city hospitals, (ii) public district hospitals and clinics, (iii) management and administration and (iv) private city hospitals. These selection criteria from different sectors help ensure that the issues of WLB, perceived value of money and impact on
well-being and work behaviour examined at an individual level enhances the quality of findings and results.

4.5 Summary

This chapter presented the research design and methodology employed to examine the research question and objectives. The study adopted a mixed-method explanatory sequential research design. In Phase 1, a quantitative research design was implemented and data was collected through a survey. The results of Phase 1 were used to design Phase 2 in which a qualitative research design employed semi-structured and in-depth interviews. This phase aimed to explore further the issues of WLB, the perceived value of money and its impact on well-being and work behaviour among participants in the East Malaysia context. The analysis and findings from Phase 1 are discussed in the next chapter.
CHAPTER 5: SURVEY ANALYSIS AND HYPOTHESES TESTING

RESULTS

5.1 Introduction

This chapter presents details of the survey data analysis from testing the measurement and structural parts of the research model and reports the outcomes for hypotheses testing. The data analysis was divided into two sections: (1) pilot study and (2) actual study.

The results of the pilot study determined whether the survey questionnaire was sufficient regarding content, format and design for use in the actual study. In the study findings, the analysis of results for doctors and nurses were separated to explain in-depth differences between them in the hypothesis testing. Firstly, the chapter highlights respondent characteristics followed by explanatory data and psychometric assessment analyses. It then presents the results of the descriptive and Pearson Correlation (r) analyses. In the final section of the chapter, the outline of the hypotheses testing results and summary is presented followed by the analyses.

5.2 Pilot Study

The pilot study was conducted in November 2014 involving 30 employees from a private clinic in Kota Kinabalu, Sabah. This feedback was used to verify the content and format of the survey questionnaire for the actual study including wording, measurement scales and design. The result of the pilot study revealed that there were no major problems regarding clarity and appropriateness of questions about WLB practices, employee well-being, work behaviour and the perceived value of money. Initially, the survey questionnaire was designed to be completed within 15–20 minutes to maximise respondent compliance.
Cronbach’s Coefficient Alpha (α) or the reliability coefficient, measures how well a set of items (or variables) measures a single unidimensional latent construct. It is defined as ‘the extent to which (measurements) are repeatable and that any random influence which tends to make measurements different from occasion to the occasion is a source measurement error’ (Nunnally et al. 1967). The questionnaire design and statistical modelling should work in tandem for optimal results of the survey (Presser et al. 2004). Thus, an attempt was made to check the homogeneity and consistency of items in the respective constructs of the survey. Coefficient alpha (Cronbach 1951) is the most common and recommended measure of the internal consistency of a set of items and should be the first measure to assess the quality of the survey instruments (Churchill Jr 1979; Nidumolu 1995). The measure shows how the instrument items are homogeneous and reflect the same underlying construct by calculating the estimated correlations of the set of items with errorless true scores (Zikmund 2003). Reliability value or Cronbach’s Coefficient Alpha (α) of 0.70 is acceptable (De Vaus 2002; Nunnally 1978) while a value below than 0.6 shows unsatisfactory internal consistency reliability (Malhotra 2004). Eliminating items with correlations near zero or increasing the number of items can push the alpha rating to an acceptable level (Cortina 1993). Table 5.1 illustrates the SPSS output of the Cronbach’s Coefficient Alpha (α) for the pilot test. It shows that all constructs had an acceptable level of Cronbach’s Coefficient Alpha (α) for this stage of the research as all constructs had an alpha higher than 0.70. Therefore, from the findings of the pilot study, it was concluded that the survey instruments were sufficiently sound for use as the final survey.

Table 5.1: Internal Consistency Reliability of Constructs

<table>
<thead>
<tr>
<th>No.</th>
<th>Variable</th>
<th>No. of Items</th>
<th>Mean</th>
<th>Scale Type</th>
<th>Cronbach Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Perceived Value of Money</td>
<td>17</td>
<td>5.19</td>
<td>7-point Likert scale</td>
<td>0.94</td>
</tr>
<tr>
<td>2</td>
<td>WLB: Flexibility and Choice in Working Hours</td>
<td>6</td>
<td>4.58</td>
<td>7-point Likert scale</td>
<td>0.80</td>
</tr>
<tr>
<td>3</td>
<td>WLB: Supportive Supervision</td>
<td>6</td>
<td>4.71</td>
<td>7-point Likert scale</td>
<td>0.86</td>
</tr>
<tr>
<td>4</td>
<td>WLB: Family-Friendly Programs and Practices</td>
<td>6</td>
<td>4.45</td>
<td>7-point Likert scale</td>
<td>0.85</td>
</tr>
<tr>
<td>5</td>
<td>Employee Well-Being</td>
<td>16</td>
<td>4.64</td>
<td>7-point Likert scale</td>
<td>0.94</td>
</tr>
<tr>
<td>6</td>
<td>Employee Work Behaviour</td>
<td>9</td>
<td>4.74</td>
<td>7-point Likert scale</td>
<td>0.94</td>
</tr>
</tbody>
</table>
5.3 Common Method Variance (Harman Single Factor Analysis)

In applied social sciences research, common method variance (CMV) refers to the variance attributable to the measurement method rather than the constructs the measures represent. Most researchers agree that CMV is a potential problem in behavioural research (Podsakoff et al. 2003). This is because method biases are one of the main sources of measurement error which could threaten the validity of conclusions about the relations between measures widely recognised to have both a random and a systematic component (Bagozzi et al. 1991; Nunnally 1978; Spector 1987).

Harman’s single factor test is one of the most widely used techniques to address the issue of CMV (Podsakoff et al. 2003). The underlying assumption of this technique is that, if a substantial amount of CMV is present, either (a) a single factor will emerge from the factor analysis or (b) one general factor will account for the majority of the covariance among the measures (Podsakoff et al. 2003). Table 5.2 below shows the results for CMV for this study.

Table 5.2: Common Method Variance

<table>
<thead>
<tr>
<th>Participants</th>
<th>Total Variance Explained</th>
<th>Extraction Sums of Squared Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% of Variance</td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>14.89</td>
<td>25.68</td>
</tr>
<tr>
<td>Nurses</td>
<td>16.20</td>
<td>27.94</td>
</tr>
</tbody>
</table>

The % value of the variance of the doctor sample for this research was 25.68%, and 27.94% for nurses. This value is well below the threshold value of 50% (Podsakoff & Organ 1986) and indicates there are no CMV problems.
5.4 Participant Characteristics

Demographic profiles were useful in establishing an accurate understanding of the features of the survey as shown in Table 5.3 below. The total number participants who were doctors was 115, and 379 were nurses.

Table 5.3: Personal Characteristics of Respondents (N = 494; Doctors = 115; Nurses = 379)

<table>
<thead>
<tr>
<th>Participant Characteristics</th>
<th></th>
<th></th>
<th>Doctors</th>
<th>No. of Respondents</th>
<th>Percentage (%)</th>
<th>Nurses</th>
<th>No. of Respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>58</td>
<td>50.4</td>
<td>332</td>
<td>87.6</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td>57</td>
<td>49.6</td>
<td>47</td>
<td>12.4</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-35 years</td>
<td></td>
<td></td>
<td></td>
<td>88</td>
<td>76.5</td>
<td>248</td>
<td>65.4</td>
<td></td>
</tr>
<tr>
<td>36-45 years</td>
<td></td>
<td></td>
<td></td>
<td>16</td>
<td>13.9</td>
<td>98</td>
<td>25.9</td>
<td></td>
</tr>
<tr>
<td>46 years and above</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
<td>9.6</td>
<td>33</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td>Length of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td>13.0</td>
<td>41</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td></td>
<td></td>
<td></td>
<td>60</td>
<td>52.5</td>
<td>148</td>
<td>39.1</td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td></td>
<td></td>
<td></td>
<td>20</td>
<td>17.4</td>
<td>76</td>
<td>20.1</td>
<td></td>
</tr>
<tr>
<td>11-15 years</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td>8.7</td>
<td>42</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>16-20 years</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>4.3</td>
<td>35</td>
<td>9.2</td>
<td></td>
</tr>
<tr>
<td>21 years and above</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>4.3</td>
<td>37</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Job Title</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Medical Specialists</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Specialists</td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>7.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td></td>
<td></td>
<td></td>
<td>105</td>
<td>91.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Nurses (Matrons)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Senior Nurses (Sisters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>54</td>
<td>14.2</td>
<td></td>
</tr>
</tbody>
</table>

88
The doctor participants had an almost equal distribution of male (49.7%) and female (50.4%). At 76.5% most respondents are young doctors aged between 21–35 years. For nurses, most participants were aged between 21-35 years (65.7%) with 1–5 years’ working experience (39.1%). The demographic data revealed some similar characteristics of both professions. Most participants worked in the public hospitals, followed by private clinics in Kota Kinabalu, Sabah.

5.5 Assumptions of the Multivariate Analysis

Several assumptions about the use of multivariate statistical tools, namely multicollinearity, outliers, linearity, normality, homoscedasticity and independence of residual must be met before conducting any multivariate analysis (Hair et al. 2006). This study adapts two statistical tests: multicollinearity and outliers to test the assumptions of the multivariate analysis.
5.5.1 Multicollinearity

Multicollinearity among variables can create a problem since high correlation in clustering variables may overweight one or more underlying constructs. Hair et al. (2006) states that multicollinearity refers to a measurement to check for inter-correlation among independent variables and is present when correlation among the exogenous variables reaches 0.90. A high score of multicollinearity might result in bias on the regression of coefficients in that standard errors and confidence interval will be vast and significant level low (Tabachnick & Fidell 2007). Independent variables are independent of each other when the multicollinearity score is low.

To access multicollinearity, Hair et al. (2006) suggest that a study make a comparison with conclusions drawn from the tolerance values and variance inflation factor (VIF) scores. They further state that these measures allow for the examination of the degree of dependencies between independent variables or how another independent variable can explicate each variable. A small value of tolerance (less than 0.10) and large value of VIF (above 10.0) would be a concern as it indicates serious multicollinearity. Tables 5.4 and 5.5 below show the results of measures for both doctors and nurses, and none of the independent variables exceed the criteria for multicollinearity. These measures indicate that multicollinearity was not a problem in this study.

Table 5.4: Multicollinearity Diagnostic for Doctors

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>VIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1.01</td>
</tr>
<tr>
<td>Age Range</td>
<td>1.19</td>
</tr>
<tr>
<td>WLB: Flexibility and Choice in Working Hours</td>
<td>1.45</td>
</tr>
<tr>
<td>WLB: Supportive Supervision</td>
<td>1.37</td>
</tr>
<tr>
<td>WLB: Family-Friendly Programs and Practices</td>
<td>1.48</td>
</tr>
<tr>
<td>Perceived Value of Money</td>
<td>1.04</td>
</tr>
<tr>
<td>(MEAN CENTRED) WLB X Perceived Value of Money</td>
<td>1.15</td>
</tr>
</tbody>
</table>
### Table 5.5: Multicollinearity Diagnostic for Nurses

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>VIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1.07</td>
</tr>
<tr>
<td>Age Range</td>
<td>1.07</td>
</tr>
<tr>
<td>WLB: Flexibility and Choice in Working Hours</td>
<td>1.36</td>
</tr>
<tr>
<td>WLB: Supportive Supervision</td>
<td>1.42</td>
</tr>
<tr>
<td>WLB: Family-Friendly Programs and Practices</td>
<td>1.26</td>
</tr>
<tr>
<td>Perceived Value of Money</td>
<td>1.06</td>
</tr>
<tr>
<td>(MEAN CENTRED) WLB X Perceive Value of Money</td>
<td>1.05</td>
</tr>
</tbody>
</table>

#### 5.5.2 Outliers

The value of the standardised residual from casewise diagnostics is used to measure outliers in the sample. Outliers are defined as observations with a unique combination of characteristics classifiable as noticeably different from the other observations (Hair et al. 1998). Outliers also refer to cases that have standardised residual of more than +/- 3.3 (Tabachnick & Fidell 2007). It is important to make a distinction between outliers that should and should not be deleted. Outliers requiring deletion are incorrect data entries, recorded missing values that have been read as real values and data from respondents who are not members of the intended populations (Fidell & Tabachnick 2003). In this study, a total of four (4) cases were deleted due to the outlier issues. The final number of survey questionnaires used for analysis was 494 (80.9%).

#### 5.6 Validity and Reliability Assessment

The assessment of validity and reliability for each construct are crucial in scientific research programs. It is the hallmark of good measurement and helps the researcher avoid any false or incorrect conclusions (Salkind 2000). The assessment also facilitates standardisation of measurement scales and the measurement of constructs by developing a method that reflects the true score of the variables (Churchill & Iacobucci 2006).
5.6.1 Reliability Analysis

Reliability is defined as the extent to which measures are free from random or unstable error and therefore yield consistent results (Malhotra 2004). Reliable instruments can be used with confidence as they are robust and work well at different times under different conditions (Cooper & Schindler 2006). The most common approach used to test the reliability of the internal consistency is the Cronbach’s Coefficient Alpha (Maholtra 2004). Reliability values of 0.70 and above are acceptable (De Vaus 2002; Nunnally 1978) and a value less than 0.6 indicates unsatisfactory internal consistency reliability (Maholtra 2004). Table 5.6 below illustrates the coefficient alpha of the measures used in this study for both doctor and nursing professions and all results have robust evidence that internal consistency has been achieved.

Table 5.6: Internal Consistency Reliability of the Constructs

<table>
<thead>
<tr>
<th>Variables</th>
<th>Doctors</th>
<th></th>
<th>Nurses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of Items</td>
<td>Cronbach Coefficient Alpha (α)</td>
<td>No. of Items</td>
<td>Cronbach Coefficient Alpha (α)</td>
</tr>
<tr>
<td><strong>Work-Life Balance Practices</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexibility and Choice in Working Hours</td>
<td>4</td>
<td>0.73</td>
<td>2</td>
<td>0.80</td>
</tr>
<tr>
<td>Supportive Supervision</td>
<td>5</td>
<td>0.84</td>
<td>5</td>
<td>0.87</td>
</tr>
<tr>
<td>Family-Friendly Programs and Practices</td>
<td>3</td>
<td>0.94</td>
<td>3</td>
<td>0.92</td>
</tr>
<tr>
<td><strong>Perceived Value of Money</strong></td>
<td>13</td>
<td>0.91</td>
<td>17</td>
<td>0.95</td>
</tr>
<tr>
<td><strong>Employee Well-Being</strong></td>
<td>14</td>
<td>0.94</td>
<td>14</td>
<td>0.93</td>
</tr>
<tr>
<td><strong>Employee Work Behaviour</strong></td>
<td>7</td>
<td>0.91</td>
<td>9</td>
<td>0.95</td>
</tr>
</tbody>
</table>

5.6.2 Validity Analysis

Hair et al. (2006) define validity as the extent to which a measure or set of measures correctly represents the research concept which is the degree the measure is free from any systematic or non-random error. Validity is concerned with how well the concept is represented by the measure(s). In assessing the validity of the survey instrument, content validity and construct validity (exploratory factor analysis) is tested.
Content Validity

The content or face validity is the degree to which the content of the items adequately represents the universe of all relevant items under study (Cooper & Schindler 2006). The evaluation of the content validity is a rational judgement process not open to numerical justification. Malhotra (2004) points out that a survey instrument had content validity when a general agreement on the measurement items covered all important aspects of the variables being measured was being achieved among the subject and the researcher. An expert review of the questionnaire content was implemented during the pre-test in addition to the scale development process helps to ensure content validity. Since the method to evaluate the content validity is subjective and judgemental (Cooper & Schindler 2006), which can lead to potential challenges from another researcher regarding the adequacy of the items, construct validity (explanatory factor analysis) is conducted to formalise the assessment (Malhotra 2004).

Construct Validity: Explanatory Factor Analysis (EFA)

Malhotra (2004) argues that construct validity helps to solve the issue of the actual measure of the list constructs or characteristics of scales in the study. It is central to the scientific research process (Churchill Jr 1979) and represents the process of the development of theory as well as testing (Mentzer & Flint 1997). This study uses factor analysis to analyse the convergent and discriminant validity in assessing the measurement scale (Nunnally 1978). Regarding the suitable sample size for factor analysis, a sample size of 150 participations is sufficient to apply this test (Hair et al. 2006; Tabachnick & Fidell 2007) and therefore, the 494-participant sample of this study was an acceptable size.

Exploratory factor analysis (EFA) was used to measure the construct validity of the scales in this study (Pallant 2005). This test is usually assessed at the early stages of research, enables the researcher to determine the structure of factors to be examined and can be conducted although the relations between latent and observed variables are unknown or uncertain (Bryne 2001). EFA was conducted to establish dimensionality and convergent validity of the relations between items and constructs.
The Kaiser-Meyer-Olkin (KMO) and Bartlett’s test of Sphericity were also employed to measure sampling adequacy (Pallant 2005). A KMO index ranging from 0 to 1 indicates whether significant correlations are present in the data matrix to justify the appropriateness of factor analysis. The interpretation of the factor analysis values is as follows: (i) 0.80 and above (meritorious), (ii) 0.70 and above (middling), (iii) 0.6 and above (mediocre), (iv) 0.5 and above (miserable), (v) 0.5 and below (unacceptable) (Hair et al. 2006). Moreover, a Bartlett’s test with a significance value of less than 0.05 (p < 0.05) and KMO with more than 0.60 indicates the appropriateness for factor analysis (Pallant 2005). The rationale for Bartlett’s test is to show whether the correlation among the factors in the matrix is identical or not whereas KMO is an index used to test the appropriateness of the factor analysis.

Pallant (2005) suggests that the method of the principal component with varimax rotation be employed for analysis because it is robust and produces more easily interpretable results. The varimax rotation also maximises the variance of the loading (Hair et al. 2006), and the factor loading indicates the strength of the relation between the item and the latent construct. A coefficient of more than 0.30 indicates a reasonable loading (De Vaus 2002). Subsequently, the factor loading is useful in assessing the convergent and discriminant validity of the scales (Hair et al. 2006).

The first part of the EFA shows the results for doctors in tables 5.7 to 5.10. The KMO value for all the constructs (WLB practices, perceived value of money, employee well-being and work behaviour) shows average results of 0.70 and above. This signifies that the variables share a significant amount of common variance. Likewise, Bartlett’s test shows a significance of 0.00, suggesting that the correlation matrix not is an identity matrix. The results of the KMO and Bartlett test show the appropriateness of the factor model.

Table 5.7 below shows the details of EFA for the WLB practices constructs. The three factors of WLB practices were produced from the result with eigenvalues greater than one. Out of the 16 items, 12 were found to have reasonable factor loading (>0.30). Three factors contributed 26.05% to the total variance explained, and the factor loadings of the items were between 0.59-0.92. These factors were identified as (i) flexibility and choice in working hours (ii) supportive supervision and (iii) family-friendly programs and practices.
Table 5.7: EFA of Work-Life Balance Practice Constructs for Doctors

<table>
<thead>
<tr>
<th>Work-Life Balance Practices</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexibility and Choice in Working Hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have personal discretion over my start and finish time (F1)</td>
<td></td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td>I can finish work within my contracted hours (e.g. 8 hours per shift) (F2)</td>
<td></td>
<td>0.70</td>
<td></td>
</tr>
<tr>
<td>I can schedule preferred days off supported by my team (F3)</td>
<td></td>
<td>0.69</td>
<td></td>
</tr>
<tr>
<td>I can change my roster if daily working hours are not consistent (F4)</td>
<td></td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Supportive Supervision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My co-workers are supportive when I talk about personal and family issues that affect my work (G1)</td>
<td></td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>My supervisor is understanding when I talk about personal or family issues that affect my work (G2)</td>
<td></td>
<td>0.81</td>
<td></td>
</tr>
<tr>
<td>I work very smoothly in handover to the next shift because of a good management system (G3)</td>
<td></td>
<td>0.76</td>
<td></td>
</tr>
<tr>
<td>I accept working overtime each day because I am committed to my job (G4)</td>
<td></td>
<td>0.59</td>
<td></td>
</tr>
<tr>
<td>Employees in my department have good relationships with other departments in the organisation (G5)</td>
<td></td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>Family-Friendly Programs and Practices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have enough time for my family (I1)</td>
<td></td>
<td>0.89</td>
<td></td>
</tr>
<tr>
<td>I have enough time for my friends (I2)</td>
<td></td>
<td>0.92</td>
<td></td>
</tr>
<tr>
<td>I have enough time after work to carry out personal matters (I3)</td>
<td></td>
<td>0.89</td>
<td></td>
</tr>
</tbody>
</table>

In addition, Table 5.8 below shows the EFA of the perceived value of money with eigenvalues greater than one. Out of the 17 items, 13 were found to have reasonable factor loading (>0.30). The factor solution accountable for approximately 48.38% of the total variance is explained. The values of factor loading ranged between 0.56-0.81.

Table 5.8: EFA of the Perceived Value of Money for Doctors

<table>
<thead>
<tr>
<th>Perceived Value of Money</th>
<th>F1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money is important to people working in your field (B1)</td>
<td>0.64</td>
</tr>
<tr>
<td>Money is valuable to people working in your field (B2)</td>
<td>0.60</td>
</tr>
<tr>
<td>Money is good for people working in your field (B3)</td>
<td>0.56</td>
</tr>
<tr>
<td>Money is an important factor in the lives of people working in your field (B4)</td>
<td>0.62</td>
</tr>
<tr>
<td>Money represents the achievement of people working in your field (B6)</td>
<td>0.70</td>
</tr>
<tr>
<td>Money is a symbol of success for people working in your field (B7)</td>
<td>0.78</td>
</tr>
<tr>
<td>Money reflects the accomplishments of people working in your field (B8)</td>
<td>0.75</td>
</tr>
<tr>
<td>Money is how people in your industry compare each other (B9)</td>
<td>0.73</td>
</tr>
<tr>
<td>I am motivated to work hard for money (B10)</td>
<td>0.68</td>
</tr>
<tr>
<td>Money reinforces my motivation to work harder (B11)</td>
<td>0.69</td>
</tr>
</tbody>
</table>
I am highly motivated by money (B12) 0.71
Money is a motivator for people working in your field (B13) 0.81
Having a lot of money (being rich) is good for people working in your field (B14) 0.71

Table 5.9 below shows the EFA of the employee well-being with eigenvalues greater than one. Out of the 16 items, 14 were found to have reasonable factor loading (>0.30). The factor solution accountable for approximately 59.06% of the total variance is explained. The values of factor loading ranged between 0.63-0.86.

Table 5.9: EFA of Employee Well-Being for Doctors

<table>
<thead>
<tr>
<th>Employee Well-Being: KMO = 0.90; Bartlett: Sig. = 0.000</th>
<th>F1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The physical working condition (N1)</td>
<td>0.70</td>
</tr>
<tr>
<td>Relationship with management (N2)</td>
<td>0.80</td>
</tr>
<tr>
<td>Relationship with immediate supervisor (N3)</td>
<td>0.81</td>
</tr>
<tr>
<td>Your working hours (N5)</td>
<td>0.79</td>
</tr>
<tr>
<td>Your job security (insurance, pension plan, career development) (N6)</td>
<td>0.77</td>
</tr>
<tr>
<td>Recognition for good work (N7)</td>
<td>0.86</td>
</tr>
<tr>
<td>Chance of promotion (N8)</td>
<td>0.78</td>
</tr>
<tr>
<td>Opportunity to use abilities and attention paid to suggestions you make (N9)</td>
<td>0.81</td>
</tr>
<tr>
<td>Freedom to choose own method of work (N10)</td>
<td>0.80</td>
</tr>
<tr>
<td>Amount of job responsibilities you are given (N11)</td>
<td>0.78</td>
</tr>
<tr>
<td>In most ways, my life is close to ideal (N12)</td>
<td>0.73</td>
</tr>
<tr>
<td>The conditions of my life are excellent (N13)</td>
<td>0.73</td>
</tr>
<tr>
<td>I am satisfied with my life (N14)</td>
<td>0.75</td>
</tr>
<tr>
<td>So far, I have achieved the important things I want in my life (N15)</td>
<td>0.63</td>
</tr>
</tbody>
</table>

Table 5.10 below shows the EFA of the employee work behaviour with eigenvalues greater than one. Out of the 15 items, 7 were found to have reasonable factor loading (>0.30). The factor solution accountable for approximately 66.29% of the total variance is explained. The values of factor loading ranged between 0.69-0.90.

Table 5.10: EFA of Employee Work Behaviour Constructs for Doctors

<table>
<thead>
<tr>
<th>Employee Work Behaviour: KMO = 0.891; Bartlett: Sig. = 0.000</th>
<th>F1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The quantity of work I produce meets or occasionally exceeds job expectations (Q1)</td>
<td>0.69</td>
</tr>
<tr>
<td>I effectively delegate to subordinates with clear directives and guidelines (Q4)</td>
<td>0.68</td>
</tr>
<tr>
<td>I served competently in completing all departmental and unit responsibilities (Q5)</td>
<td>0.84</td>
</tr>
<tr>
<td>I demonstrate a strong work ethic (Q6)</td>
<td>0.90</td>
</tr>
</tbody>
</table>
I am motivated, dedicated and demonstrate a strong sense of responsibility when a task is assigned (Q7)
I devote adequate time & thought to work assignments & resource allocation (Q8)
I am frequently successful in reaching a common understanding with others through verbal and non-verbal communication (Q9)

The results of the EFA analysis for nurses are illustrated in tables 5.11 to 5.14. The KMO value for all the constructs (WLB practices, perceived value of money, employee well-being and work behaviour) shows meritorious results of 0.80 and above. This signifies that the variables share a large number of common variances. Likewise, Bartlett’s test shows a significance of 0.00, suggesting that the correlation matrix is not an identity matrix. Results of the KMO and Bartlett tests demonstrate the appropriateness of the factor model.

Table 5.11 below shows the details of EFA of the WLB practices constructs for nurses. The three factors of WLB practice were produced from the result with eigenvalues greater than one. Out of the 16 items, 10 were found to have reasonable factor loading (>0.30). The three factors contributed 31.18% to the total variance explained, and the factor loadings of the items were between 0.74-0.91. Similar to the doctor cohort, three factors were identified: (i) flexibility and choice in working hours (ii) supportive supervision and (iii) family-friendly programs and practices.

Table 5.11: EFA of Work-Life Balance Practice Constructs for Nurses

<table>
<thead>
<tr>
<th>Work-Life Balance Practices: KMO = 0.84; Bartlett: Sig. = 0.000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F1</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Flexibility and Choice in Working Hours</strong></td>
</tr>
<tr>
<td>I have personal discretion over my start and finish time (F1)</td>
</tr>
<tr>
<td>I can finish work within my contracted hours (e.g. 8 hours per shift) (F2)</td>
</tr>
<tr>
<td><strong>Supportive Supervision</strong></td>
</tr>
<tr>
<td>My co-workers are supportive when I talk about personal and family issues that affect my work (G1)</td>
</tr>
<tr>
<td>My supervisor is understanding when I talk about personal or family issues that affect my work (G2)</td>
</tr>
<tr>
<td>I work very smoothly in handover to the next shift because of a good management system (G3)</td>
</tr>
<tr>
<td>I accept working overtime each day because I am committed to my job (G4)</td>
</tr>
<tr>
<td>Employees in my department have good relationships with other departments in the organisation (G5)</td>
</tr>
</tbody>
</table>

**Family-Friendly Programs and Practices**
Table 5.12 below shows the EFA of the perceived value of money with eigenvalues greater than one. None of the seventeen (17) items were dropped. The factor solution accountable for approximately 53.85% of the total variance is explained. The values of factor loading ranged between 0.64-0.86.

Table 5.12: EFA of the Perceived Value of Money for Nurses

<table>
<thead>
<tr>
<th>Perceived Value of Money</th>
<th>F1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money is important for people working in your field (B1)</td>
<td>0.68</td>
</tr>
<tr>
<td>Money is valuable for people working in your field (B2)</td>
<td>0.68</td>
</tr>
<tr>
<td>Money is good for people working in your field (B3)</td>
<td>0.72</td>
</tr>
<tr>
<td>Money is an important factor in the lives of people working in your field (B4)</td>
<td>0.68</td>
</tr>
<tr>
<td>Money is attractive for people working in your field (B5)</td>
<td>0.73</td>
</tr>
<tr>
<td>Money represents the achievement of people working in your field (B6)</td>
<td>0.78</td>
</tr>
<tr>
<td>Money is a symbol of success for people working in your field (B7)</td>
<td>0.74</td>
</tr>
<tr>
<td>Money reflects the accomplishments of people working in your field (B8)</td>
<td>0.80</td>
</tr>
<tr>
<td>Money is how the people in your industry compare each other (B9)</td>
<td>0.74</td>
</tr>
<tr>
<td>I am motivated to work hard for money (B10)</td>
<td>0.74</td>
</tr>
<tr>
<td>Money reinforces my motivation to work harder (B11)</td>
<td>0.76</td>
</tr>
<tr>
<td>I am highly motivated by money (B12)</td>
<td>0.86</td>
</tr>
<tr>
<td>Money is a motivator for people working in your field (B13)</td>
<td>0.82</td>
</tr>
<tr>
<td>Having a lot of money (being rich) is good for people working in your field (B14)</td>
<td>0.72</td>
</tr>
<tr>
<td>It would be nice to be rich (B15)</td>
<td>0.68</td>
</tr>
<tr>
<td>I want to be rich (B16)</td>
<td>0.64</td>
</tr>
<tr>
<td>My life will be more enjoyable if I was rich and had more money (B17)</td>
<td>0.65</td>
</tr>
</tbody>
</table>

Table 5.13 below shows the EFA of employee well-being with eigenvalues greater than one. Out of the 16 items, 14 were found to have reasonable factor loading (>0.30). The factor solution accountable for approximately 53.57% of the total variance is explained. The values for factor loading ranged between 0.62-0.83.
### Table 5.13: EFA of Employee Well-Being for Nurses

<table>
<thead>
<tr>
<th>Employee Well-Being: KMO = 0.91; Bartlett: Sig. = 0.000</th>
<th>F1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical working conditions (N1)</td>
<td>0.71</td>
</tr>
<tr>
<td>Relationship with management (N2)</td>
<td>0.78</td>
</tr>
<tr>
<td>Relationship with immediate supervisor (N3)</td>
<td>0.76</td>
</tr>
<tr>
<td>Relationship with fellow colleagues (N4)</td>
<td>0.76</td>
</tr>
<tr>
<td>Your working hours (N5)</td>
<td>0.78</td>
</tr>
<tr>
<td>Your job security (insurance, pension plan, career development) (N6)</td>
<td>0.67</td>
</tr>
<tr>
<td>Recognition for good work (N7)</td>
<td>0.83</td>
</tr>
<tr>
<td>Chance of promotion (N8)</td>
<td>0.77</td>
</tr>
<tr>
<td>Opportunity to use abilities and attention paid to suggestions you make (N9)</td>
<td>0.77</td>
</tr>
<tr>
<td>Freedom to choose own method of work (N10)</td>
<td>0.74</td>
</tr>
<tr>
<td>Amount of job responsibility you are given (N11)</td>
<td>0.71</td>
</tr>
<tr>
<td>In most ways, my life is close to ideal (N12)</td>
<td>0.67</td>
</tr>
<tr>
<td>The conditions of my life are excellent (N13)</td>
<td>0.64</td>
</tr>
<tr>
<td>I am satisfied with my life (N14)</td>
<td>0.62</td>
</tr>
</tbody>
</table>

Table 5.14 below shows the EFA of employee work behaviour with eigenvalues greater than one. Out of the 15 items, 9 were found to have reasonable factor loading (>0.30). The factor solution accountable for approximately 53.57% of the total variance is explained. The values of factor loading ranged between 0.79-0.89.

### Table 5.14: EFA of Employee Work Behaviour for Nurses

<table>
<thead>
<tr>
<th>Employee Work Behaviour: KMO = 0.93; Bartlett: Sig. = 0.000</th>
<th>F1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The quantity of work I produce meets or occasionally exceeds job expectations (Q1)</td>
<td>0.79</td>
</tr>
<tr>
<td>I constantly discuss career interests, provide advice and feedback to my fellow subordinates and inspire them (Q2)</td>
<td>0.82</td>
</tr>
<tr>
<td>I lead, motivate and work closely with subordinates under me (Q3)</td>
<td>0.85</td>
</tr>
<tr>
<td>I effectively delegate to subordinates with clear directives and guidelines (Q4)</td>
<td>0.87</td>
</tr>
<tr>
<td>I served competently in completing all departmental and unit responsibilities (Q5)</td>
<td>0.89</td>
</tr>
<tr>
<td>I demonstrate a strong work ethic (Q6)</td>
<td>0.82</td>
</tr>
<tr>
<td>I am motivated, dedicated and demonstrate a strong sense of responsibility when a task is assigned (Q7)</td>
<td>0.86</td>
</tr>
<tr>
<td>I devote adequate time &amp; thought to work assignments &amp; resource allocation (Q8)</td>
<td>0.85</td>
</tr>
<tr>
<td>I am frequently successful in reaching a common understanding with others through verbal and non-verbal communication (Q9)</td>
<td>0.82</td>
</tr>
</tbody>
</table>
**Criterion Validity: Pearson Correlation Analysis**

Criterion validity was also performed on the data analysis. Malhotra (2004) states that criterion validity would specify whether a scale performs as predicted in relation with other variables selected (criterion variables) as meaningful measures. Criterion validity also emphasises the importance of comparing the scale used with criterion variables. It also enables the researcher to predict any relation between the measure and behavioural outcomes. Concurrent validity was applied and correlation analysis was used to examine criterion validity in this study (Malhotra 2004).

A Pearson Correlation (r) analysis was conducted to understand the relation between the major constructs as well as the multicollinearity of the independent variables of the study. Correlation coefficient values between +/- 1.00 and +/- 0.81 are considered to be ‘very high’, which, in turn, create multicollinearity. This can be problematic; for example, a very high correlation among clustering variables may overweight one or more underlying constructs (Burns & Bush 2000). The results of the correlation coefficients for the relation between independent variables were less than 0.90 indicating that data were not affected by a serious collinearity problem (Hair et al. 1998). These included WLB practices of (i) flexibility and choice in working hours, (ii) supportive supervision and (iii) family-friendly programs and practices; the moderating variable that is, the perceived value of money; and the relation between the dependent variables, that is, employee well-being and employee work behaviour.

The descriptive statistics (means and standard deviations) for the variables were measured using a 7-point Likert scale. Among doctors, the mean scores for all variables were between 3.52 and 4.95 signifying that perceived value of money, WLB practices, employee well-being and employee work behaviour ranged from mid (3) to high (5). For nurses, the mean scores for all the variables were between 4.11 and 5.31 signifying the perceived value of money, WLB practices, employee well-being and employee work behaviour ranged from mid (4) to high (5). The details of these results for both doctor and nursing professions are illustrated in tables 5.15 and 5.16 below.
Table 5.15: Descriptive Statistics and Pearson Correlations (r) Analysis: Doctors

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gender</td>
<td>1.49</td>
<td>0.50</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age Range</td>
<td>1.33</td>
<td>0.65</td>
<td>0.06</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Family-Friendly Programs and</td>
<td>3.52</td>
<td>1.54</td>
<td>0.08</td>
<td>0.32***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Supportive Supervision</td>
<td>4.69</td>
<td>1.05</td>
<td>0.06</td>
<td>0.28***</td>
<td>0.41***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Flexibility and Choice in</td>
<td>4.28</td>
<td>1.18</td>
<td>0.06</td>
<td>0.30***</td>
<td>0.46***</td>
<td>0.38***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Perceived Value of Money</td>
<td>4.58</td>
<td>1.06</td>
<td>0.05</td>
<td>0.10</td>
<td>0.07</td>
<td>-0.00</td>
<td>0.14</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Employee Well-Being</td>
<td>4.95</td>
<td>0.85</td>
<td>0.02</td>
<td>0.38***</td>
<td>0.25***</td>
<td>0.34***</td>
<td>0.15</td>
<td>0.11</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8. Employee Work Behaviour</td>
<td>4.39</td>
<td>1.10</td>
<td>-0.06</td>
<td>0.32***</td>
<td>0.60***</td>
<td>0.66***</td>
<td>0.32***</td>
<td>-0.06</td>
<td>0.46***</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Correlation Value is significant at *p<0.05, **p<0.01, ***p<0.001, N=115
Reliability estimations are shown diagonally (value 1)
Table 5.16: Descriptive Statistics and Pearson Correlations (r) Analysis: Nurses

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gender</td>
<td>1.12</td>
<td>0.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age Range</td>
<td>1.43</td>
<td>0.65</td>
<td>-0.14*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Perceived Value of Money</td>
<td>5.31</td>
<td>1.00</td>
<td>0.07</td>
<td>-0.06</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Flexibility and Choice in Working Hours</td>
<td>4.78</td>
<td>1.07</td>
<td>0.11*</td>
<td>0.13***</td>
<td>0.21***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Supportive Supervision</td>
<td>4.72</td>
<td>0.97</td>
<td>-0.03</td>
<td>0.13**</td>
<td>0.03</td>
<td>0.44***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Family-Friendly Programs and Practices</td>
<td>4.11</td>
<td>1.28</td>
<td>0.03</td>
<td>0.17***</td>
<td>0.01</td>
<td>0.28***</td>
<td>0.41***</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Employee Well-Being</td>
<td>4.73</td>
<td>0.79</td>
<td>-0.03</td>
<td>0.17***</td>
<td>0.08</td>
<td>0.36***</td>
<td>0.58***</td>
<td>0.47***</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8. Employee Work Behaviours</td>
<td>4.70</td>
<td>0.82</td>
<td>-0.05</td>
<td>0.21***</td>
<td>0.05</td>
<td>0.38***</td>
<td>0.49***</td>
<td>0.23***</td>
<td>0.60***</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Correlation Value is significant at *p<0.05, **p<0.01, ***p<0.001, N=379
Reliability estimations are shown diagonally (value 1)
5.7 Multiple Regression Analysis for Hypotheses Testing

This section reports the data results of the multivariate analysis carried out in the study. The main analysis undertaken was a multiple regression analysis as a basis for the acceptance and rejection of hypotheses set out in chapter four. A recap of the survey analysis will help explain the first two objectives of the research which are: 1) to examine the relations between WLB practices and employee outcomes (employee well-being and work behaviour; and 2) to examine the moderating effect of the perceived value of money in the relations between WLB practices and employee outcomes (employee well-being and work behaviour).

The analysis was performed for two sample cohorts: doctors and nurses. This section first outlines the results of the multiple regression analysis for employee well-being and work behaviour as the dependent variable for doctors. This is followed by the multiple regression analysis for the nurse cohort. The aim is to examine the extent to which the variance of the dependent variable (employee well-being and employee work behaviour) can be explained by the independent variable of WLB practices (i.e. flexibility and choice in work hours, supportive supervision, and family-friendly programs and practices) in the multiple regression analysis.

5.7.1 Controlled Variables

Aguinis and Vandenberg (2014) state that ‘because most research designs are observational in nature, control variables are usually needed to rule out alternative explanations for observed substantive relationships. However, control variables are often used indiscriminately and may ironically, accentuate the problems they are intended to remedy’ (p.574). Furthermore, there is a need for the researcher to provide a sound conceptual basis as to how the variables in those alternatives will operate in the model. In the current study, the demographic variables of age and gender were considered as controls. Prior research (Greenhaus et al. 2003; Morganson et al. 2010) on the effects of WLB on employee outcomes has theoretically and empirically linked these variables. There was a significant difference between the variables of age and gender in the sample of the current study. Therefore, to generate standardised results that represent the target professions of the study, these variables
were required by the model. Age was measured as (1 = 21 to 35 years), (2 = 36 to 45 years), (3 = 46 years and above). Gender was dummy coded (1 = female, 2 = male).

5.7.2 *The Principle of Multiple Regression Analysis*

To test the hypothesised research model of the first stage and direct effect, the study used a moderation model suggested by Edwards and Lambert (2007). The effect of a moderator is a casual model that postulates ‘when’ and for ‘whom’ an independent variable most strongly (or weakly) causes a dependent variable, which will modify the strength or direction (positive or negative) of a causal relation (Baron & Kenny 1986; Frazier et al. 2004; Kraemer et al. 2002; Wu & Zumbo 2008). Statistically, this is known as the ‘interaction effect’ where the strength or direction of the effect of the independent variable towards the dependent variable depends on the value and level of another independent variable (Wu & Zumbo 2008). The dimension of the moderator can be on a continuous scale (e.g. value of self-confidence) or a categorical scale (e.g. gender, age) (West et al. 1996).

This study adapts the concept of the perceived value of money as an extension of studies by Tang et al. (2002) and Tang (2007a). However, the concept is tested as a moderating variable in the framework of WLB and employee outcomes (employee well-being and work behaviour) in the healthcare industry settings of East Malaysia. The regression analysis was suitable to measure the moderating impact of the quantitative scale because of its greater statistical power (Cohen et al. 2013; Frazier et al. 2004; Jaccard et al. 1990; MacCallum et al. 2002; West et al. 1996).

The main principle of the regression analysis is that, before the analysis, the continuous moderator needs to be centred before creating a cross-product term (Cohen et al. 2013; Frazier et al. 2004; Rose et al. 2004). Wu and Zumbo (2008) state that the reason for centring is that, unless the moderator has a meaningful zero point, the interpretations of the main effects, a and b, are meaningless. Centring is accomplished by subtracting the sample mean from each score on the continuous moderator. Centring produces two straightforward and meaningful interpretations of the main-effect coefficients: (i) the effect of the individual cause at the mean of the sample, and (ii) the average effect of every single predictor across the range of the other variables (Wu & Zumbo 2008). In addition, centring eliminates the
problems of non-essential multicollinearity between the two independent variables, X and Mo, with the product term X*Mo (Cohen et al. 2013). Centring does not alter the significance of the moderation test, nor does it alter the value of the regression coefficient. Note that centring a continuous dependent variable is unnecessary; in fact, keeping the metric of the dependent variable helps the interpretation consistent with the original metric of the data. In addition, this study incorporates the principle of simple slopes from moderated regression analysis (Aiken et al. 1991) to analyse the direct, indirect and total effects at selected levels of the moderating variables (Stolzenberg 1980; Tate 1998). The simple slope test is conducted to probe the pattern of an interaction effect (Aiken et al. 1991).

The application involves the following three steps to test the research model suggested by Aiken et al. (1991). At the first step, demographic variables (i.e. gender and age) were entered. Then, all independent variables of WLB practices (i.e. flexibility and choice in working hours, supportive supervision, family-friendly programs and practices) and the moderating variable (perceived value of money) were entered. Finally, the interaction (WLB X perceive value of money) was entered. Before this three-step application, the researcher calculated the mean-centred values for all variables as a component of the interaction term to avoid multicollinearity issues. Since there are two dependent variables in this research (i.e. employee well-being and work behaviour) a two-factor model of multiple regression analysis for each cohort profession, doctors and nurses, was required.
5.7.3 Results for Multiple Regression Analysis with Employee Well-Being as Dependent Variable (Doctors)

Table 5.17: Moderated Regression Analysis: Work-Life Balance Factors, Perceived Value of Money and Interaction Predicting Employee Well-Being for Doctors

<table>
<thead>
<tr>
<th>Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>-0.08</td>
<td>-0.11*</td>
<td>-0.11</td>
</tr>
<tr>
<td>Age Range</td>
<td>0.33***</td>
<td>0.09</td>
<td>0.08</td>
</tr>
<tr>
<td>Flexibility and Choice in Working Hours</td>
<td>-0.06</td>
<td>-0.03</td>
<td></td>
</tr>
<tr>
<td>Supportive Supervision</td>
<td>0.50***</td>
<td>0.53***</td>
<td></td>
</tr>
<tr>
<td>Family-Friendly Programs &amp; Practices</td>
<td>0.41***</td>
<td>0.39***</td>
<td></td>
</tr>
<tr>
<td>Perceived Value of Money</td>
<td>-0.08</td>
<td>-0.09</td>
<td></td>
</tr>
<tr>
<td>Work-Life Balance Practices X Perceived Value</td>
<td></td>
<td></td>
<td>-0.13**</td>
</tr>
<tr>
<td>of Money</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R Square                                           0.11  0.59  0.61
R Square Change                                     0.11  0.48  0.01

N=115, *p<0.05, **p<0.01, ***p<0.001

Table 5.17 above shows the results of testing the research hypotheses for doctors. Hypothesis 2 predicted that there is a significant relation between supportive supervision and employee well-being. After controlling for gender and age, step 2 of Table 5.17 shows that supportive supervision significantly predicted employee well-being ($\beta=0.50$, $p<0.001$); it thus supports H2.

Hypothesis 3 predicted that a significant relation between family-friendly programs and practices with employee well-being. After controlling for gender and age, step 2 shows that family-friendly programs and practices significantly predicted employee well-being ($\beta=0.41$, $p<0.001$); therefore, H3 was supported.

However, Hypothesis 1 predicted a significant relation between flexibility and choice in working hours towards employee well-being. After controlling for gender and age, step 2 shows that flexibility and choice in working hours do not predict employee well-being ($\beta= -0.06$, $p=\text{n.s.}$); therefore, H1 was not supported.

In terms of explanatory power, the inclusion of WLB practices (i.e. flexibility and choice in working hours, supportive supervision and family-friendly programs and practice) in step 2 explained 59.0% of the variance in the dependent variable (employee well-being).
Hypothesis 7 predicted that perceived value of money negatively and significantly moderates the relation between WLB practices and employee well-being. The result of regression analysis at step 3 reveals that the perceived value of money as moderator was significantly associated with WLB practices and employee well-being after controlling gender and age ($\beta=-0.13$, $p<0.01$). Figure 5.1 presents the interaction between the perceived value of money and WLB.

Figure 5.1: Interactive Effects of Work-Life Balance Practices and Perceived Value of Money on Employee Well-Being

Following a procedure outlined by Aiken et al. (1991), the researcher tested the significance of simple slopes. For an individual with a high perceived value of money (indicated by the broken line), there was a significant negative relation between WLB and well-being. For an individual with low perceived value of money, there was a positive correlation between WLB and well-being. In terms of explanatory power, the inclusion of all variables, including the interaction terms (WLB practices X perceived value of money) in step 3, explained 61.0 % of the variance in the dependent variable (employee well-being). The significance value of the interaction term ($p<0.05$) suggests that there was a moderating effect of the perceived value of money in the relation between WLB practices and employee well-being in the doctor sample. This result meets the requirement of Baron and Kenny (1986) in moderating effect model testing.
5.7.4 Results for Multiple Regression Analysis with Employee Work Behaviour as Dependent Variable (Doctors)

Table 5.18: Moderated Regression Analysis: Work-Life Balance Factors, Perceived Value of Money and Interaction Predicting Employee Work Behaviours For Doctors

<table>
<thead>
<tr>
<th>Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.00</td>
<td>-0.01</td>
<td>-0.01</td>
</tr>
<tr>
<td>Age Range</td>
<td>0.38***</td>
<td>0.30***</td>
<td>0.3***</td>
</tr>
<tr>
<td>Flexibility and Choice in Working Hours</td>
<td>-0.10</td>
<td>-0.10</td>
<td>-0.10</td>
</tr>
<tr>
<td>Supportive Supervision</td>
<td>0.27***</td>
<td>0.27***</td>
<td>0.27***</td>
</tr>
<tr>
<td>Family-Friendly Programs &amp; Practices</td>
<td>0.08</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Perceived Value of Money</td>
<td>0.09</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>Work-Life Balance Practices X Perceived Value of Money</td>
<td></td>
<td>-0.01</td>
<td></td>
</tr>
<tr>
<td>R Square</td>
<td>0.14</td>
<td>0.22</td>
<td>0.22</td>
</tr>
<tr>
<td>R Square Change</td>
<td>0.14</td>
<td>0.08</td>
<td>0.00</td>
</tr>
</tbody>
</table>

N=115, *p<0.05, **p<0.01, ***p<0.001

Table 5.18 above shows the outcomes of testing the research hypotheses for doctors. Hypothesis 5 predicted a significant relation between supportive supervision and employee work behaviour. After controlling for gender and age, step 2 of Table 5.18 shows that supportive supervision significantly predicted employee work behaviour (β=0.27, p<0.001); therefore, H5 was supported.

However, Hypothesis 4 predicted a significant relation between flexibility and choice in working hours towards employee work behaviour. After controlling for gender and age, step 2 shows that flexibility and choice in working hours do not predict employee work behaviour (β= -0.09, p=n.s.); therefore, H4 was not supported.

Additionally, Hypothesis 6 predicted a significant relation between family-friendly programs and practices towards employee work behaviour. After controlling for gender and age, step 2 shows that family-friendly programs and practices do not predict employee work behaviour (β= -0.08, p=n.s.); thus, H6 was not supported.
This result demonstrated that, in terms of explanatory power, the inclusion of WLB practices (i.e. flexibility and choice in working hours, supportive supervision and family-friendly programs and practice) in step 2 explained 22.0% of the variance in the dependent variable (employee work behaviour).

Furthermore, Hypothesis 8 predicted that perceived value of money significantly moderates the relation between WLB practices and employee work behaviour. The result of regression analysis at step 3 reveals that the perceived value of money as the moderator was not significantly associated with WLB practices and employee work behaviour after controlling gender and age (β=-0.01, p=n.s.); therefore, H8 was not supported. The inclusion of all variables including the interaction terms (WLB practices X perceived value of money) in step 3 explained 22.0% of the variance in the dependent variable (employee work behaviour).

5.7.5 Results for Multiple Regression Analysis with Employee Well-Being as Dependent Variable (Nurses)

Table 5.19: Moderated Regression Analysis: Work-Life Balance Factors, Perceived Value of Money and Interaction Predicting Employee Well-Being For Nurses

<table>
<thead>
<tr>
<th>Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>-0.01</td>
<td>-0.04</td>
<td>-0.04</td>
</tr>
<tr>
<td>Age Range</td>
<td>0.17***</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Flexibility and Choice in Working Hours</td>
<td></td>
<td>0.09**</td>
<td>0.09**</td>
</tr>
<tr>
<td>Supportive Supervision</td>
<td></td>
<td>0.42***</td>
<td>0.42***</td>
</tr>
<tr>
<td>Family-Friendly Programs &amp; Practices</td>
<td></td>
<td>0.27***</td>
<td>0.27***</td>
</tr>
<tr>
<td>Perceived Value of Money</td>
<td></td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Work-Life Balance Practices X Perceived Value</td>
<td></td>
<td>-0.02</td>
<td></td>
</tr>
<tr>
<td>Value of Money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Square</td>
<td>0.03</td>
<td>0.41</td>
<td>0.41</td>
</tr>
<tr>
<td>R Square Change</td>
<td>0.03</td>
<td>0.38</td>
<td>0.00</td>
</tr>
</tbody>
</table>

N=379, *p<0.05, **p<0.01, ***p<0.001

Table 5.19 above shows the outcomes of testing the research hypotheses for nurses. Hypothesis 1 predicted a significant relation between flexibility and choice in working hours towards employee well-being. After controlling for gender and age, step 2 of Table 5.19 shows that flexibility and choice in working hours significantly predicted employee well-being (β=0.09, p<0.01); thus, H1 was supported.
Hypothesis 2 predicted a significant relation between supportive supervision towards employee well-being. After controlling for gender and age, step 2 shows that supportive supervision significantly predicted employee well-being ($\beta=0.42$, $p<0.001$); therefore, H2 was supported.

Hypothesis 3 predicted a significant relation between family-friendly programs and practices towards employee well-being. After controlling for gender and age, step 2 shows that flexibility and choice in working hours significantly predicted employee well-being ($\beta=0.27$, $p<0.01$); thus, H3 was supported.

This result indicates that the inclusion of WLB practices (i.e. flexibility and choice in working hours, supportive supervision and family-friendly programs and practice) in step 2 explained 41.0% of the variance in the dependent variable (employee well-being).

Finally, Hypothesis 7 predicted that the perceived value of money significantly moderates the relation between WLB practices and employee well-being. The result of the regression analysis at step 3 reveals that the perceived value of money as the moderator was not significantly associated with WLB practices and employee well-being after controlling gender and age ($\beta=-0.02$, $p=n.s.$); thus, H7 was not supported. In terms of explanatory power, the inclusion of all variables including the interaction terms (WLB practices X perceived value of money) in Model 3 had explained 41.0% of the variance in the dependent variable (employee well-being).
Table 5.20: Moderated Regression Analysis: Work-Life Balance Factors, Perceived Value of Money and Interaction Predicting Employee Work Behaviours For Nurses

<table>
<thead>
<tr>
<th>Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>-0.03</td>
<td>-0.05</td>
<td>-0.05</td>
</tr>
<tr>
<td>Age Range</td>
<td>0.21***</td>
<td>0.13***</td>
<td>0.13***</td>
</tr>
<tr>
<td>Flexibility and Choice in Working Hours</td>
<td>0.20***</td>
<td>0.20***</td>
<td></td>
</tr>
<tr>
<td>Supportive Supervision</td>
<td>0.38***</td>
<td>0.38***</td>
<td></td>
</tr>
<tr>
<td>Family-Friendly Programs &amp; Practices</td>
<td>-0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Perceived Value of Money</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Work-Life Balance Practices X Perceived Value</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Square</td>
<td>0.05</td>
<td>0.29</td>
<td>0.29</td>
</tr>
<tr>
<td>R Square Change</td>
<td>0.05</td>
<td>0.25</td>
<td>0.00</td>
</tr>
</tbody>
</table>

N=379, *p<0.05, **p<0.01, ***p<0.001

Table 5.20 above shows the outcomes of testing the research hypotheses. Hypothesis 4 predicted a significant relation between flexibility and choice in working hours towards employee work behaviour. After controlling for gender and age, step 2 shows that flexibility and choice in working hours significantly predicted employee work behaviour ($\beta=0.20$, $p<0.001$); thus, $H1$ was supported.

Hypothesis 5 predicted a significant relation between supportive supervision towards employee work behaviours. After controlling for gender and age, step 2 shows that supportive supervision significantly predicted employee work behaviour ($\beta=0.38$, $p<0.001$); thus, $H5$ was supported.

Hypothesis 6 predicted a significant relation between family-friendly programs and practices towards employee work behaviours. After controlling for gender and age, step 2 shows that flexibility and choice in working hours do not significantly predict employee well-being ($\beta=-0.00$, $p=n.s.$); thus, $H6$ was not supported.

This result demonstrated that in terms of explanatory power, the inclusion of WLB practices (i.e. flexibility and choice in working hours, supportive supervision and family-friendly
programs and practice) in step 2 explained 29.0% of the variance in the dependent variable (employee work behaviour).

Hypothesis 8 predicted that the perceived value of money significantly moderates the relation between WLB practices and employee work behaviour. The result of regression analysis at step 3 reveals that the perceived value of money as the moderator was not significantly associated with WLB practices and employee work behaviour after controlling gender and age ($\beta=-0.02$, p=n.s.); thus, H8 was not supported. In terms of explanatory power, the inclusion of all variables including the interaction terms (WLB practices X perceived value of money) in step 3 had explained 29.0% of the variance in dependent variable (employee work behaviour).

### 5.8 Summary of Hypotheses Testing

The summary of results for all hypotheses testing is presented in Table 5.21 below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Hypotheses</th>
<th>Results</th>
<th>Doctors</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.</td>
<td>H1: There is a significant relation between flexibility and choice in working hours and employee well-being</td>
<td>Not Supported</td>
<td>Supported</td>
<td>Supported</td>
</tr>
<tr>
<td>02.</td>
<td>H2: There is a significant relation between supportive supervision and employee well-being</td>
<td>Supported</td>
<td>Supported</td>
<td>Supported</td>
</tr>
<tr>
<td>03.</td>
<td>H3: There is a significant relation between family-friendly programs and practices and employee well-being</td>
<td>Supported</td>
<td>Supported</td>
<td>Supported</td>
</tr>
<tr>
<td>04.</td>
<td>H4: There is a significant relation between flexibility and choice in working hours and employee work behaviour</td>
<td>Not Supported</td>
<td>Supported</td>
<td>Supported</td>
</tr>
<tr>
<td>05.</td>
<td>H5: There is a significant relation between supportive supervision and employee work behaviour</td>
<td>Supported</td>
<td>Supported</td>
<td>Supported</td>
</tr>
<tr>
<td>06.</td>
<td>H6: There is a significant relation between family-friendly programs and practices and employee work behaviour</td>
<td>Not Supported</td>
<td>Not Supported</td>
<td>Not Supported</td>
</tr>
<tr>
<td>07.</td>
<td>H7: The perceived value of money significantly moderates the effect of work-life balance practices and employee well-being</td>
<td>Supported</td>
<td>Not Supported</td>
<td>Supported</td>
</tr>
<tr>
<td>08.</td>
<td>H8: The perceived value of money significantly moderates the effect of work-life balance practices and employee work behaviour</td>
<td>Not Supported</td>
<td>Not Supported</td>
<td>Supported</td>
</tr>
</tbody>
</table>
Phase 1 of this study utilised a quantitative methodology design that helped the researcher investigate the study’s major quantitative question: How does the perceived value of money moderate the relations between WLB practices and employee outcomes (i.e. employee well-being and work behaviour)? It has helped the researcher to address the first two (2) research objectives, namely:

1. To examine the relations between work-life balance practices towards employee outcomes
2. To examine the moderating effect of perceived value of money in the relations between work-life balance practices and employee outcomes

The study was conducted in the public and private sectors of the health care industry in Sabah and Sarawak. After data screening, checking multicollinearity and outliers, a total of 494 participants participated in this study including senior medical specialists, doctors, matrons (head nurses), sisters (senior nurses) and nurses. A multiple regression analysis was conducted for hypothesis testing. The results of the quantitative analysis of the doctors revealed that the WLB practices of supportive supervision and family-friendly programs and practices had significant relations towards employee well-being. Supportive supervision also had a significant relation with employee work behaviour. For nurses, the WLB practices of flexibility and choice in working hours and supportive supervision had significant relations with employee well-being. Furthermore, flexibility and choice in working hours and supportive supervision had a significant relation with employee work behaviour.

In the context of the healthcare industry in East Malaysia, the concept of flexible working hours could be established in the collective working culture that prioritises group-oriented teamwork and shared goals within the teams (Markus & Kitayama 1991; Sim & Bujang 2012). A sense of empathy and understanding between colleagues and supervisors facilitates the establishment of a flexible working environment. The concept of supportive supervision is an extension of this cultural influence, where supervisors play a significant role in providing support to employees in a challenging work environment with significant staff shortages. Furthermore, the continuous improvement in some HR and Employment policies, such as a flexible working environment (Employment Act 1955), the Childcare Act 1984 and paid maternity and paternity leave (Employment Act 1955, Section 37), play a critical role in
improving the motivation of doctors and nurses. A more flexible environment also serves as an attraction and retention strategy by providing workplace conditions that enable the professions to perform effectively. It has been noted that the healthcare industry in Sabah and Sarawak are facing a severe manpower shortages, which could potentially decrease the potential implementation of family-friendly programs and policies. Furthermore, this situation could also lead to a lack of flexibility in work time due to extra hours required to meet workloads in hospitals and clinics.

In assessing the concept of the perceived value of money as a moderating variable in these relations, this study revealed that it has a significant impact on the relation between WLB practices and employee well-being among doctors. However, in the most part, the Phase 1 of this study found that the perceived value of money does not moderate the relation between WLB practices and employee outcomes (employee well-being and work behaviour). Consistent with Adams’ (1965) equity theory, the Phase 1 study indicated that employees will evaluate the competitiveness of their compensation packages (i.e. salary, bonuses, allowances and employment benefits packages) in comparison with other employees in comparable job levels and industries. In the context of the healthcare industry in East Malaysia, both doctors and nurses may perceive that the salary and benefit packages they receive is not commensurate with employment responsibilities conducted in a high-intensity work environment. These issues are examined in more detail in Phase 2 of this study. More specifically, three qualitative research questions are addressed in chapter 6 and 7 that follow:

1. What are the key factors that influence employee WLB, well-being and work behaviour in the East Malaysian healthcare industry?
2. Why is there a difference between the perceptions of doctor and nurse on the value of money?
3. What are other emerging issues that influence employee WLB and perceived value of money?
The first and second research questions aim to provide an in-depth explanation for the results of the Phase 1 study. Question 3 explores emerging themes and issues that arise in the analysis of the Phase 2 data. These new elements further enrich our understanding of the concepts of WLB and the perceived value of money in the context of the health service professions in East Malaysia.
CHAPTER 6: FACTORS INFLUENCE WORK-LIFE BALANCE AND PERCEIVED VALUE OF MONEY OF MEDICAL PROFESSIONALS

6.1 Introduction

This chapter presents the analysis and discussion of the main themes emerging from the qualitative study. It takes up questions raised by the earlier survey analysis.

The interviews suggested two key themes are critical in the analysis of employee WLB and its influence on well-being and work behaviour in the East Malaysian context. Firstly, respondents indicated that individual factors play a very important role in employee WLB. Supportive supervision, flexibility in working hours and the implementation of family-friendly programs and practices are essential elements that interconnect individual factors such as gender norms and parental/family status as well as work hierarchy. Secondly, the collectivist working culture in East Malaysia also appears to shape employee well-being and work behaviour in that it accommodates and contributes to greater WLB. As reported by respondents, this culture values togetherness, loyalty and long-term commitment to colleagues and helps facilitate flexible working hours.

Two key factors explain the discrepancy between doctors and nurses in relation to the intervening impact of the perceived value of money. Firstly, there is a difference in the compensation and benefits structure offered to each profession. This includes basic salary, increments, allowances and locum opportunities for doctors. Second, the career development structure, including promotion opportunities, career development policies and skill development policies, also influence employee perceived value of money. This study extends the concept of the perceived value of money to include employee attitudes towards compensation and benefits. The analysis suggests that both doctors and nurses prefer long-term future financial stability and life stability to short-term monetary rewards. Both professions also value employment benefits such as the opportunity for locum work for doctors as well as permanent job status and career development opportunities that provide them and their family with economic stability.
6.2 Interaction of Individual Factors: Gender Norms, Parental Status and Work Hierarchy

6.2.1 The Role of Gender Norms and Parental Status in Influencing Work-Life Balance

The study raises several issues about gender norms and parental/family status. Firstly, the differences between gender and sector employment force female medical professionals with young children to request flexible working hours more often than male counterparts. In the East Malaysian social culture, women are still seen to be responsible for taking care of household duties and family care, whereas men are perceived as the ‘family head’ (ketua keluarga), responsible for providing financial protection and economic stability for the family. The results therefore indicate that most female nurses and doctors working in clinical departments face significant conflicts in balancing work and personal life as they are required to fulfil dual roles.

This situation is illustrated by the experience of MDR9, a medical officer in an administration department. The key reason for her transfer from a clinical to an administration department was to nurture and care for her one-year-old son and helped lessen her work-life conflict by having more time to spend with her young son and family. MDR9 also acknowledged the importance of gender norms in the Malaysian context:

In Malaysia, [the] women’s role is leaning more towards family matters such as raising children and helping their husband to take care of their family. The family is always more of a priority than self-fulfilment at work. Even though we have our career at work, we are still expected to be responsible for our family and to incorporate the traditional view of women with family (Interview, 24 January 2016).

The influence of this cultural view about women in Malaysia was also raised by NR5, a senior nurse in a similar administration department. She requested a transfer to administration to have adequate time to nurture her three young children. The lack of career progress for 13 years gave her the chance to focus on nurturing her children and take care of her family. As a mother, she viewed her role as teaching her children good values, religion and acceptable social norms in the society (Interview, 7 January 2016).
Interestingly, some unmarried female doctors working in clinical departments also wanted to transfer to administrative and management departments or district health clinics so that they would have less potential work-life conflicts. MDR5 stated she was looking forward to work in the district health clinic after getting married. Her view was that continuously working in hospital clinical wards could increase her work-life conflict due to the high intensity of work and long working shifts. She explained her decision to conform with cultural and gender norms which had little impact on her job security:

After getting married, I am planning to shift my focus to care for my future children. According to the Malaysian Labour Law, we will get 90 days paid maternity leave. However, after that, I would still need to nurture my children closely, I will need help but I want to spend more time with them. So, by working in these departments or clinics, I will have sufficient time with my family because it requires only standard working time (8:00 am-5:00 pm) with off-days on weekends. It doesn’t influence my career development at all, as the employment in the public sector is permanent with annual salary increments (Interview, 17 January 2016).

MDR3, a senior medical specialist in a general hospital in Kota Kinabalu, also had firm views about the role of men in the household and the importance of a stable career for the family. Therefore, the opportunity to work as a locum doctor helps to improve his earnings. However, this choice may lead to inflexible working hours:

Husbands play a key role as the family head (ketua keluarga). They are perceived as the main provider (breadwinner) for their family even though their spouse has a stable job. They [……] control the family finances, provide the necessities for their wife and children, primarily childcare and household bills, as well as providing a comfortable shelter for their families. It is important for every husband to hold [sic] steady wage employment which helps the economic sustainability of their family. Therefore, as a doctor, I am grateful to have the opportunity to work as [a] locum doctor because it will increase the economic security of my family. Even though, I will have less time with my family, it’s okay because they could understand my work commitment and tight schedules (Interview, 22 January 2016).
These responses suggest that, within the female cohort, female nurses and doctors working in administrative and management departments reported less conflict in achieving a balance between work and personal life compared to those working in clinical departments. Similarly, male doctors working in these departments also reported having less work-life conflict, due to standard working times rather than shift work.

6.2.2 The Influence of Employee Work Hierarchy on Work-Life Balance

Work hierarchy is another factor that influences employee work-life balance, well-being and work behaviour. Public-sector employment in Malaysia is regulated by the federal government body of the Public Service Commission of Malaysia: Suruhanjaya Perkhidmatan Awam Malaysia (SPA), and the MoH. Employment among public-sector employees is mostly permanent and pensionable. Salary, allowances, increments and other benefits also follow SPA policies. Doctor career structures comprises UD41 (Houseman Officer/Trainee Medical Officer), UD44 (Medical Officer), UD48 (Senior Medical Officer), UD52 (Medical Specialist) and UD54 (Senior Medical Specialist). Job promotion is time-based (seniority-based promotion); for example, a Houseman officer, UD41 must be working as a trainee doctor for at least three years before promotion to a medical officer (UD44). Nurses must hold at least a Diploma in Nursing for entry into the profession as Nurse U29 in the career structure. Job promotion profession is based on seniority, which requires nurses to serve at the U29 level for at least 13 years before being qualified or recommended for promotion to Sister/Senior Nurse (U32). They require a Bachelor in Nursing for promotion to Matron (U41). The highest level of employment for nurses in the public sector is Senior Matron/Head Nurse (UD45). The job responsibility and workload for matron and senior matron are supervisory which allows them to work in the national standard working hours, 8:00am – 5:00pm. Shift work is not required. These findings suggest a paradox in WLB where high-level employees (senior doctors and nurses) have less conflict because they are work standard working hours (8:00am–5:00pm) with less commitment to other activities outside working hours.

NR8, a head nurse (matron) reported she has less work-life conflict because she is no longer required to do shift work or work weekends. This allows her to spend more time with her
family and hobbies. However, there are situations which require her to extend her working time due to the demands of her position:

_During audit month, I feel too overwhelmed with all these administrative responsibilities; it could influence my job performance in the clinics or wards. However, this happens only several times in a year, which is still manageable with the help from my cohesive departmental team (Interview, 13 January 2016)._}

These experiences of work-life conflict were also shared by some doctors and nurses working in the administration and management department. MDR11, an Assistant Director in the State Health Department, stated his current job responsibilities and roles allow him more free time for personal activities compared to his previous tenure as a clinical doctor:

_Working according to the national standard working hours allows me to continue with my hobbies, spent more time with my family and friends, travelling and attend ... important family functions. In the past (during my clinical years), I could not do these activities because I worked in shifts and sometimes I had to extend my working shifts to attend work-related issues (Interview, 24 January 2016)._}

Moreover, some participants agreed that at the beginning of their careers, they were bound to work extra hours and follow decisions made by their supervisor. A lower position, normally held by the younger employees, has a higher work-life conflict because employees are required to work beyond regular hours.

MDR5, a medical officer (UD44) reflected on her Houseman officer tenure as challenging and frustrating. She felt the training could motivate many doctors in the public sector to discontinue their service within the sector. Since Housemen officers (HO) cannot choose their working shifts, it becomes a push factor for employee turnover in public hospitals. MDR5 found that:

_HO training is a very challenging period for most doctors in the country. The medical training was very exhausting... What frustrates most doctors are the long working hours, the inequality of task distribution, [and] task overloads, and this is not healthy..._
as it decreases our job performance and well-being. In some cases, these working conditions will lead for turnover intention among doctors in the public hospital (Interview, 17 January 2016).

Because junior medical professionals are still early in their career and have less family commitments, team members with parental duties often rely on them in an emergency. NR1, an unmarried nurse experienced this situation:

I often replace other nurses or even extend my shifts due to a request from a colleague, especially those who have young children in a situation which they must settle some personal matters. Since I am still single with less family responsibility, I do not mind extending my shift to cover theirs (Interview, 5 January 2016).

Thus, at the early stage of their career, doctors tend to have more job responsibilities which can determine their career development opportunities in the future. MDR4, a medical specialist, described intensity of the Houseman officer responsibilities in relation to his career development. He also stated that close and supportive supervision is crucial in promoting effective and efficient medical training for Houseman officer:

... because of extensive medical training, it is important to ensure supervisors have the sole responsibility to arrange schedules so these young doctors have a good foundation of medical knowledge and skills (common diseases, treatments, etc.). Supervisors are the ones who have the expertise and could see the gaps in their employees. Having said that, it may sound rigid and intense, but as a supervisor, I always make myself available for my team members to guide and teach them to become a better doctor. It is an exhausting training, but for those who success [sic], it will be a rewarding experience (Interview, 22 January 2016).

On the other hand, a mentoring program was implemented to guide young clinical nurses in the public and private sectors to ensure that they could adapt to their job environment and routine daily tasks. This practice was implemented to ensure all nurses working in the state of Sabah and Sarawak could understand standard practices and KPIs established by the state health department and clinical wards.
NR4, a sister (senior nurse), and NR8, the head of nursing (matron), both in a clinical ward of a public hospital in Kota Kinabalu reported that the mentoring practice is an initiative in every clinical department even though it is not stated in their HR policy. NR8 further said that due to the intensive working conditions, good support from mentors and supervisors is crucial. For this reason, that she proposes a formal mentoring policy in all clinical departments (Interview, 13 January 2016).

Most junior nurses agreed the mentoring program in clinical wards was crucial to helping them adapt to their job environment and daily routines. The guidance and close supervision of their assigned mentor helped decrease medical errors due to inconsistencies in practice. All junior nurses acknowledged the outcomes and benefits of this program. NR3, a nurse who recently transferred from Peninsular Malaysia acknowledged the effectiveness of the program in improving her job performance, competency and confidence in performing medical tasks and procedures. She explained the differences in medical practice between Peninsular Malaysia and East Malaysia:

*As a nurse in this hospital, we were assigned to take the patient’s blood. This medical procedure is not practised in Peninsular Malaysia—only doctors could perform this procedure. One of the reasons nurses are allowed to perform this medical procedure is due to the lack of doctors in this state. With guidance from my mentor, I could perform this task since I [had] not done it for a while....This mentoring program should be formalised so that it helps both doctors and nurses in coping with the needs of their job and improving ... department performance* (Interview, 20 December 2015).

Supportive supervision in this context is crucial and evident through the practice of mentoring, teamwork, supportive supervisors and team leaders. Mentoring programs intend to guide employees to adapt to the working culture and be familiar with common medical practices. Medical professionals in these two states have diverse medical knowledge, cultures, and values. The investigator’s interviews and observations suggest that this is due to (i) education/ medical training background), (ii) cultural background (e.g. Peninsular versus East Malaysia), and (iii) the capacity to adapt to the East Malaysian culture. This diversity forces organisations and supervisors to be more attentive in their supervision towards staff.
Cohesive teamwork reflects the collective working culture in East Malaysia, and most employees are helpful in taking over shifts or extending their work shifts to cover for colleagues during an emergency. Supportive supervision and team leadership are also crucial in employee career development, especially in giving support to pursue medical training and development.

6.3 Collective Workplace Culture and its Influence on Work-Life Balance

The collective workplace culture in East Malaysia is another key influence shaping employee well-being and work behaviour that accommodates and contributes to greater WLB. National cultural values in Malaysia are mainly collectivist (Bochner 1994; Burns & Brady 1992) and characterised by group-oriented connections, activities and goals which value cooperation, helpfulness, obedience, dependence and interpersonal relationships (Hassan et al. 2010; Keshavarz & Baharudin 2009; Kling 1995). These cultural values shape the Malaysian workforce which privileges group-orientation, group harmony, avoiding confrontation and respecting the elderly and authority. Cultural values also draw on human orientation concepts which emphasise being empathetic towards each other in the workplace which helps to achieve flexibility in working hours (Abdullah 1996; Hassan et al. 2010). Most participants agreed that it is important for everyone to take responsibility for fellow members of their team during an emergency.

NR2 and NR3 nurses spoke about the working culture crucial during an emergency. This collectivist culture suggests cooperation and helpfulness that allows them to empathise with the personal situations of their colleagues. Both nurses agreed that the willingness of their colleagues to take over and cover for them during their shifts was a crucial practice that helped them to achieve work flexibility. Typically, colleagues understand that sometimes emergency, family and/or personal matters may require staff to take emergency leave or be late for work. NR2, a mother with three children under the age of 12, described how this works:

_There are times where I do have to request for last-minute emergency leave.... In a situation to attend a school (PTA) meeting or if my kids are sick (I should bring them to the clinic); my colleagues understand this situation and are willing to replace_ [and
support] *me during this emergency* [or] *difficult situation* (Interview, 20 December 2015).

This collegiality was also the experience of NR1, a male nurse working in a similar general hospital for three years. He spoke about the benefits of the collectivist culture:

> Since we have excellent relationships among team members, we do not have any problems to replace anyone if they have important matters to do at that time. In this hospital, we must work collectively as a team— all nurses need to instil this value in themselves. I often replace other nurses or even extend my shifts due to a request from a colleague, especially those who have young children in a situation which they must settle some personal matters. Since I am still single with less family responsibility, I do not mind extending my shifts to cover theirs.... However, I am expecting the same treatment from them as well during an emergency (Interview, 5 January 2016).

In the private healthcare sector, limited staffing can potentially decrease the flexibility in working hours, where employees work in shift arrangements. However, both NR6 and NR7 agreed that team cohesiveness and the willingness of colleagues to take over shifts is the key to work flexibility. The support of their supervisors in approving last-minute leave requests during an emergency is another significant factor in facilitating flexibility.

In respect to doctors, MDR7 (UD 44) also spoke about the collectivist working culture in East Malaysia facilitating work flexibility. MDR7 had recently transferred to a district hospital and spoke about the cooperation between department teams that allows doctors to have some flexibility in working hours. The preparedness of their colleagues to replace them, especially during an emergency, depends on the availability of their colleagues and their willingness to take over their shift (Interview, 17 January 2017).

The working culture in the East Malaysian healthcare industry may be heavily influenced by the unique culture of the professions, and not only those of the organizations (e.g. as a public/private hospitals or clinics) and of the society (e.g. collectivism). However, there are numerous studies in the health care industry, for example regarding emergency department teams, in Western countries, that highlight the unique working culture that forces them to
back up colleagues. It is also often driven by the strict standard of medical procedures (SOP) or high organisational citizenship behaviours, and not due merely to societal culture, namely collectivism versus individualism. In the East Malaysian healthcare industry, this can be reflected by the intense nature and high-demand regulation of work which also affects employee WLB, well-being and work performance. A shortage of doctors and nurses in these two states were confirmed by most doctors who participated in the study. They reported that shortages have a significant impact on work flexibility which leads to high intensity of workloads and a demand to cater to large numbers of patients.

MDR1, a medical officer (UD44), argued that the national issue of doctor shortages had led to inflexible work hours. Similar to the nursing profession, doctors can request monthly rosters. However, most times, the outcomes of such requests do not reflect their preferences. MDR1 reported that the situation is worsening for Houseman officers, and reflecting on his experience said:

...during my attachment as a Houseman officer, any personal request in the monthly roster is almost impossible. Our boss (a medical specialist) is the final decision maker. We have to work according to the schedule given by them. Is this fair? My response is yes and no. Yes, in a way that we need intensive training since we graduate from different medical schools (e.g. internal vs. external universities). However, is it fair for a human being to work for 24 to 36 straight hours? No-This situation will cause exhaustion, stress and lead to decreased job performance (Interview, 10 January 2016).

The issue of manpower shortages and inflexible working hours was addressed by MDR3 (UD52), a senior medical specialist and head of a clinical department in a general hospital in Kota Kinabalu. He was responsible for arranging subordinate work schedules, departmental manpower planning and medical operations procedures and schedules. He stated that:

This occupation is a 24/7 job. You must always make yourself available due to the nature of the profession especially if you are assigned to the general hospital. Expect massive; I mean huge! a massive number of patients, it is endless! On top of that, we have huge manpower shortages—this means that we should expect inflexibility in our
working hours. This issue (shortages of doctors) has been highlighted for several years now since I started working in this state, about eight years ago (Interview, 22 January 2016).

Heavy workloads patient demands and the nature of medical work make it hard to have flexible work arrangements. MDR4, a medical specialist in a general hospital in Kota Kinabalu, stated that most doctors in the public sector are aware of the high workloads. They are expected to stay in clinical wards to monitor patient pre-and post-operation (Interview, 22 January 2016). This view was shared by MDR1 who also explained the nature of public healthcare policy in Malaysia. Public healthcare offers the lowest price-per-treatment which costs as low as RM 1.00 per consultation by government subsidised organisations. This attracts large numbers of patients, which, under customer service policy, all medical professionals must ensure they meet the demands and needs of their patients during their shift. This situation leads to inflexible working arrangements because doctors must attend clinical wards or clinics most of the time. In most cases, they are also expected to work extra hours if there are patients still waiting in line (Interview, 10 January 2016).

Even though the healthcare industry in East Malaysia are facing the shortages of medical professional, the collective culture, where possible, mitigates this problem and help established adequate work-life balance. This strong support and the willingness of colleagues to help employees balance work and personal life, preserves well-being and improves the work performance of their respective departments. Both doctors and nurses in East Malaysia value a work culture that emphasises the needs and goals of their department and staff rather than individual needs. The welfare and care of their patients is their primary responsibility and therefore, a collective work culture is important to maintain a high quality of care and service in the workplace. Like elsewhere, they have a strong commitment to patient care and well-being. Both professions believe in working efficiently and closely as a team which requires them to support each other and produce the best outcomes in their jobs. They tend to put their patient needs ahead of individual needs, but rely on their colleagues in an emergency. Thus, based on these interviews and observations, a collective working culture and the concept of supportive supervision are the key components in establishing flexibility in working hours and family friendly work practices in East Malaysia.
6.4 The Perceived Value of Money by Medical Professionals

6.4.1 Extending the Perceived Value of Money Concept through an East Malaysian Perspective

Initially, in Chapter 2, the concept of the perceived value of money was defined as the frame of reference and symbol of success in which medical professionals evaluate their everyday lives. Their perceptions are dependent on employment status and the amount of compensation and benefits they receive from their job (Tang & Chiu 2003; Tang et al. 2002). The investigation extended this concept by incorporating two factors from the case study of medical professionals in East Malaysia. Firstly, this study found that medical professionals value their permanent job status which contributes to providing a stable monthly income to ensure economic stability and job security. Secondly, in terms of the amount of compensation and benefits, the importance of financial retirement plans for future stability was reported as a critical aspect, rather than the amount of their current compensations and benefits. This is because security is more critical in planning long-term financial stability. All medical professionals in the public sector agreed they have high job security due to the permanency policy regulated by the Malaysian government and several private agencies. This factor significantly influences how money is valued.

As a doctor in public sector, MDR2 has a permanent and pensionable position. It also guarantees a stable monthly income with consistent annual salary increments and bonuses. These increments apply to all job levels across the service. MDR2 reported that, in comparison with a private sector employee:

As a public service officer, I do not have the feeling of insecurity even [when] receiving poor performance appraisal results—The worst situation that could happen is a transfer of service to another state or district hospitals/clinics! In the private sector, job security depends highly on individual job performance and the financial performance of the organisation (Interview, 10 January 2016).

MDR11, another doctor in a public hospital, stated that the high-level of job security and ‘equal opportunity’ in salary increments was an excellent attraction strategy for the sector
(Interview, 24 January 2016). NR2, a nurse in a public hospital also reported that a high job security helped to improve life stability. She favoured the standard salary increment policy as it helps to increase trust among co-workers. She believed that individual pay-for-performance could lead to the issues of favouritism and increase perception bias among co-workers which influences employee motivation and feeling of unfairness. (Interview, 20 December 2015).

In the private sector, there has been a noticeable shift in HR practices in recent years. NR7 mentioned the high probability of transfer of service for private sector nurses from contract to a permanent job position after several years. This opportunity will depend highly on job performance and seniority. She explained the importance of this ‘improvement in policy’ in relation to nurses’ retention and attraction strategy to work in the country:

There are a huge number of nurses attracted to work in the Middle East as they provide many employment benefits (e.g. higher salaries, free accommodation, transportation, free plane ticket once a year, etc.)….Therefore, to ensure our nurses feels secure [in] their job, it is important to offer them a permanent job position. A permanent job position helps to guarantee long-term economic stability. It could attract and retain our nurses to work in the country as we do have huge shortages of nurses (Interview, 7 January 2016).

This study also extended the concept of the perceived value of money by incorporating the importance of financial retirement plans for future stability. All participants from both public and private sectors agreed that the nations’ financial retirement plan is the key for them to live a stable and balanced life in the future.

In Malaysia, public-sector employees are given two options for financial retirement: (i) an employee provident fund scheme (EPF) or (ii) a pension plan. The EPF scheme requires the employee to invest an amount of their salary (around 13%) to their retirement fund. On top of that, their employers are obliged to contribute around 15% to their respective employees. Employees can access these savings after their retirement age. The pension scheme is a retirement plan that allows employees to receive around 50% of their basic salary after retirement until their death. Recently, the retirement age for public service employees was increased to 65 years from 55 years for women and 56 years for men. For private sector
employees, the only one option is the EPF scheme for their retirement plan, with the retirement age still in accord with the previous policy of 55 years for women and 56 years for men. However, several private companies are considering increasing the retirement age to 65 years following the current government policy (Personal note, 6 January 2016).

6.4.2 Different Perceptions about Perceived Value of Money among Medical Professionals

This study also thoroughly explored perceptions about the value of money in medical professions. In Phase 1, the survey data analysis showed that doctors had a high perceived value of money whereas nurses had a low perceived value. All doctors participating in this study reported that several policies imposed by the government allows them to earn a higher salary and leads to an increase of their perceived value of money. These policies include (i) locum practice (ii) time-based job promotion and (iii) a transparent career-development policy. They unanimously agreed that these opportunities help improve their well-being and livelihood of their family but could also potentially decrease job performance.

All doctors in this study are eligible to work as locum doctors in other private hospitals or clinics, with many working as locum doctors. The locum policy gives them the opportunity to be paid on hourly service. It has increased their ‘love’ and value of money. Most male doctors have no issue with a trade-off in family and personal time because this job opportunity helps them to improve the economic status of their family. This is because their female partners attend to family and domestic responsibilities, which allows them to work overtime.

MDR8, a father of two young children who works as a doctor in a public clinic, emphasised his role and its necessity in improving his family’s economic status:

The benefits and allowances of working in a public sector are fixed. As a father, it is my responsibility to provide and improve the economic status of my family. So, by taking locum hours, it helps to provide economic stability to my family. I will be compensated at least RM45.00/ hour. I will usually work as locum doctors at least 8–10 hours per week. The money is great! (Interview, 7 January 2016).
MDR2, a medical officer, also favoured this policy, but reported that sometimes the situation decreased time to pursue hobbies, spend quality time with his family, and impacted his job performance.

Well, money does motivate me to work and, with this generous policy, it increases my earnings. However, I have to sacrifice... some activities (hobbies) on my free time, and I may not be able to attend some family functions such as birthdays, anniversaries, weddings, etc. Besides, taking too many locum hours sometimes could decrease my job performance because of sleep deprivation and fatigue (Interview, 10 January 2016).

Most unmarried doctors stated that they regularly worked as a locum due to lower family commitments. MDR1 explained his experience as well as the importance of earning extra income through the locum:

I enjoyed working as a locum doctor after hours or during off-day because of the extra pay! I do not have any relationship commitments, and being young, I am taking advantage of this opportunity to work hard for the money so that I can live a better life in the future (Interview, 24 January 2016).

Surprisingly, this study revealed that some female doctors with parental duties sometimes declined these opportunities to attend their domestic family responsibilities. As previously mentioned, women in East Malaysia are responsible for the household and family-care duties. MDR9, a doctor in the administration department, shared her views about this situation:

After marriage, I... stopped working as a locum doctor because as a wife, I have a greater responsibility in the home. My domestic responsibility... increased after the birth of my son; I must nurture and care for my children. Now, this is my primary role in life. However, it does not bother me because of my job security in a permanent position, the stable monthly income and annual increments (Interview, 24 January 2016).
A time-based job promotion policy also influenced doctors’ perceived value of money. All doctors stated this policy allows them to get standard annual salary increments, bonuses and other allowances. The job promotion policy is seen to value their work experience, unlike merit based systems (pay-for-performance) and helps to eliminate perceptions of bias in the collective working culture, especially with the issues of favouritism in relation to the performance based pay. MDR9, a medical officer, briefly explained the job promotion process and its influence in avoiding conflict in the workplace:

_In...time-based job promotion, a doctor is required to work at a job level for several years. For example, a Houseman officer (UD41) must work in this job position for at least 2–3 years. Then, he/she will be promoted to UD44, a medical officer. This ‘seniority-based promotion’ is important in the profession as it reflects our maturity and skill levels as a doctor. For example, if a junior doctor [was] promoted to a senior medical officer after only three years, it could create mistrust in the minds of our clients (patients) [regarding] his/ her medical skills level. Besides, this policy also will eliminate favouritism and nepotism in the professions (Interview, 24 January 2016)._

In respect to nurses, the survey analysis revealed that the perceived value of money did not moderate the relation between WLB, well-being and work behaviours. In interviews, this study explored the stagnant career progress for nurses in the public sector that contributed to their perceived low value of money in the profession. Junior nurses (UD29) are bound to work for at least 13 years before promoted to senior nurse (UD32). Their job promotion depends heavily on their seniority and the completion of post-basic nursing certifications. In recent years, the MoH proposed to reduce the seniority requirement to 7–8 years, but it is still an unconfirmed policy.

Some nurses revealed that a stagnant career progression gave them the opportunity to switch their focus to nurturing and taking care of their family. This suggests that being aware of the lack of career progress lowers their job expectations, but increases their life satisfaction. NR4, a senior nurse in public sector, illustrated this trade-off:
Yes, it’s a bit sad with the situation of our career progress, but at least it gave me an opportunity to attend the needs of my young kids. Nursing is a routine job and (Yes!) sometimes we may have to extend our working time, but at least this job is a permanent post. So, we will still get the annual salary increments and bonuses. Then, the support from my team, especially during an emergency, allows me to have some flexibility. For an example, I do have time to attend the school PTA meeting for my children. I am a mother and I am responsible for the needs of my children (Interview, 13 January 2016).

NR5 spoke about the potential drawbacks of the progression policy in terms of the retention of nurses, especially the impact of routine tasks that could lead to boredom and decrease in motivation. However, permanent job status, as well as the annual salary and allowances increments, has a significant impact on retaining nurses in the sector. The study indicates that most nurses favour these policies given their ‘confirmed’ job promotion in the future, so career stagnancy for several years does not have a huge impact on their life and career because of low expectations and gender roles (Interview, 13 January 2016).

This study explored explanations for differences between doctors and nurses in the perceived value of money. Organisational and institutional policies drive these differences. The locum policy, time-based job promotion and transparent career development appears to increase doctor-perceived value of money. However, stagnant career progress for nurses lessens their perceived value of money. Nevertheless, both professions unanimously agreed that permanent job status is a key retention strategy as it provides economic and life stability. They also favoured seniority-based promotion and work experience. In a medical industry based on a collectivist society, this is seen to reflect skill levels and career maturity, which increases the respect and trust in their professions.
6.5 Discussion

6.5.1 Human Resource Management in the East Malaysian Healthcare Industry

Similar to most countries in Asia, there have been several changes in human resource practices in the healthcare industry of East Malaysia. The results of this study support the previous study conducted by Zhu et al. (2007) which revealed that most organisations in Malaysia are rigorously adopting the HPWS oriented to HRM practices due to the process of globalisation. The healthcare industry in Malaysia is reshaping its HR practices due to emphasis on being a health tourism destination promoted by the Malaysian government. This industry became one of the largest economic contributors to the nation as the country is known as a popular destination for medical tourism, as it provides one of the best services in the region (Allianz 2013). Thus, the healthcare industry has been forced to develop competitive HR practices to retain and attract employees to work in the country and to provide high-quality healthcare services to the locals, expatriates, visitors and tourists.

Regarding the concept of HPWS, there has been some evolution of HR policies and practices in the healthcare industry at the national level. These practices have been referred to as innovations, flexible work practices, work reforms and new work practices (Godard 2001). And an organisational policy that promotes WLB is one element that supports the concept of HPWS (Nord et al. 2002). WLB has also become an emerging issue of concern among the workforce in Malaysia. This study found that there were several continuous improvements by the government in the implementation of family-friendly work policies and policies designed to improve female participation in the labour market. The findings of this study support the study conducted by Noor and Mohd (2015) and Ahmad (2007) which indicated there has been an evolution and reformation of several HR policies that support the concept of WLB including: (i) flexible working arrangements, (ii) childcare policy and (iii) leave policy. Most participants supported and favoured these policies especially the parental leave policy of 90 days and 60-day maternity leave. In Malaysia, where women are still viewed as responsible for household duties, this policy allows female employees to have sufficient time to nurture newborn children while still retaining their full-time job.
One strategy for an organisation to improve employee WLB is providing and continuing to improve tools that support this initiative (Chandra 2012). In the case of the healthcare industry in East Malaysia, this is evidenced by the efforts of the MoH in continuously improving several HR and employment policies that promote WLB, such as flexible working environment (Employment Act, 1955), Childcare Act, 1984 and paid Maternity and paternity leaves (Employment Act 1955, Section 37). Participants in this study collectively recognised the benefits of these policies in supporting the concept of work-life balance. It assisted them in improving their work performance as well as providing adequate time to nurture and care for their families.

Specifically, in East Malaysia, the State Health Department and hospital management were also systematically improving their HR and operational practices to assist doctors and nurses to achieve a WLB. As proposed by Barnett et al. (2010), organisations need to implement strategic initiatives and practices to deal with the shortages of nurses in Malaysia to improve the attraction and retention of staff. In the context of East Malaysia, this study revealed that the mentoring practice and close supervision was implemented across both public and private sectors. This study highlighted the success of the mentoring practices as it provides a closed guidance and on-the-job training to young nurses from different states to adapt to medical practices in East Malaysia. For doctors, this study revealed that close supervision by senior doctors was important in guiding trainee doctors on the job. Mentoring practices could reduce potential occupational hazards and help improve nurse competencies.

Finally, the perceived successes of the implementation of WLB practices and initiatives by both government and organisations rely heavily on the collective working culture in hospitals and clinics. This study supports the previous study by Khoo (1999) and Manion (2004) which revealed that Malaysian uphold the core values of shared values and community orientation and relationships are builds based on trust, mutual respect and strong teamwork. In comparison with the individualism and active competitiveness in the Western culture, which can decrease collective teamwork, participants in this study agreed that their trust in their team and their willingness to take over shifts during an emergency could decrease work-life conflict. Thus, most doctors and nurses agreed that good relationships with team members and supportive supervisors could lead to improving their well-being, work performance and organisational commitment.
6.5.2 Conceptualising Work – Life Balance in the Context of East Malaysian Healthcare Industry

The results of this study have extended work conducted by Pocock et al. (2012) ‘about how work, family and communities “fit together” and are shaped by the larger social context’ (p. 399). In this study, the larger social context adapted and extended the conceptualisation of work by relating this context to human resource management. All participants in this study agreed with the necessity of their job in providing economic stability and security for them and their families over both the short- and long-term period. The following discussion on re-conceptualising WLB focuses on a deeper analysis of the domain of work in relation to the nature of work and employment, supervisor-supervisee relationships, the location of work and the social factors of culture and gender roles.

The first level of work is ‘the job’ (Pocock et al. 2012). The analysis in this thesis shows that the intense nature of work and manpower shortages affects WLB. Most medical professionals believed the shortages of doctors and nurses in these states could potentially decrease flexibility in working hours and increase work-life conflict; a finding consistent with Tanaka et al. (2011) and Barnett et al. (2010). Both researchers found that shortages of manpower could lead to longer working hours that in turn influence work behaviour among medical professionals. The public healthcare sector provides the cheapest service cost, which attracts large numbers of patients and increases job demands for both professions. Most participants agreed that this situation could lead to unscheduled and unreasonable organisational demands for large patient numbers and shortages of manpower. In addition, nature of doctors’ work also could impede WLB. This result is consistent with a study by Aryee and Tan (2005) that predicted that doctors with a high burden of responsibility were likely to experience exhaustion, fatigue and decreased time with family. In addition to long shifts, doctors in this study also highlighted the requirements to extend their work shifts for observing patients during pre- and post-operation. Moreover, some doctors who regularly work as locum doctors also reported having a significant work-life conflict. These intense work demands could influence job performance and well-being due to fatigue, exhaustion and sleep deprivation.

Workplace factors are another aspect that can influence employee WLB (Pocock et al. 2012). The study found workplace factors such as organisation size and structure, supervision
practice, workplace culture, gender composition and culture will influence employee WLB. All clinical doctors and nurses reported having higher work-life conflict compared to their colleagues in administration and management. As elsewhere, in East Malaysia, clinical employees are required to work on fixed schedules and their monthly rosters are organised by their supervisors or head of departments, whereas employees in administrative departments work according standard working hours. Working in shifts and fixed schedules could create work-life conflicts due to inflexibility. In at least some cases, this practice triggered female nurses and doctors with parental status to request transfers of service to administrative roles. Some clinical employees claimed this decision was due to the difficulty in balancing their career with household and domestic responsibilities due to the demand to work overtime and the burden of excessive shifts. This situation was similar to the experience of the nursing profession in Japan (Japanese Nursing Association 2007; Tanaka et al. 2011).

Workplace culture and supportive supervision have a greater positive influence than organisation policies and practices in promoting employee WLB. This is because, despite flexibility being formally granted, practical access to flexibility can frequently be obstructed when workloads are excessive (Pocock & Charlesworth 2015, p. 38). The collective working culture (Abdullah 1996; Hassan et al. 2010; Keshavarz & Baharudin 2009) is critical in the Malaysian context for establishing work flexibility and family-friendly practices. The concept of collective social support helps ease possible work and family conflicts among participants with parental duties. They depend on the good-will of their colleagues to replace them during an emergency. Most participants expressed their willingness to extend their shifts for their colleagues, given the priority to care for patient well-being. This situation illustrates that a collectivist culture of East Malaysia can facilitate team collaboration, dependency and strong commitment. This helps to establish work flexibility in a high-intensity work environment with labour shortages, such as the healthcare industry in East Malaysia.

The mentoring program set up by the nursing profession, as well as the close supervisor support practised by the medical profession, was the key to establishing substantive supervisor and department support. These practices are crucial in guiding employees in the medical practices and procedures as well as helping them to adapt to the working culture and environment in East Malaysia. This study revealed several different characteristics among employees due to their medical training and cultural backgrounds (e.g. Peninsular and East
Malaysian). This is consistent with a study conducted by Al-Dubai et al. (2013) which suggests that appropriate mentorship, sufficient motivation and fair assessment are the keys to preventing emotional burnout among employees. For doctors and nurses in this study, adequate support from supervisors, mentors and colleagues was crucial to lessen work-related conflict and increase the quality of work. In a collectivist society of East Malaysia with high-power distance (McShane et al. 2015), employees have respect for superiors; they are dependent on their decisions and comfortable in receiving instructions from them. Therefore, mentoring and close supportive supervision is an effective workplace practice. Participants in this study agreed their supervisors and heads of department have excellent medical competencies and skills as well as being their ‘point of reference’ for consultative matters. They also recognised several key competencies of their superiors which include their medical knowledge and skills, high job integrity and cognitive and practical intelligence (McShane et al. 2015). Thus, their superiors can play a major role in creating a workplace that promotes WLB by reducing work-life conflict and improving well-being and work behaviour.

This study also revealed a similar trend in employment in Malaysia to affluent western countries, such as the increase of dual-earner families and number of working women in the industry (Hassan et al. 2010). Regarding gender norms, women with parental roles reported having a higher work-life conflict than their male counterparts. Women in East Malaysian society have a dual-role as a working woman and a mother at home. Most female employees from both sectors reported that it was necessary for them to nurture and care for children and take responsibility for household and domestic duties. Most female nurses and doctors working in clinical departments face significant conflicts in keeping a balance between work and personal life as they are required to fulfil both roles. Therefore, they often request flexible working hours and replacements during an emergency. This study also revealed the tendency for female doctors to apply for a transfer of service from a clinical department to a district clinics or administrative roles because of the pressure to fulfil their domestic roles. On the other hand, this study supports the study of Razak et al. (2011), which revealed that spousal support could lessen employee work-life conflict. This situation was illustrated by male doctors and nurses who reported less work-life conflict because of their spousal support and understanding about their roles as *ketua keluarga* (family head).
For the most part, the results of this study were consistent with the role of balance theory proposed by Marks and MacDermid (1996). In this study, medical professionals with more stable role systems have greater well-being and better work behaviours. In this regard, supportive supervisors and management and cohesive teamwork will improve employee well-being and job performance. The results from the Pearson correlations (r) also suggested that there were correlations between supportive supervision towards employee well-being and work behaviour (see tables 5.15 and 5.16). Besides, it is also assisted by continuous improvement in human resource policies in the healthcare industry. The empathy and support from colleagues is also enhanced by the collective culture which enables flexible working arrangements and family-friendly practices.

This study revealed the criticality of a collective working culture which helps to established WLB despite the high demands and intensity of work with staff shortages in the East Malaysia healthcare industry. Both doctors and nurses stressed the importance of the mentoring and close supportive supervision in the workplace to promote a positive, productive and a cooperative work environment which could improve their work performance and quality of work. Finally, gender norms significantly influence employee work-life conflict, while a collectivist work culture helps to ease their situation. A culture that values dependency and close collaborations between team members and a strong team commitment provides work flexibility, family-friendly environment and fair balance between work and personal lives.

6.5.3 Conceptualising the Perceived Value of Money by Medical Professionals in the Context of East Malaysian Healthcare Industry

This study has extended the explanation of this concept provided by Tang and Chiu (2003) and Tang et al. (2002) from the perspective of medical professionals in East Malaysia. Both doctors and nurses stated that the importance of money in their lives was more than the amount of monthly salary and allowances. Their perceived value of money reflects their frame of reference and success, the importance of their job status and job security in providing economic stability and long-term financial security. Participants emphasised the importance of planning for financial retirement for future economic and financial security and stability.
This study extended the explanations of the two concepts of factor motivator and factor importance in the LOMS developed by (Tang et al. 2002) and (Tang 1995) adapted for this study. Money as a factor motivator refers to employee attitudes to working hard to earn more money (Tang 1995; Tang et al. 2002). In this study, this situation can be explained by participant perceived importance of their current income in providing support for their spouse, children, parents and family members and the need for future stability. On the other hand, money as factor importance reflects on the perceptions about the important roles of money in individual life (Tang 1995; Tang et al. 2002). In this research, this situation was reflected by participant views on job and income stability that provide freedom and security. They reflected on the importance of their financial retirement plan for future stability as well as the status of their employment. Most participants preferred permanent job status because of high job security and stable income, annual increments and other employment benefits. This study also confirmed that compensation and benefits as well as job security were still an effective tool for employee retention, attraction and motivation.

The study revealed the high perceived value of money among doctors compared to nurses. This study discovered two key themes that justify this situation: (i) compensation and benefits structure and (ii) career development structure.

Locum income, time-based (seniority-based) job promotion and a transparent career development policy will lead to increase doctor perceptions towards the value of money. Most doctors also agreed that even though these policies improve earnings, it leads to reduced time with family and friends other activities and hobbies. This study also revealed that life satisfaction and long-lasting happiness is not subjected to higher salary alone. The results of this study support Lee’s (2006) study, which suggests that despite different cultural and economic settings, employee perceived value of money is comparable to other countries.

Moreover, the results of this study also support the association of doctors with a Type A personality behaviour pattern (Tang 1995). This study revealed that most male doctors have high job involvement, are upwardly mobile, have pride in their work and value accomplishment and success (Burke & Deszca 1984). This is due to the gender norms in East Malaysia which associates the role of men as *ketua keluarga*. Men are perceived as the main provider for their family and doctors are one of the highest paid professions in Malaysia.
High-income individuals often believe that the capability to earn money is based on their effort and ability (Furnham 1984a).

On the other hand, this study revealed that nurses have a low perceived value of money in their profession due to the 13-year stagnant career development progress in the public sector. In addition, the majority of nurses who participated in the survey and interviews were female. In East Malaysian society, women with parental duties are responsible for their domestic roles. The stagnant career progress enables them to shift their focus to household and domestic roles. Most female nurses and doctors stated that they would have a better well-being and life satisfaction if they could successfully fulfil both work and domestic roles.

The current study expanded Adams’ (1965) equity theory by reflecting on the fairness of the job promotion process in the context of an Asian country with a strong collectivist values. Most doctors and nurses favour ‘seniority-based promotions’. This process values and rewards employee work experience, seniority, level of medical knowledge and skill evidenced by medical certification (e.g. post-basic certifications for nurses and medical specialist degrees for doctors). In a collective culture that values group harmony and respecting the elderly (Hassan et al. 2010; Keshavarz & Baharudin 2009), these promotion practices seem to limit favouritism, avoids disputes among colleagues and encourages motivation.

6.6 Summary

This chapter presented and analysis and discussion of themes emerging from the interviews. It identified and discussed two key themes critical in influencing employee WLB and its influence on well-being and work behaviour: (i) individual factors and (ii) collective working culture. The study expands the concept of the perceived value of money (Tang 1995; Tang et al. 2002) by identifying two explanations for discrepancies between doctors and nurses. Compensation and career development structures influence these differences. The next chapter presents and discuss two other key themes: the meaning of work and life contentment which directly influence employee perceptions of WLB, attitudes towards money, compensation and benefits, well-being and work behaviour.
CHAPTER 7: THE MEANING OF WORK AND LIFE CONTENTMENT OF MEDICAL PROFESSIONALS

7.1 Introduction

This chapter presents the analysis and discussion of two key themes that emerged from the qualitative study and contribute to understanding of WLB in the Malaysian context. Chapter 2 of the study proposed that other factors could influence employee WLB, perceived value of money, employee well-being and work behaviour. The analysis in Phase 2 suggested that the concept of the meaning of work and life contentment can significantly contribute to identifying others issues that influence WLB and the perceived value of money. These issues will help to expand the concept of WLB and the perceived value of money specifically in the East Malaysia context and could contribute to a more comprehensive WLB model for future the research.

The chapter begins with an analysis and discussion of the concept of meaning of work focusing on enrichment of the meaning of work as tangible and intangible factors and ‘calling’ versus ‘career’ work orientation. Then, it analyses and discusses the individual perception on the concept of life contentment by exploring how this is experienced in 4 healthcare settings: (i) management and administration, (ii) public city hospitals, (iii) public district hospitals/clinics and (iv) private city hospitals.

7.2 The Meaning of Work Influences: Relations between Work-Life Balance and Employee Outcomes

7.2.1 Expanding the Meaning of Work Concept

The study revealed that the concept of the meaning of work could moderate relations between WLB and employee well-being and work behaviour. Initially, the study defined this concept as employee perceptions of their job to: (i) contribute to the economic maintenance of their family; (ii) allow employees to have a positive impact on the organisation they work with;
and (iii) perceived their job as self-expression (Colby et al. 2002). In understanding the concept of the meaning of work in the context of East Malaysia, the study suggests that individual meaning of work comprises: (i) an individual feeling of accomplishment through recognising that their medical skills and capabilities will make a difference to patient lives; (ii) trust and respect given by the society to the profession; and (iii) the role of their job as the main contributor to the economic maintenance and stability of themselves and their family.

7.2.2 The Tangible and Intangible Meaning of Work

The study enriched the concept of the meaning of work by providing in-depth explanations of the tangible and intangible of meaning of work. The tangible meaning refers to the physical aspects of compensation and benefits packages such as monthly income, annual increments, bonuses and permanent job status. Both professions agreed that these employment benefits could assist them to provide the necessities for their family, spouses, partners, children, parents and other family members. Having a job guarantees stability and security in life. This feeling helps to improve well-being as well as motivation and performance at work.

Medical officer, MDR1 emphasised the criticality of a stable monthly income to help planning his monthly and long-term financial commitments. Continuous and stable earnings helped him contribute to his parents, his savings and make several property investments. This financial security increased his job and life satisfaction (Interview, 10 January 2016). In addition, medical officer MDR9 stated that the permanent job status and stable income helped her to contribute to her family economic stability as a secondary income earner. She mentioned that:

*The current increase in the current cost of living due to the country’s economic situation makes me grateful to work full-time. My income as a doctor could ease the financial stress in my family as I could support my husband to pay my children’s education insurance as well as supporting our extended family, especially my mother in-law, who needs financial assistance for medical treatment* (Interview, 24 January 2016).
Her views were confirmed by NR4, a female nurse who stated that the permanent job status, annual increments and monthly salary helps alleviate the financial burden of their household. She described her monthly financial contribution as follows:

> *My husband and I usually split the monthly bills. My financial responsibilities are for groceries, children and tuition fees, electricity and water bills, whereas my husband is responsible for our house mortgages and maintenance, two car loans and long-term family savings. Besides, our annual bonuses contributed to our family holiday or will be kept for an emergency situation* (Interview, 13 January 2016).

Therefore, these findings suggest that the tangible meaning of work is reflected by the perceptions of the job as a source of economic fulfilment and maintenance. It then improves an individual’s feeling of joy and satisfaction because it allows them to provide the necessities for their close and extended family members and underpins financial security. The intangible meaning of work for doctors and nurses was reflected by the positive psychological influence of their job which affects well-being and work performance. In the case of East Malaysia, these aspects were highlighted by three factors: (i) recognition of professional skills and capabilities in making difference in other people lives (e.g. patients); (ii) societal trust and respect towards the profession; and (iii) involvement with local community services.

MDR3, a senior medical specialist, reported that he felt satisfied with his job through recognising that his medical skills and capabilities could make a difference to patient lives. Even though he faces intense pressure at work and demanding workloads, he felt his job was meaningful because it helped saved lives. He expresses his feelings of contentment as:

> ... *Seeing my patients smile again and their family feeling relief after their recovery as well as observing their stable condition and recovery from a major medical operation, makes me feel that I did something meaningful... I feel satisfied with my hard work and it leads to makes me feel happy at home* (Interview, 22 January 2016).

MDR1 also reported a similar experience. He described his job as high risk because he was dealing with human lives. This gave him a great feeling of meaningfulness if there were no
errors or if he could help reduce serious risk during surgical procedures. He gave credit to his team members as well for their effectiveness and efficiency during operations (Interview, 10 January 2016).

The trust and respect shown by the patient, their family members and society is another element that contributes to the meaning of work for medical professionals in East Malaysia. MDR8 reported that the trust given by his patients was shown in their willingness and openness to share their medical history with them. The faith of the patient is important to help doctors to identify and prepare medical procedures. He said that:

*Patients can be very transparent with their doctors when they share their medical history. They are willing to share several very sensitive medical issues such as their last sexual intercourse if infected with HIV. This issue is something very personal to them that they may not share with their close family members because it is still perceived as a taboo in our society. However, they trust our judgement as medical professionals. I perceive this as the highest confidence in this profession and it makes me feel that I am doing something meaningful and could change their life* (Interview, 22 January 2016).

MDR5 further stated that the trust given to the profession extends to the faith that family members and relatives show during surgical procedures. She said that they respect their decisions and explanations without any doubt or argument (Interview, 17 January 2016). NR4 also shared her views that community admiration and respect about their decisions makes her feel she is doing a meaningful job (Interview, 13 January 2016).

Both professions also acknowledge their service to the local community as an essential element that contributes to the meaning of work. MDR6 stated that his job indirectly links to the development of and shared responsibility for the community. She enjoyed her involvement with community services including visiting rural areas for medical checks, health awareness programs and other activities. These activities help her learn about the community culture and reciprocally earn respect for her profession (Interview, 17 January 2016). MDR5 also reported that her involvement with community service programs makes her job meaningful:
I feel accomplished and satisfied whenever I undertake any community service.... I feel satisfied whenever I share my knowledge to improve their knowledge.... I know that our people, especially in the rural and remote areas, do need some help and knowledge about dealing with health issues, especially sensitive health problems such as breast and cervical cancer, malaria and others. This involvement is very personal to me because I am indirectly helping my people! (Interview, 17 January 2016).

Therefore, the intangible meaning of work in the healthcare industry in East Malaysia expressed by both professions lays in the recognition of their skills and capabilities in making a difference in other people's lives, including their patients, their families and friends and local communities.

7.2.3 A Calling versus Career: The Preferences of Male and Female Medical Professionals

Another factor that could be contributed to the meaning of work is the concept of a ‘calling’ and ‘career’ work orientation. The concept of a calling was previously defined as an individual’s feeling of fulfilment by doing the work rather than monetary rewards or career advancement that comes with the job. It also reflects an individual’s belief in their job which helps to contribute to the greater good and improve the world (Wrzesniewski 2003). In the context of East Malaysia, this concept is an extension of the intangible meaning of work as an individual’s feeling about the contribution of their job as doctors and nurses to the wider community. Their medical skills and capabilities will significantly contribute to improve the nation healthcare system and the quality of medical treatment and care.

In general, medical professionals who participate in this study refer to their medical career as a ‘calling’. MDR5 described this situation by referring to the nature and core value of their job, which is to help and care for others. She further spoke about the uniqueness of being a doctor:

*Doctors’ role is an extension of the hand of God! Our role is to do good deeds to other people. We are the only professions that deal with the ‘life’ and ‘death’ of an*
On the other hand, the concept of a vocational ‘calling’ helps to improve retention and motivation to work by nurses despite their 13-year career hiatus. Similar to nurses in western countries, this profession is still seen as women’s work in East Malaysia. The majority of nurses in East Malaysia perceived the nature of their job was associated with a calling. On the other hand, most female nurses with parental duties also believed that their domestic roles were equally important and favoured adequate time for their children and family. By fulfilling both roles (professional and domestic responsibilities), they believed that they contributed to a greater good for the society and this increased their job and life satisfaction.

The majority of nurses in this study stated that they felt accomplished and satisfied with the nature of their work and perceived it as a vocational calling. On the other hand, female nurses also emphasize the importance of their domestic roles in raising and nurturing their children and family. Therefore the 13-years career hiatus allows them to shifts their focus to look after their family. NR8, a matron, spoke about the novelty of the nursing job and the criticality of her domestic roles as a wife and mother:

*The foundation to become a nurse required us to have the heart to serve. It is similar with the medical doctor training which is intense with long-working hours. So, you must love your job and your team to succeed and to keep going... and then, there’s these 13 years of stagnant career which could demotivate some people. But for me, this is the best time to raise my children. I appreciate this ‘career stagnancy’ because it allows me to spend more time with my children and it is possible to have some flexibility in our (collective) culture [as] my colleagues are very understanding and willingly help to assist me during [an] emergency* (Interview, 13 January 2016).

Work flexibility and family-friendly practices can be more easily established in a collective and conservative work culture. This situation was confirmed by NR5, a senior nurse who highlighted that for married women with children, the role of motherhood role is similarly important as having a stable and permanent job. The calling of motherhood as an intangible outweighs tangible monetary benefits. Therefore, the collegial understanding between
colleagues is the key to establish work flexibility. This support helps them to juggle their family and job responsibilities. NR5 spoke about her role as a young mother in the East Malaysian culture:

*I got married after three years in the service and had my first child a year after that. In our culture, it is the role of the mother to instil manners, religion and traditions in our young children. So, in this period I was always by their side, which is a very crucial time in their lives. So, I can say that this household responsibility has switched my focus from aiming to climb the career ladder... because at the end of the day, I will still get my promotions, Therefore the period of ‘no job promotion’ is a chance for us to nurture our young children* (Interview, 13 January 2016).

Surprisingly, several female doctors also spoke about their intention and desire to be transferred to the administration and management departments or district clinics so that they could have an adequate balance between work and personal life. As medical professionals, the concept of calling could be extended as caring for family as well as community. MDR9 illustrates how she balanced her decision to be transferred to the administration department in order to nurture her one-year old son, as well as her job contribution to the society:

*I [applied] for the transfer of service from the clinical to management office after I got married. I wanted to have sufficient time to with my future children.... After the birth of my first son, Yes! This was the right choice. Now, I do not have to work extra hours with locum and on-calls on weekends. As a young mother, I need sufficient time to nurture my son. Since this is a permanent position, I don’t lose anything in my career and at the end of the day, I am still contributing in improving the healthcare system in our country* (Interview, 24 January 2016).

Her decision was supported by several other unmarried female doctors, who mentioned their desire for a transfer of service to these departments after having children. The obligation to fulfil these domestic responsibilities eventually lessens their attraction to the value of money. Since this required them to closely nurture their children, they were willingly trade the opportunity of locum and on-call work. MDR6 stated that the Malaysian culture requires women with parental duties to prioritise their children and be intimately involved in nurturing
them. Therefore, she was looking forward to work in the administrative department of district health clinic to have an adequate and balanced time for her future children. However, this decision may lead to a reduction in extra allowances through locum and on-call work (Interview, 17 January 2016).

In exploring the concept of a vocational calling, the result of this study is similar to an earlier study conducted by Skinner et al. (2011) in the western context, which revealed that nurses described their work as a ‘calling’ that provides an opportunity for personal and professional growth, also had a positive effect on many life domains. In the context of East Malaysia, both doctors and nurses perceived that their career fulfilment is associated to the belief and perceptions that this profession contributes a significant impact to the wider society. The trust and respect by the society towards the professions helps to improve their motivation and job satisfaction. However, this study revealed that, working women with parental duties have two callings and the vocational one may enhance the familial one, if work-life balance is achieved and supported by the culture. Besides, among nurses in this study, the career hiatus allows women to shift their focus to care for their family and children. Domestic responsibilities have indirectly decreased their attraction towards the value of money and career advancement opportunity because of high job security and steady monthly income.

In addition, several female doctors also highlighted the importance of fulfilling their domestic roles which required adequate WLB. Their profession was the key foundation for meaning, purpose and personal satisfaction whereas the balance between work and life is about flexible time, part-time work and work from home. In the context of East Malaysia, the collective working culture creates a mutual understanding between employees which ultimately allows flexibility and family-friendly practices. Moreover, this study also indicated that young parents were also preferred an adequate balance between their professional career and personal life. These results are consistent with the study of Jamieson et al. (2013) which revealed that young nurses in the western context are in favour of the concept of WLB. Most young nurses around the world favour flexibility in their work shifts and rosters to allow them to have sufficient time with their young children and family.

Moreover, this study also enriched the concept of a career work orientation, which refers to the individual perception of their job as the source for rewards that attend progression
through an organisational or occupational structure. Initially, career orientation includes salary increments, reputation and status as results from job promotion and career advancement which eventually leads to increased self-esteem, power and social status (Bellah et al. 1985; Wrzesniewski 2003). In the context of East Malaysia, career orientation was associated with the tangible meaning of work which consists of all material aspects of compensation and benefits packages and permanent job status. The majority of male doctors stated that their motivation to work was driven by thigh salaries, time-based job promotion and locum policy as means to earn higher allowances, on-call allowances and high job security due to the high demand of doctors in both public and private sectors. Indirectly, it increased their attraction to the value of money and they believed that earning more money would improve well-being and life satisfaction.

One of the key explanations in relation to the gender norms are perceptions towards the role of men and husbands in the East Malaysian culture. As noted, in general, men are being perceived as *ketua keluarga*, who have the responsibility for economic stability of their family. MDR3, a senior medical specialist stated that as the *ketua keluarga*, they need to work to increase their income to ensure they are capable to sustain and improve family economic stability. Therefore, they were motivated by both intrinsic and extrinsic compensation elements of their job. He described the role of husband in the East Malaysia context as follows:

*In our society, man is the provider and held the principal responsibility in the family. As a husband, we are the one who has to buy and pay for our house, car(s) and maintain savings for our family and children education funds. Therefore, due to these commitments, I am motivated by the benefits offered in this job. Being a doctor, we are privileged because of the transparent and attractive policies that contribute to this profession. I perceived that these benefits help to maintain my family’s economic stability* (Interview, 22 January 2016).

MDR2, a medical officer also expressed his preference for compensations policies which enhance his motivation towards perceived value of money as well as its contribution to improving and sustaining his life.
The time-based job promotion helps this profession receive ‘auto-salary increments’. Besides that, we are allowed to work as a locum doctor. Then, the government are very encouraging in offering scholarships in pursuing our medical specialist degree. These policies promote our [positive] attitude towards the benefits (Interview, 10 January 2016).

The concept of career work orientation in East Malaysia refers to the perception of employees towards their job as a tool to earn rewards that complement advancement through organisational or occupational structure. Professionals will be motivated by salary increments, prestige and status as a result of job promotion and advancement. These elements improve their self-esteem and achieve higher social status. The career work orientation could be associated closely with the medical professions because of policies that allow time-based job promotion, higher salary scales, the locum policy, on-call allowances, high job security, supportive supervisors and transparency in career development progress. This study revealed that most doctors were in favour with these policies as it improves work motivation and satisfaction. These policies were also seen as an effective retention strategy for doctors to continuing to work in the country, even though several physicians in the public healthcare sectors expressed their intention to work in the private health sector.

On the other hand, this study also supported the results of Noor and Mahudin’s (2016) research which stated that the role of women in Malaysia is associated with family-oriented obligations whereas the role of men is associated with the work-oriented role. For the majority of male participants among doctors, they perceived their role as the ketua keluarga which is the main provider for their family, which leads to increase their motivation towards the intrinsic and extrinsic elements of compensations. Conversely, women value their steady salary and job security but seek adequate flexibility to care for their family as well as to nurture and raise children. Since the culture emphasised women with parental to nurture and raise their young children, most female doctors expressed their voluntary to request for a transfer to the administration and management department or district clinics after getting married and having children.

Overall, this study revealed that the concept of the meaning of work and the impact of cultural views in regard to the role and women in the society could significantly impact the
perceived WLB among employees in the organisation. This study confirmed that participants perceived their job as the key contributor for their economic maintenance, by viewing their profession to have a positive impact on their organisation and wider society besides providing sustainability to their family. However, due to cultural influences, this study discovered that women are keen to spend more time with their families and raise children, but still work full-time. On the other hand, men saw their role as the main source of income and therefore were motivated by the extrinsic and intrinsic motivation for working. Both professions agreed that steady income and secured job position could guarantee life stability. Therefore, the study has found that the concept of the meaning of work and the influence of culture could intervene employees WLB, well-being and work behaviours.

7.3 Life Contentment: The Outcome of Work-Life Balance, Well-Being and Work Behaviour

7.3.1 Expanding the Life Contentment Concept

This study also made a proposition in Chapter 2 that an individual desire to finding balance between work and personal life will lead to life contentment. Initially, this study defined the concept of ‘contentment’ as the personal feelings of fulfilment with ‘work and leisure, pleasure and pain, reward and sacrifice. It is durable and involves a form of selfhood or self-understanding that becomes a source of satisfaction and fulfilment’ (McKenzie 2015, p. 254). In addition, it was noted that individual life contentment maybe influenced by work-related interference such as time constraints, work-community interaction, the frequency of feeling rushed or pressed for time as well as their overall satisfaction with WLB (Skinner & Pocock 2008; Skinner & Pocock 2010). This influences the individual perceptions towards the adequacy of WLB, level of satisfaction with work responsibilities as well as their availability for leisure activities outside work.

This study found that life contentment among doctors and nurses in East Malaysia can be explained by: (i) their perceptions of a balanced life with adequate time spent with their family, children and spouse; (ii) good relationships with immediate family, relatives and friends; (iii) having good values in life besides a religious belief; and (iv) positive perceptions of their role as medical professionals in the community. Furthermore, respondents also
reflected that the contribution of their job in provided economic stability, time management, a
sense of identity, professional and status, and a chance for personal growth all contribute to
life contentment (Gallie 2002).

7.3.2 Life Contentment as an Outcome of Work-Life Balance

This study investigated the concept of life contentment in four sector dimensions: (i) public
city hospitals, (ii) public district hospitals/clinics, (iii) private city hospitals and (iv)
administration and management departments. The interview analysis revealed that doctors
and nurses in the administration and management departments have high WLB and life
contentment followed by participants from the district hospitals. Doctors and nurses in the
public and private city hospitals reported the least satisfaction with WLB and life
contentment.

Firstly, medical professionals in the administration and management departments reported to
have the highest WLB and life contentment. MDR11, a doctor cum Assistant Director, in the
state health department stated that he has an adequate balance between work and personal life
and was satisfied with his current life. He mentioned that his current job position does not
interfere with other activities outside work and does not restrict his time with family and
friends. He explained this balance and contentment as follows:

My working hours are 8:00 am–5:00 pm and I am no longer working as a locum
doctor. Now I can enjoy my evening time with my family, friends and do sports. I have
sufficient time to go to the gym every evening compared to the time of my attachment
to the clinical department, which I did not have any time to do these activities. I do
feel that my current position helps me a lot to build relationships with the community
because we are directly involved with community services with health checks in the
rural areas, health awareness talks and community workshops (Interview, 24 January
2016).

NR5, a senior nurse in the research centre in a public hospital in Kota Kinabalu, stated she
was grateful to be working in the administration department for the past 5 years because she
had time to spend with her young children. As a mother, it was important to have an adequate
balance with her family and children. On the other hand, working in this department allowed her to have some personal time to do her hobbies. This opportunity makes her feels content and fulfilled with life. She described this situation as follows:

*I love gardening… Working in this department allows me to spend most of my Sunday in my garden. It is important for us to have some break from work to forget all the stress in the office. Gardening helps me to have some peace and distress. Besides, as a mum I need to teach my young children about religion and other life lessons* (Interview, 13 January 2016).

Secondly, most medical professionals working in district hospitals were also quite satisfied with their WLB. MDR6 and MDR7, doctors in a district hospital in Sabah, reported that they enjoyed their new workplace and the job position because it gave them some flexibility to adjust their work schedules (e.g. on-calls and locums) to cater to their own preferences. Both doctors mentioned that their current job was more manageable because they were only required to take charge of one particular department. This helped them to established flexibility and allowed them to closely organise wards inspections, attend clinics and perform medical operations. MDR7 also said that he had more time for holidays and sports in comparison to his previous position as a trainee doctor in the public city hospital. He stated that:

*Finally, last Christmas, I had time off from work and this was my first ever long holiday. It is only possible to take time-off in the district hospital [rather] than a city hospital because of the large number of patients and busy schedule. If I continued to work in the city hospital, I may not be able to obtain several days’ time off from work.* (Interview, 17 January 2017)

In relation to work-community interactions, doctors and nurses in the district hospitals shared similar views with those working in the administration and management departments. MDR7 stated that their professions were bound to develop a great relationship with the local community.
We have a great relationship with the community in this district. Almost every month we have several health programs with the community. It is important for all medical professionals to help to create health awareness with the community. Moreover, rural communities are more appreciative than communities in the city. Their appreciations make me more content with this job (Interview, 17 January 2017).

Finally, medical professionals in public and private city hospitals reported the least satisfaction with their WLB and life contentment. This feeling of dissatisfaction was reflected in the comments of two doctors working in a clinical ward in a public hospital in Kota Kinabalu. MDR1 stated that he always experienced the feeling of being frequent rushed and pressed for time at work, which limited time with family and friends. He said that working in the general hospital required him to attend to an endless number of patients and always be on stand-by for surgical or operation procedures. He mentioned that:

In most times, the job responsibilities do interfere with my other responsibilities outside work because of the intense work schedule. If I have time off from work, I rather prefer to rest at home to unwind... Sometimes I am not able to attend important family functions such as functions such as weddings, birthday dinners, and anniversaries because I am tired from work (Interview, 10 January 2016).

Some nurses in public and private city hospitals also shared the similar views on the overwhelming work demands that could limit their WLB. NR2, a nurse in an emergency department stated that she felt the pressure of juggling her role as a mother and a nurse. She felt frustrated whenever she did not have the time to spend with her children because of the demand to work extra hours to cater to a high number of patients (Interview, 20 December 2016). NR7, a senior nurse cum nurse manager in a private specialist hospital in Kota Kinabalu also reported feeling frequent time-pressures. She stated that as a nurse manager, she is responsible to maintain the KPIs of the department. She reported that she frequently had to work overtime because of her administrative duties as the nurse manager. It limited her time with her family and often declined important family events (Interview, 7 January 2016).

This result is similar with the studies of Kaliterna et al. (2004) in the western context which revealed that non-shift employees have a better quality of life and subjective well-being.
compared to employees working in shifts arrangements. For doctors and nurses in the administration department of East Malaysia, the standard working hours allowed them to have sufficient time for hobbies, sports, time with family, children and friends, as well as attending relevant events on weekends. These activities are emphasised as important because employees demand the control and prospects for improvement of their physical and psychological health, personal values and spiritual beliefs. On the other hand, doctors and nurses in the clinical departments are required for shift work with occasionally extra hours due to the shortage of manpower.

Another dimension of life contentment revealed in this study was the importance of quality time individuals spend with their families, spouses, children, close friends and communities. Most parents in this study stated that it was their responsibility to have sufficient time with their family to instil good values and religion to their young children. In the conservative culture of East Malaysia, spiritual beliefs become a central domain in life and parents are responsible for nurturing their young children with religious activities and other life lessons. Spiritual well-being is one of the major findings of this study which enriched the life contentment concept in this study. Participants in this study stated that good values and stability in life incorporates a religion to ensure all individuals feel content with life. This apparent result is in-contradiction with Carson (1981) which revealed that social and cultural values do not adequately recognise an individual’s perception of a good life in the western context. However, more recent research by Lu and Gilmour (2004) reveals that culture does influence individual subjective well-being. In the western context, happiness is conceptualised as being ‘emotionally charged, upbeat and unmistakably positive’ (Lu & Gilmour 2004 p. 286) whereas Chinese culture values harmonious relationships among individuals and their surroundings. Furthermore, Lu and Gilmour’s study also revealed that the Chinese societies value spiritual enrichment in defining happiness than most western cultures.

In the context of East Malaysia, this study revealed the influence of the collectivist and strong conservative culture on individual happiness and life contentment. All parents in this study constantly sought a fair balance between work and personal life to ensure they can carry out their parental responsibility as to become a ‘good parent’. In regard to their role and relationships with the community, both doctors and nurses acknowledged the vast
opportunities they had to continuously engage with local communities. It is in the nature and purpose of their job that requires them to be engaged with the communities. These relationships help build their job and life satisfaction as it involved the purpose to serve others. Thirdly, participants in this study also valued relationships among colleagues and supervisors. These support systems are important and necessary to ensure every employee can achieve organisational goals and objectives as well as the department KPIs. Besides that, in a collectivist culture (Hofstede 2017), the support from supervisors and colleagues could allow some flexibility in working arrangement and family-friendly work practices.

The study has found that the concept of life contentment is an important outcome of WLB practices. Doctor and nurse respondents in East Malaysia outlined four key aspects to achieve life contentment: (i) the role of their job in providing economic stability; (ii) the importance of quality time with family, spouse and children; (iii) role in the community and relationships with colleagues and supervisors; and (iii) spiritual and religious enrichment. On the other hand, participants also emphasised the influence of their job sector and locations in determining life contentment. This is due to the direct influences of flexibility in shift working arrangements, capacity of manpower and the number of patients as well as the demand of job roles and intensity of daily tasks. In addition, the meaning of work and the collectivist and conservative culture of East Malaysia culture indicated an influence on individual life contentment.

7.4 Summary

This aim of this chapter was to explore and discuss secondary factors that could influence employee WLB, well-being and work behaviour. There are two key factors that emerged from this study which had a significant impact on East Malaysian doctor and nurse respondents. Firstly, the meaning of work influenced the relations between employee work-life balance, well-being and work behaviour. Further, life contentment was an important outcome of WLB. The next chapter will present the contributions of this study for HR theory and management practices.
CHAPTER 8: CONCLUSION

8.1 Introduction

The aim of this chapter is to discuss the key contributions of the study to academia and HR practices as well as to provide suggestions for future research. This chapter firstly outlines the theoretical contributions of the study in the context of the relevant literature. It then highlights specific industry implications for the MoH, State Health Department and hospitals in East Malaysia. Finally, as well as discussing the limitations of this study, it provides some possible themes for future research.

8.2 Theoretical Contribution

Theoretically, the concept of WLB and the perceived value of money developed and analysed in this study differentiates it from existing studies. In contrast to most previous research, this is the first study of its kind of medical professionals in East Malaysia and that by adopting a sequential mixed-methodology approach, it established relations between key variables concerned with WLB; it then further investigates the reasons why these relations exist by qualitative interviews. The results of the study thus provide a holistic and integrated scenario of WLB and the perceived value of money and its impact on employee well-being and work behaviour as well as the influence of the meaning of work and life contentment. These enriched dimensions comprise the main theoretical contribution of the study and enhance WLB literature specifically in the East Malaysian context.

8.2.1 The Inclusion of Collective Culture and Gender Norms in Work-life Balance

In investigating the issues of WLB, this study revealed that the collective working culture in an organisation is a core variable in studying employee WLB issues. Although Al-Dubai et al. (2013) and Hassan et al. (2010) have discussed these elements, they did not specifically investigate the influence of the collective working culture in the East Malaysian context. One significant finding of the study is that flexibility in working hours and family-friendly
practices can be established and supported within a collective work environment. This type of culture values cooperation, group harmony, dependence and empathetic collegiate relations (Abdullah 1996; Hassan et al. 2010; Keshavarz & Baharudin 2009). The study also revealed that mentoring programs and close supportive supervision can promote a positive, productive and cooperative environment which will influence employee motivation and job performance. At the same time, the role of gender norms also impacts employee WLB. The study found that women reported a higher work-life conflict due to the pressure of dual roles. This is particularly salient in the East Malaysian context where working women have significant and almost exclusive roles in their household for nurturing children and family. However, working life is possible due to the collective working environment that builds high mutual understanding among colleagues. Besides that, the permanent job position helps to secure a long-term employment with stable monthly salary and annual increments. Men continue to be perceived as ketua keluarga (family head) responsible for providing financial security and economic stability for their families.

8.2.2 Extension of the Concept the Perceived Value of Money

The study built based on Adams’ (1965) equity theory. This theory has been explained through the fairness of the work promotion process in the healthcare industry of East Malaysia. This study shows that most doctors and nurses seen the ‘seniority-based promotions’ as a fair job promotion practices. This type of promotion system values employee work experience, seniority in the job and level of medical knowledge and skills established through several medical certifications (e.g. post-basic certifications for nurses and medical specialist degree for doctors). In a collective culture that values group harmony and respecting the elderly (Hassan et al. 2010; Keshavarz & Baharudin 2009), these promotion practices limit favouritism, avoid disputes among colleagues and encourage motivation at work—as demonstrated by many of the doctors and nurses interviewed.

In addition, the study also extended the concept of the perceived value of money by incorporating two new elements that not previously considered in extant literature. The perceived value of money was defined as the frame of reference and symbol of success in which medical professionals evaluate their everyday lives (Tang & Chiu 2003; Tang et al. 2002). In the East Malaysian context, medical professionals highlighted the importance of
their permanent job status because it contributes to providing a stable monthly income and ensures economic stability and job security. Secondly, the perceived value of money is dependent on their employment status and the amount of compensation and benefits received (Tang & Chiu 2003; Tang et al. 2002). Participants in this study valued their permanent job position and stressed the importance of financial retirement plans for future stability. This led them to take a longer-term view of the time-money trade off rather than immediate financial rewards. The study also revealed the differences among doctors and nurses as to the perceived value of money. For doctors, access to locum practice, time-based job promotion and transparent career development policies increased their perceived value of money. For the nurses, mandatory stagnant career progress contributed to their low perceived value of monetary compensation.

8.2.3 The Meaning of Work for Medical Professionals in East Malaysia

The concept of the meaning of work (Colby et al. 2002; Wrzesniewski 2003) also helps understand why the perceived value of money was not found to be a significant moderating factor by identifying the distinction between tangible and intangible meanings of work. Tangible meaning of work includes such factors as the material aspects of compensation and benefits packages received by the professions. Most participants in the study reported these elements assisted them in providing necessities for spouses, partners, children, parents and other family members. They saw their job as a basis for economic stability. The intangible meaning of work can be expressed as the positive psychological influence of a job which affects well-being and work performance. Three key aspects highlighted by both doctors and nurses were: (i) the recognition of their professional skills and capabilities in making a difference in other people lives (e.g. patients); (ii) the trust and respect given by the community towards the profession; and (iii) involvement with the local community.

In understanding the meaning of work in East Malaysia healthcare sector, the concept of a vocational calling proved an important concept. Medical professionals generally saw the meaningfulness of their work as much more than financial reward and career advancement opportunities. Their sense of fulfilment was associated with their belief that their profession contributed to making a significant positive impact on the wider society. The understanding of the meaning of work could also be further explained by a perception of work as a career
orientation among doctors. Employees with a career orientation see their job as a tool to earn rewards that complement their advancement through organisational or occupational structure (Wrzesniewski 2003). Most male doctors revealed they were motivated by salary increments, prestige and status as a result of job promotion and advancement. These elements improved self-esteem and provided a higher social status as well as providing financial protection and economic stability to their family as the *ketua keluarga*.

### 8.2.4 Life Contentment as an Important Outcome of Work-life Balance

The study also included work on the concept of happiness (Turner 2009) and its relation to spiritual well-being (McKenzie 2015) by incorporating both concepts to explain employee life contentment. This was an important measure of WLB practice. As well as linking its findings to social culture and gender norms of East Malaysia, the study revealed three key explanations for individual perceptions of life contentment. Firstly, medical professionals appreciate the role of their job in providing current and future economic stability for themselves and their families. Secondly, medical professionals in East Malaysia also valued the importance on having quality time with family, spouses and children by fulfilling their domestic roles. As previously mentioned, men are the *ketua keluarga* whereas women are responsible for household duties. However, as parents, men also value their role with children and families. Finally, the study also revealed the importance of spiritual and religious enrichment in shaping an individual’s perception of life contentment. In a collective working culture, life contentment was also reflected through healthy relationships with communities, supervisors, colleagues and friends.

Figure 8.1 illustrates the outcome of this research and its contribution to the conceptual framework developed in chapter 3, from the perspective of the healthcare industry in East Malaysia.
Figure 8.1: The Work-Life Balance Model from the Perspective of East Malaysia

1. The Meaning of Work
   - Collective Culture
   - Gender Norms

2. Work-Life Balance Practices
   - Flexibility in working hours
   - Supportive supervision
   - Family-friendly programs and practices

3. Employee Outcomes
   - Employee well-being
     - Job satisfaction
     - Life satisfaction
   - Employee work behaviour
     - Job performance

4. The Perceived Value of Money

5. Life Contentment
8.3 Implications for HR Practices

The strong collective culture in East Malaysia could facilitate the establishment of flexible working arrangements and family-friendly practices. However, formal policies in promoting employee WLB are still needed. This study hopes to contribute to three different policy options.

First, the MoH in Malaysia needs to formalise and create better policies in promoting WLB in the healthcare industry. A significant fundamental reform on the WLB policy at the national level of the healthcare industry is needed to achieve a positive work-life balance among medical professionals. Due to the increase of the dual-income earners in most families in Malaysia, the results of this study suggest that a formal WLB policy should be included in HR and organisational policies. In addition, policies need to be flexible to cater for the diverse range of employee personal needs. In developing these policies, some essential employment aspects need to be taken into consideration such as marital and parental status, job responsibilities and individual ability to fulfil work demands, department team cohesiveness and the number of employees in one department. The findings of this study suggest that participants favour these working arrangements: job share arrangement, flexible working hours, school term work arrangement and flexible (negotiated) arrangement during an emergency. Therefore, these options should be included in this proposed WLB policy for medical professionals in Malaysia. In order to ensure this policy will be fully accepted and perceived as ‘fair-practice’, it should shield all range of employment conditions and job positions that fit well with individual preferences, while still fulfilling department and organisational demands. Therefore, all employees across all job positions and employment levels should be given an opportunity to negotiate their duty preferences with their head of departments and/ or hospitals and clinics directors based on their work and family demands. This WLB policy should aim to recognize the different work and life needs and demands of individual employees. Therefore, a WLB policy that is tailored based on individual needs and demands and accommodates a diverse range of employees will help to reduce work-family related stress, improve employee engagement and motivation which eventually increases employee attraction and retention, especially in the public sector.
Given the shortages of manpower (doctors and nurses) in both states, attractive career development and compensation and benefits could assist the federal government to retain current employees working in Sabah and Sarawak and attract doctors and nurses from Peninsular Malaysia. The MoH also needs to initiate pre-departure training for employees before their transfer to service in Sabah and Sarawak. This training could prevent culture shock and improve adaptation to the culture of East Malaysia. The training program should include cross-cultural awareness training, preliminary visits and basic native language training. The federal government should also assign a manager in this state to support transfer employees and reduce any anxiety for potential assignments in East Malaysia. The responsibilities of the manager could be: to assist employees in their early months of working and provide professional support. Finally, in reviewing the stagnant career structure for nurses, consideration should be given to providing them with similar job promotion opportunities as doctors. Seniority-based promotion could be examined and reduced to 5 years to improve retention of nurses in the sector.

It is crucial for the HR practitioners in the State Health Department to have an awareness of WLB issues and their influence on well-being and organisational performance. Since these two states have a shortage of doctors and nurses, supporting a collaborative working culture could be included in HR policy. Firstly, a mentoring program is seen to be an efficient and an effective tool to guide and manage young nurses in clinical departments. It could be expanded and formalised for doctors to improve job and organisational performance. In addressing the shortages of doctors and nurses in the rural areas, the State Health Department may need to extend the benefits of employment in these areas. Besides focusing on the improvement of monetary benefits (salary and increments), consideration should be given to providing extra housing allowances, hardship allowances and career development opportunities for those working in these areas. These practices could facilitate higher organisational performance.

Finally, the research hopes to provide some insights for doctors and nurses in East Malaysia concerning the issues of the value of money and the importance of balancing career and professional aspirations with personal life. Doctors and nurses working in these states should recognise the working culture and practices in Sabah and Sarawak. A collaborative working culture that promotes flexible working arrangement, cohesive teamwork and strong
supervisor support could easily be implemented in the collective culture (Abdullah 1996; Hassan et al. 2010), but open communication will encourage employees to identify their needs and the needs of their team in the workplace. Social events and engagement could be initiated to celebrate departmental or individual achievement to strengthen the cohesiveness of the team. Recognition of their efforts could improve well-being and job motivation.

8.4 Limitations and Future Research

The study has successfully demonstrated that WLB practices can have a considerable influence on employee well-being, work behaviour, the perceived value of money and the meaning of work and life contentment in the healthcare industry in East Malaysia. However, several limitations need to be acknowledged. Firstly, the data was collected from only two states in East Malaysia which have different economies, cultures and norms compared to the other states in Peninsular Malaysia. Therefore, the immediate findings of this study are limited to the East Malaysian healthcare industry. In addition, the dominance of public hospital respondents may also have led the result to focus on public healthcare settings. An expansion of this research to the national level, other industries as well as other developing nations would be useful in further investigating the effectiveness of the conceptualisation of WLB used in this study. Moreover, national level research on strategic reformation of the HR practices and policies in the healthcare industry is crucial to recognize and address the importance of WLB issues and other related employment conditions of all medical professionals across all employment levels. Since this industry is facing a significant problem in attraction and retention of staff, this research should be able to recognize the current worldwide employment trends as well as to incorporate WLB policy in the Malaysia employment and labour law.

Further, the findings from the qualitative study seem to lead to a curvilinear shape of perceived value of money. It pinpoints that the perceived value increases to a point where they are financially stable and then decreases. This is why some informants admit that they can now enjoy more time with their families and attend to their hobbies. Future in-depth research and exploration in this area is needed to further investigate the influence of the perceived value of money for other professions.
The data for the study were collected in a cross-sectional manner. That is, the perceptions regarding employee WLB, the perceived value of money, well-being, work behaviour, the meaning of work and life contentment were collected at a single point in time and conditions and influence could change over time. For any future research, the adoption of a longitudinal research design (Dean & Sharfman 1996) could provide a better understanding of the relations between the variables. Furthermore, a more in-depth qualitative approach through a multiple case study (Yin 2011) and ethnography could be applied to studying the complex dynamics of the WLB concepts in the healthcare industry.

The scope of the study explained, evaluated, explored and enriched the concept of WLB, the perceived value of money, employee well-being, work behaviour, the meaning of work and life contentment. However, the concepts of the meaning of work and life contentment were not included in the survey and a future study should incorporate these elements into surveys of WLB. This would enrich and extend related survey items in the current literature and allow them to be tested by a quantitative research design.

8.5 Conclusion

WLB practices are a key strategy that assists organisations to attract and retain valuable employees in a highly competitive labour market. It is an important area in contemporary HRM that has received significant attention from academics, management, government and employees. This study examined and explored WLB issues through a pragmatic mixed-methods approach by adopting a sequential explanatory research design among medical professionals in the East Malaysian healthcare industry. Conducting the study in this context allowed the researcher to explore some significant factors influencing WLB apart from the more traditional focus on access to flexible work arrangements and supervisor support. The study found that for doctors and nurses in East Malaysia, there is a specific interaction between gender norms and the collectivist culture which together mediate the stresses of high-intensity work for both doctors and nurses. Paradoxically, the gendered career hiatus imposed on nurses opened opportunities for them to work full-time and fulfil their roles as mothers as nurturers responsible for instilling both cultural and religious values in their children.
Due to the growth and expansion of the healthcare industry in Malaysia and because of its significance as one of the key economic contributors to the nation, there is a need for continuous improvement and transformation of this sector, both at the national and state levels. An employee can achieve an adequate balance between work and life because of a collective work culture, but the challenge of shortages of doctors and nurses remains in East Malaysia. Therefore, continuous improvement in attraction, motivation and retention strategies and practices is required to ensure valuable employee loyalty, career growth and improve employee well-being. This, in turn, will assist in meeting current and future labour demand.
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APPENDIX 1: HUMAN RESEARCH ETHICS APPROVAL

Notice of Approval

Date: 6 November 2014
Project number: 18/015
Risk classification: Low Risk
Principal Investigator: Dr Ngan Collins
Student Investigator: Mr Oscar Dousain
Project Approved: From: 6 November 2014 To: 22 July 2017

Terms of approval:

1. Responsibilities of the principal investigator
   It is the responsibility of the principal investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by BCHEAN. Approval is only valid while the investigator holds a position at RMIT University.

2. Amendments
   Approval must be sought from BCHEAN to amend any aspect of a project including approved documents. To apply for an amendment submit a request for amendment form to the BCHEAN secretary. This form is available on the Human Research Ethics Committee (HREC) website. Amendments must not be implemented without first gaining approval from BCHEAN.

3. Adverse events
   You should notify BCHEAN immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Participant Information and Consent Form (PICF)
   The PICF must be distributed to all research participants, where relevant, and the consent form is to be retained and stored by the investigator. The PICF must contain the RMIT University logo and a compliance clause including the above project number.

5. Annual reports
   Continued approval of this project is dependent on the submission of an annual report.

6. Final report
   A final report must be provided at the conclusion of the project. BCHEAN must be notified if the project is discontinued before the expected date of completion.

7. Monitoring
   Projects may be subject to an audit or any other form of monitoring by BCHEAN at any time.

8. Retention and storage of data
   The investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.
PARTICIPANT INFORMATION

Project Title: Work – life balance and the Healthcare Industry in Malaysia

Investigators:
Oscar Dousin, PhD Candidate, School of Management, RMIT University, Melbourne, Australia
Dr. Ngan Collins, Senior Lecturer, School of Management, RMIT University, Melbourne, Australia

Dear participant,
You are invited to participate in a research project being conducted by the School of Management, RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?
The investigator is a PhD student enrolled in the School of Management, RMIT University. The research project is being supervised by Dr. Ngan Collins who is a senior lecturer in the School of Management, RMIT University.
The aim of this survey is to explore issues of work–life balance practices, employees’ perception towards the value of money and employees’ outcomes of Malaysia’s healthcare industry. It aims at understanding and evaluating the effects and benefits of work–life balance practices, the perception towards the value of money and opinion on well–being and work behaviours among medical doctors and officers in Sabah and Sarawak. This research project has been approved by the RMIT Human Research Ethics Committee.

**Why have you been approached?**
You have been approached to participate in this research because the researchers believe your position as medical doctors/ nurses/ medical officers directly relates to the Malaysia’s healthcare industry as suggested by the HR department who helped us to identify the suitable participants for this study. You have been individually and personally selected by the researcher and your contact details are obtained from your organisation’s website. It is important to note, official permission has been granted to distribute survey questionnaires among medical doctors/ nurses/ medical officers by the State Department of Health. Your participation is still voluntary and you are entitled to decide not to participate in this research.

**What is the project about? What are the questions being addressed?**
This study aims at understanding and evaluating the effect and benefit of work–life balance practices, perception towards the value of money and opinions on well–being and work behaviours among medical doctors and officers in Sabah and Sarawak. The research aim above will be achieved by the following objectives

a) To examine the relationships between employees’ perceived value of money and work–life balance practices

b) To understand how the work–life balance practices impacts employees’ well–being and work behaviours

c) To investigate the relationship between perceived value of money towards employees’ well–being and work behaviours.

Four public hospitals in Sabah and Sarawak will be selected for this research and each organization is kindly requested to provide their medical doctors/ nurses/ medical assistants and non-medical employees as primary participants for the study. Each primary participant will be involved to complete one survey questionnaire.
If I agree to participate, what will I be required to do?
If you agree to participate, you will be required to complete one survey. The survey will take about 40 – 45 minutes of your time to complete. Your answers will be kept strictly confidential and will be only accessed by the researcher. You are not required to reveal your identity at any stage within this survey. In completing the survey questions please read the given instructions carefully as there are a number of different response formats in the attached survey document. There are NO right or wrong answers for any question. Completing this survey is simply a matter of reading and circling a response that comes closest to your situation. Once you completed the survey, please return it to the HR Manager in your organization. Please put the survey questionnaire in the attached envelope addressed to Dr. Ngan Collins, the Chief Investigator for this research.

What are the possible risks or disadvantages?
The only disadvantage is a loss of time but your participation will make a valuable contribution to this research. All participants will remain strictly confidential and will not be able to be identified by any comments made.

If you are unduly concerned about your responses to any of the survey questions, or if you find participation in the project distressing, you should contact Dr. Ngan Collins (the chief researcher) as soon as convenient. We will discuss your concerns with you confidentially and suggest appropriate follow-up, if necessary. If you wish to make a complaint about your participation in this project please see the complaints box below and please follow the complaints procedure.

What are the benefits associated with participation?
Your organization will receive a final report containing a summary of the project. In the report, you will find valuable insights on the effects of work – life balance practices and perceived value of money towards employees’ well – being and work behaviours in Malaysia’s healthcare industry. Besides, the outcome of this research could provide better understanding and insights as well as possible solutions to solve these challenges. These will be beneficial for long-term human resources management and development plans in your organization.
What will happen to the information I provide?
Confidentiality and privacy will be strictly maintained during all stages of the research. No information you provide will be directly passed on to your organization. Only codes or numbers will be used to represent participants and their organizations in reporting results, which will be made public in the forms of thesis and papers published in journals or conferences.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) if specifically required or allowed by law, or (3) you provide the researchers with written permission. All electronic data will be stored on password secured university network systems. Hard copy data will be archived in the locked filing cabinet and locked office at School of Management at RMIT University. The research data will be kept securely at RMIT for 5 years after publication, before being destroyed. Please note that due to the nature of data collection we will be requesting written informed consent from you.

What are my rights as a participant?
Your participation in this research is completely voluntary. There are no penalties if you decide not to participate. As a participant, you have the right:

- to withdraw from participation at any time
- to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant;
- to be de-identified in any photographs intended for public publication, before the point of publication; and
- to have any questions answered at any time.
Whom should I contact if I have any questions?

If you have any questions or enquires regarding this project or your participation you can contact Dr. Ngan Collins, Senior Lecturer/Chief Researcher, School of Management, RMIT University.

Yours sincerely,

____________________                   _____________________
OSCAR DOUSIN        DR. NGAN COLLINS
PhD candidate        Senior Lecturer
RMIT University       RMIT University

If you have any concerns about your participation in this project, which you do not wish to discuss with the researchers, then you can contact the Ethics Officer, Research Integrity, Governance and Systems, RMIT University
PARTICIPANT’S CONSENT FORM

Name of Participant: ____________________________________

Project Title:
Work – life balance and Healthcare Industry in Malaysia

1. I have had the project explained to me, and I have read the information sheet
2. I agree to participate in the research project as described
3. I agree:
   • to complete a questionnaire
4. I acknowledge that:
   (a) I understand that my participation is voluntary and that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
   (b) The project is for the purpose of research. It may not be of direct benefit to me.
   (c) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (d) The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to me upon request. Any information which will identify me will not be used.

Participant Consent

Participant: ____________________  Date: ____________________

Participant should be given a photocopy of this PICF after it has been signed.
APPENDIX 3: PROJECT INFORMATION AND CONSENT FORM OF
PHASE 2 STUDY

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

PARTICIPANT INFORMATION

Project Title: Work – life balance and the Healthcare industry in Malaysia

Investigators:
Oscar Dousin, PhD Candidate, School of Management, RMIT University, Melbourne, Australia
Dr. Ngan Collins, Senior Lecturer, School of Management, RMIT University, Melbourne, Australia

Dear participant,
You are invited to participate in a research project being conducted by the School of Management, RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?
The investigator is a PhD student enrolled in the School of Management, RMIT University. The research project is being supervised by Dr. Ngan Collins who is a senior lecturer in the School of Management, RMIT University.

This research explores issues of work – life balance practices, employees’ perception towards the value of money and employees’ outcomes of Malaysia’s healthcare industry. It aims at understanding and evaluating the effects and benefits of work – life balance practices and the perception towards the value of money among medical doctors and officers in Sabah and
Sarawak. This research project has been approved by the RMIT Human Research Ethics Committee.

**What are the possible risks or disadvantages?**
The only disadvantage is a loss of time but your participation will make a valuable contribution to this research. All participants will remain strictly confidential and will not be able to be identified by any comments made.

If you are unduly concerned about your responses to any of the interview questions, or if you find participation in the project distressing, you should contact Dr. Ngan Collins (the chief researcher) as soon as convenient. We will discuss your concerns with you confidentially and suggest appropriate follow-up, if necessary. If you wish to make a complaint about your participation in this project please see the complaints box below and please follow the complaints procedure.

**What are the benefits associated with participation?**
Your organization will receive a final report containing a summary of the project. In the report, you will find valuable insights on the effects of work–life balance practices and perceived value of money towards employees’ well-being and work behaviours in Malaysia’s healthcare industry. Besides, the outcome of this research could provide better understanding and insights as well as possible solutions to solve these challenges. These will be beneficial for long-term human resources management and development plans in your organization.

**What will happen to the information I provide?**
Confidentiality and privacy will be strictly maintained during all stages of the research. No information you provide will be directly passed on to your organization. Only codes or numbers will be used to represent participants and their organizations in reporting results, which will be made public in the forms of thesis and papers published in journals or conferences.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) if specifically required or allowed by law, or (3) you provide the researchers with written permission. All electronic data will be stored on password secured university network systems. Hard copy data will be archived in the locked filing cabinet and locked
office at School of Management at RMIT University. The research data will be kept securely at RMIT for 5 years after publication, before being destroyed. Please note that due to the nature of data collection we will be requesting written informed consent from you.

**What are my rights as a participant?**
Your participation in this research is completely voluntary. There are no penalties if you decide not to participate. As a participant, you have the right:

- to withdraw from participation at any time
- to request that any recording cease
- to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant;
- to be de-identified in any photographs intended for public publication, before the point of publication; and
- to have any questions answered at any time.

**Whom should I contact if I have any questions?**
If you have any questions or enquiries regarding this project or your participation you can contact Dr. Ngan Collins, Senior Lecturer/Chief Researcher, School of Management, RMIT University.

**What other issues should I be aware of before deciding whether to participate?**
There are no other issues that you should be aware of as a participant.

Yours sincerely,

__________________________                  _____________________
OSCAR DOUSIN       DR. NGAN COLLINS
PhD candidate       Senior Lecturer
RMIT University      RMIT University

*If you have any concerns about your participation in this project, which you do not wish to discuss with the researchers, then you can contact the Ethics Officer, Research Integrity, Governance and Systems, RMIT University*
PARTICIPANT’S CONSENT FORM

Name of Participant: ________________________________

Project Title:
Work – life balance and Healthcare Industry in Malaysia

1. I have had the project explained to me, and I have read the information sheet
2. I agree to participate in the research project as described
3. I agree:
   • to be interviewed
   • that my voice will be audio recorded
4. I acknowledge that:
   • I understand that my participation is voluntary and that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
   • The project is for the purpose of research. It may not be of direct benefit to me.
   • The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   • The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to me upon request. Any information which will identify me will not be used.

Participant Consent

Participant: ____________________________ Date: ________________

Participant should be given a photocopy of this PICF after it has been signed.
This survey contains the following sections:

Part I: Demographic Information
Part II: Perceived Value of Money
Part III: Work-Life Balance Practices
Part IV: Employee Outcomes
  - Employee Well-Being
  - Employee Work Behaviors

ALL INFORMATION WILL REMAIN STRICTLY CONFIDENTIAL & ONLY USED FOR ACADEMIC PURPOSE.

Researchers:
Oscar Dousin
Ngan Collins, PhD
PART I DEMOGRAPHIC INFORMATION

Please tick (✓) in the appropriate brackets

1. Gender
   □ Female   □ Male

2. Age
   □ 21 – 25   □ 36 – 45
   □ 26 – 35   □ 46 and above

3. Education Level
   □ PhD Degree
   □ Masters / Specialist Degree
   □ Bachelor Degree
   □ Diploma
   □ Malaysian Higher School Certificate/ Sijil Tinggi Pelajaran Malaysia (STPM)
   □ Malaysian Certificate of Education/ Sijil Pelajaran Malaysia (SPM)

4. Length of Service
   □ Less than 1 year
   □ 1–5 years
   □ 6–10 years
   □ 11–15 years
   □ 16–20 years
   □ 21 years and above
5. Job Title

☐ Medical Specialist
☐ Medical Doctor
☐ Nurse
☐ Medical Assistant
☐ Non-Medical Executive/ Officer
☐ Non-Medical Management

6. Job Locations

☐ Kota Kinabalu, Sabah
☐ Sandakan, Sabah
☐ Kuching, Sarawak
☐ Miri, Sarawak

7. Job sectors

☐ Public hospital
☐ Private hospital
INSTRUCTION: Please rate your answer based on the scale given.

<table>
<thead>
<tr>
<th>Answer Scale</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
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<tr>
<td>7</td>
</tr>
<tr>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

**PART II: THE PERCEIVED VALUE OF MONEY**

**Factor 1: Importance**

<p>| | | | | | | |</p>
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</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Money is important for people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>02</td>
<td>Money is valuable for people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03</td>
<td>Money is good for people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>04</td>
<td>Money is an important factor in the lives of the people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>05</td>
<td>Money is attractive for people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>

**Factor 2: Motivator**

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</thead>
<tbody>
<tr>
<td>06</td>
<td>I am motivated to work hard for money</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>07</td>
<td>Money reinforces me to work harder</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>08</td>
<td>I am highly motivated by money</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>09</td>
<td>Money is a motivator for people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

**Factor 3: Rich**

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</thead>
<tbody>
<tr>
<td>10</td>
<td>Having a lot of money (being rich) is good for people working in your field</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>It would be nice to be rich</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>I want to be rich</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>My life will be more enjoyable, if I am rich and have more money</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
INSTRUCTION: Please rate your answer based on the scale given.

<table>
<thead>
<tr>
<th>Answer Scale</th>
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<tbody>
<tr>
<td>1</td>
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<tr>
<td>Strongly Dissatisfied</td>
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</tbody>
</table>

PART III: WORK – LIFE BALANCE PRACTICES

Flexibility and Choice in Working Hours

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</thead>
<tbody>
<tr>
<td>01</td>
<td>I have personal discretion over my starting and finishing time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>02</td>
<td>I can finish work within my contracted hours (e.g. 8 hours per shift)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03</td>
<td>I can schedule my preferred days off supported by my team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>04</td>
<td>I can change my roster if the daily working hours are not consistent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>05</td>
<td>Employees in my organisation actively participate in developing their work schedules (e.g. days of work, days off, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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Supportive Supervision

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<tbody>
<tr>
<td>06</td>
<td>My co-workers are supportive when I talk about personal and family issues that affect my work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>07</td>
<td>My supervisor is understanding when I talk about personal or family issues that affect my work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>08</td>
<td>I work very smoothly to handover to the next shift because of a good management system</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>09</td>
<td>I accept working overtime each day because I am committed to my job</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Employees in my department have good relationships with other departments in the organisation</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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Family-Friendly Programs and Practices

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</thead>
<tbody>
<tr>
<td>11</td>
<td>I have enough time for my family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>I have enough time for my friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>I have enough time after work to carry out personal matters</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>I look forward to being with the people I work with each day</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>15.</td>
<td>I find it easy to concentrate at work because of family support</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16.</td>
<td>I feel happy when I have quality time for my family life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

**INSTRUCTION:** Please rate your answer based on the scale given.

**Answer Scale**

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</thead>
<tbody>
<tr>
<td>Strongly Dissatisfied</td>
<td>Dissatisfied</td>
<td>Somewhat Dissatisfied</td>
<td>Neutral</td>
<td>Somewhat Satisfied</td>
<td>Satisfied</td>
<td>Strongly Satisfied</td>
<td></td>
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</table>

**PART IV(a): EMPLOYEES OUTCOME (EMPLOYEES WELL-BEING)**

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<tbody>
<tr>
<td><strong>Job Satisfaction</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>01. The physical working condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>02. Relation with management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>03. Relationship with immediate supervisor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>04. Relationship with fellow colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>06. Your working hours</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>07. Your job security (insurance, pension plan, career development)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>08. Recognition for good work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>09. Chance of promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. Opportunity to use abilities and attention paid to suggestions you make</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. Freedom to choose own method of work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>12. Amount of job responsibility you are given</td>
<td>1</td>
<td>2</td>
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</thead>
<tbody>
<tr>
<td><strong>Life Satisfaction</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>13. In most ways, my life is close to ideal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. The conditions of my life are excellent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>15. I am satisfied with my life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. So far, I have got the important things I want in life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. If I could live my life over, I would change almost nothing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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</tbody>
</table>
**INSTRUCTION:** Please rate your answer based on the scale given.

<table>
<thead>
<tr>
<th>Answer Scale</th>
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</thead>
<tbody>
<tr>
<td>1 Strongly Disagree</td>
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</tbody>
</table>

**PART IV(b): EMPLOYEES OUTCOME (EMPLOYEES WORK BEHAVIOURS)**

### Job Performance

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.</td>
<td>The quantity of work I produce meets or occasionally exceeds job expectations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>02.</td>
<td>I constantly discuss career interests, provide advice and feedback to my fellow subordinates and inspire them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>03.</td>
<td>I lead, motivate and work closely with subordinates under me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>04.</td>
<td>I effectively delegate to subordinates with clear directives and guidelines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>06.</td>
<td>I served competently in completing all departmental and unit responsibilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>07.</td>
<td>I demonstrate a strong sense of work ethic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>08.</td>
<td>I am motivated, dedicated and demonstrate a strong sense of responsibility when a task is assigned</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>09.</td>
<td>I devote adequate time and thoughts to work assignments and resource allocations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10.</td>
<td>I am frequently successful in reaching a common understanding with others through verbal and non-verbal communication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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**END OF SURVEY**

**THANK YOU**
APPENDIX 5: PHASE 2-INTERVIEW GUIDE FOR MEDICAL PROFESSIONALS
(Medical Doctors and Nurses)

Part 1: Introductory Questions

Background of participants
Age : ........
Gender : ........
Marital status : ........ (No. of children: ........)

Opening Questions

1. Which organisation that you work with?
2. What is your job position?
3. What are your specific roles and responsibilities?
4. How long have you been working here?
5. What was the key reason for you to move from your previous organisation?
   - Personal reasons (distance of workplace from home, family reasons)?
   - Professional reasons (conflict with supervisor, stress, job security)?

Part 2: In-depth Interview Question—derived from the result of Phase 1: Quantitative Analysis

<table>
<thead>
<tr>
<th>Themes/ Results</th>
<th>Objective &amp; Proposed Questions</th>
</tr>
</thead>
</table>
| 1. **H5:** There is a significant relation between perceived value of money and employee well-being (job satisfaction & life satisfaction) | **Factor Importance**
   - Are you satisfied with your compensation and benefits packages? If yes, can you describe them? If no, why?
   - Do you think that the current compensation and benefits packages are the key element to keep you in this job? Yes/No? Why?
   - Do you think that your current salary help save for your future? Yes/No? Why?
| **Note:**  
**Medical Doctor (Job & Life Satisfaction)**  
**Nurses (Life Satisfaction)** | **Factor Motivator—Rewards**
   - Do you receive bonuses/increments for working extra hours? Yes/No? Why?
   - Does your current performance appraisal (penilaian perestasi) link with the rewards (increments, bonuses, etc.)? and how?
     - Are you satisfied with the current policy/practices?
     - Do you think the organisation gives you a proper recognition if you performed up to the expectation?
| **Public sector/private sector** | 
   - Do you think the job security in private sector is better than yours? Why?
   - Do you think the pension plan in private sector is better than yours? Why? |
• Do you think the work life balance policy in private sector is better than yours? Why?
• Do you think that working in private sector is less stress than public hospital? Why?
• Do you think that your salary is one of the motivating factors for you to stay in this job? Why?

Factor Rich
• Do you think that you make more money by ‘staying’ in this job compare with other profession?
• Do you think that by working in this profession helps you to earn more money compared if you were in other job?
• Do you think that you will enjoy life more if you earn more money (become more happy)?

Job Satisfaction
• Do you think that your workplace environment is safe for you?
• Are you satisfied with your current workplace? Yes/ No? Why?
• Are you satisfied with your current work?
• Have you been recognised properly by your immediate boss/supervisor?
  o Did you receive promotion since you work here?
    ▪ If yes, how many times?
    ▪ If no, why?
• How is your relationship with your immediate boss/supervisor?
• How is your relationship with the management in this organisation?
• Are you satisfied with the amount of job responsibilities you held? Yes/ No? Why?
• Does your supervisor give you freedom to complete your work?
• How many days do you receive for you annual leave? Do you think that they are enough for you?

Life Satisfaction
• How often do you visit your families?
• Has this been changes since you work here?
• How often do you have holidays with your families?
• How often do you spend time to catch up with your friends?
• Do you have any hobby/s?
  o What is your current hobby/s?
  o How often do you spend time for it?
  o Is it important to have hobby?
  o If no, what is your previous hobby?
  o Why did you stop?
• At this stage, are you satisfied with your life in general?
• What do you wish to have in your personal/professional life?
• If you could life your life over again, what would you change?

Work life balance practices
• Do you think that work-life balance is important at your workplace?
  If yes, please discuss?
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **2.** | **H7:** There is a significant relation between perceive value of money and employee work behaviours (job performance and turnover intention) | **Job Performance**  
- Do you think the amount of your work often meets your KPI/requirements?  
- How often have you been assessed?  
- Do you receive the feedback to improve your work performance that helps with work-life balance?  
- How often you find shortages of time in fulfilling your work requirement?  
  - If so, how do you applied to overcome the situation?  
- If you are a team leader, do you think you are a good leader for your staff?  

**Turnover Intention**  
- Do you think that you will stay in this organisation in the next 3, 5 and 10 years? And why? |
| **Note:** Medical Doctors (Job performance and Turnover intention)  
Nurses (Turnover Intention) |   |   |
| **3.** | **H9:** There is a significant difference between male and female perception about the value of money | **Job Performance**  
- What is your opinion about ‘money and work-life balance’?  
- Do you think that men and women have different perceptions towards value of money?  
- Do you think that men think more about money than having balance in life?  
- Do you think that men are more motivated by money than women? |
|   |Flexibility-Job satisfaction  
Flexibility and Supportive supervision-life satisfaction | **Flexibility and Choice in Working Hours**  
- Do you have the opportunity to schedule your duty rooster every week/month?  
- Do you think that its easy for you to find replacement for your rooster, if you have some emergency tasks to do?  
- What is your opinion about working ‘overtime”? Do you think you always have to do it? How does it affect your life? |
|   |   | **Supportive Supervision**  
- Who is your direct supervisor?  
  - Do you know each other before?  
  - Do you know them personally? (family related, friends, community)  
- What type of support you usually get from your supervisor? Management? Federal office/ HQ?  
  - Is it hard to get good support from your supervisor? |
|   |   | **Organizations’ ‘High-Performance’ Practices**  
- What is the expectation of ‘high performance’ from you?  
- Does this reflect in the organizations that you work with?  
- Do you think that your organization have a clear KPI?  
- Do you think that the organization you work with has high income?  
- Do you think that the ‘high performance’ includes in the WLB policy? For example: supervisor support, flexible work arrangements, etc.  
- Do you feel happy at home if you performed better at work? |
<table>
<thead>
<tr>
<th>5</th>
<th>Perceived value of money mediates the relations between WLB and Employee Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Conclusion</td>
</tr>
</tbody>
</table>

- Do you think that you feel satisfied at work if you have a good lifestyle at home?
- What kind of programme/s support that your organization gives you outside your work? (e.g. birthday visits, wedding, family matters)
- In which way, your supervisor help/support you to achieve ‘high performance’?

**AWALI Survey Questions**
- General Interference:
  - Do you think that your work/job interfere with your other responsibilities/activities outside work? Yes? No? Why?
- Time Strain:
  - Do you think that your work/job restrict your time with family and friends? Yes? No? Why?
- Work to community interaction:
  - Do you think that your work/job interfere with your connections and friendships with your local community? Yes? No? Why?
  - Do you feel that you are having a frequent ‘rushed or pressed for time’?
  - How do you feel about your overall ‘work – life balance’?

- Do you think that having more money (working hard for it), had make you trade your time with family/friends/children? Yes/No? Why?
- Do you think that it's ok to work hard for money and spent less time with family? Yes/No? Why?
- What do you prefer? Having more money or having more time with your family/spouse/children/friends?
  - What is the meaning of balance for you?
- Do you think that working in this profession makes you more respectable by the society?
- Is it hard to balance your working time and family time? Yes/No? Why?
- How do you manage to achieve a good balance between work, family, and personal life?
  - If you haven’t achieved that, how do you do it?
  - Do you think you need to have a support from your spouse, family, and children?
  - Support from supervisor?
  - Support from friends?

- Why did you choose to become medical practitioners? (Medical Doctor/Nurses)?
- What’s the best thing about your job?
- What change do you want most in (1) your life? (2) your job?
- If you have one wish in personal life/work life, what would it be?

Any other points about the topics we have talked about today that you would like to add?

Thank you
APPENDIX 6: PANDUAN TEMUDUGA UNTUK KAKITANGAN PERUBATAN (DOKTOR & JURURAWAT)

Bahagian 1: Latar Belakang Calon

Umur: ........
Jantina: ........
Status perkahwinan : ........ (Bilangan anak: ........)

Soalan Pengenalan
1. Organisasi tempat anda bekerja?
2. Jawatan anda?
3. Apakah peranan dan tanggungjawab kerja anda?
4. Berapa lama anda telah bekerja di sini?
5. Apakah sebab utama anda berpindah dari organisasi anda yang terdahulu?
   - Adakah atas sebab peribadi (jarak tempat kerja dari rumah, sebab keluarga)?
   - Adakah atas sebab profesional (bertentangan dengan penyelia, tekanan, keselamatan kerja)?

Bahagian 2: Temuduga ‘In-depth’ bagi menjawab keputusan dari Fasa 1: Analisis Kuantitatif

<table>
<thead>
<tr>
<th>Tema (Theme)/ Keputusan</th>
<th>Objektif &amp; Soalan Cadangan</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. There is a significant relationship between perceived value of money and employee well – being (job satisfaction &amp; life satisfaction)</td>
<td>Faktor Kepentingan (Factor Importance)</td>
</tr>
<tr>
<td></td>
<td>• Adakah anda berpuas hati dengan pakej pampasan dan faedah anda terima? Jika ya, mengapa? Jika tidak, mengapa?</td>
</tr>
<tr>
<td></td>
<td>• Adakah anda merasa bahawa pakej pampasan dan faedah adalah aspek utama untuk anda kekal dalam jawatan serta pekerjaan ini? Ya atau tidak? Mengapa?</td>
</tr>
<tr>
<td></td>
<td>• Adakah anda merasa bahawa gaji semasa anda membantu dalam simpanan untuk masa depan anda? Ya atau tidak? Mengapa?</td>
</tr>
</tbody>
</table>

Faktor Motivasi – Ganjaran (Factor Motivator)

- Adakah anda menerima bonus / bayaran jika bekerja lebih masa? Ya atau tidak? Mengapa?
- Adakah penilaian prestasi semasa anda (penghitungan penilaian) selari dengan ganjaran (kenaikan, bonus, dll)? Bolehkah anda terangkan dengan lebih lanjut mengenai proses ini?
- Adakah anda berpuas hati proses penilaian perestasi ini?
- Adakah anda fikir organisasi harus memberi anda pengiktirafan yang lebih baik sekiranya anda mendapat penilaian yang lebih baik?

Sektor awam / sektor swasta
- Apakah pendapat anda mengenai ‘job security’ di sektor swasta? Adakah ia lebih baik dari sektor awam? Mengapa?
- Apakah pendapat anda mengenai pelan pencen di sector swasta? Adakah ia lebih baik dari sektor awam? Mengapa?
- Apakah pendapat anda mengenai ‘work-life balance’/
Keseimbangan hidup dan kerja di sektor swasta? Adakah ia lebih baik dari sektor awam? Mengapa?
- Adakah tekanan kerja di sektor swasta adalah kurang berbanding sektor awam? Mengapa?
- Adakah gaji merupakan motivasi untuk anda berada di sektor ini (awam)? Mengapa?

Faktor Kekayaan (Factor Rich)
- Adakah dengan pekerja profesion ini mendapat gaji dan ganjaran yang lebih tinggi berbanding profesion lain?
- Adakah anda rasa bahawa dengan berkerja di sektor ini membantu anda untuk mendapat gaji/ ganjaran yang tinggi?
- Adakah anda rasa bahawa anda lebih gembira/ bahagia jika anda mendapat gaji/ ganjaran yang tinggi?

Kepuasan kerja (Job satisfaction)
- Apakah pendapat anda mengenai persekitaran tempat kerja anda? Adakah ia selamat untuk anda?
- Adakah anda berpuas hati dengan tempat kerja ini? Ya atau tidak dan mengapa?
- Adakah anda berpuas hati dengan kerja hakiki anda?
- Bagaimana pula dengan pengiktirafan oleh penyelia anda? Adakah anda berpuas hati?
- Adakah anda dinaikkan pangkat seikatnya anda berkerja selaras dengan kemahuan pejabat?
  - Jika ya, berapa kalakah anda dinaikkan pangkat setakat ini?
  - Jika tidak, mengapa?
- Bagaimana pula dengan hubungan anda dengan penyelia anda?
- Bagaimanakan hubungan anda dengan pihak pengurusan di organisasi ini?
- Adakah anda berpuas hati dengan beban tanggugjawab kerja anda? Ya atau tidak? Mengapa?
- Adakah penyelia anda memberi anda kebebasan untuk menyelesaikan masalah kerja anda?
- Berapakah jumlah cuti tahunan anda? Adakah ia cukup untuk anda?

Kepuasan Hidup (Life Satisfaction)
- Berapa kerapakah anda melawat keluarga terdekat dalam satu tahun?
- Adakah jumlah alwatan ini berubah sejak anda bekerja di sini?
- Bagaimana pula dengan masa bercuti dengan keluarga?
- Bagaimana pula dengan masa dengan rakan-rakan?
- Adakah anda mempunyai hobi dan apakah hobi anda?
  - Berapa kerapakah anda membuat hobi tersebut?
  - Adakah penting bagi setiap individu untuk mempunyai hobi?
- Jika tidak, apakah hobi anda yang dahulu?
<table>
<thead>
<tr>
<th>No.</th>
<th>Perbincangan</th>
<th>Isu dan Tanyaan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td><strong>H7</strong>: Ada isu signifikan hubungan antara perasaan nilai wang dan pekerjaan</td>
<td>Apakah pendapat anda mengenai wajah dan keseimbangan kerja-hidup (WLB practices) di tempat kerja anda? Apakah ia adalah penting? Mengapa?</td>
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<tr>
<td></td>
<td><strong>Nota:</strong></td>
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<tr>
<td></td>
<td>Doktor (Job Performance &amp; Turnover Intention)</td>
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</tr>
<tr>
<td></td>
<td>Jururawat (Turnover Intention)</td>
<td></td>
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<tr>
<td>3.</td>
<td><strong>H9</strong>: Ada isu signifikan perbezaan antara pendapat lelaki dan wanita mengenai nilai wang</td>
<td>Apakah pendapat anda mengenai 'wang' dan 'keseimbangan kerja-hidup'? Apakah pendapat anda mengenai persepsi lelaki dan wanita mengenai nilai wang? Adakah mereka mempunyai persepsi yang berbeza? Adakah lelaki lebih berminat untuk mendapatkan gaji (wang) yang lebih tinggi daripada aspek keseimbangan kerja-hidup? Adakah lelaki lebih tertarik dengan wang berbanding wanita?</td>
</tr>
<tr>
<td>Soalan AWALI</td>
<td></td>
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<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General Interference</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adakah anda rasa bahawa kerja hakiki anda menggangu aktiviti peribadi/ luar kerja? Ya atau tidak dan mengapa?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time Strain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adakah pekerjaan anda menghadkan masa anda dengan keluarga dan rakan-rakan? Ya atau tidak dan mengapa?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Work to Community Interaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adakah pekerjaan anda mengganggu masa anda untuk berinteraksi dengan komuniti setempat anda? Ya atau tidak dan mengapa?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>05. Perceive value of money mediates the relationships between WLB and Employee Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adakah dengan berkerja keras bagi mendapatkan ‘banyak wang’ (gaji) telah memberi kekangan kepada anda untuk beriadah dengan keluarga, kawan serta anak-anak anda? Ya atau tidak dan mengapa?</td>
</tr>
<tr>
<td>Adakah menglimitasi masa dengan keluarga dan kawan-kawan bagi berkerja keras bagi mendapatkan wang adalah ok (boleh diterima)? Ya atau tidak dan mengapa?</td>
</tr>
<tr>
<td>Apakah perasaan dan pendapat andan mengenai keseimbangan kerja-hidup anda?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>06. Kesimpulan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mengapa anda memilih untuk menjadi seorang doctor/ jururawat? Apakah kepuasan yang terbaik tentang kerja serta profesi anda? Adakah anda berpuas hati dengan kehidupan anda sekarang? Apakah perubahan yang anda ingini (i) di dalam kehidupan peribadi</td>
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<tr>
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</tr>
</tbody>
</table>
| **dan (ii) profesion anda?**<br>Apakah satu kemahuan (wish) yang anda mahu di dalam (i) kehidupan peribadi dan (ii) profesiion anda?<br>Sekiranya anda ada peluang untuk menjalani hidup ini semula, apakah benda yang akan anda ubah?  
Adakah anda ingin menambah apa-apa elemen dalam perbincangan hari ini?  
Terima kasih. |
## APPENDIX 7: EMPIRICAL STUDIES-TIME SERIES ANALYSIS

Time-Series Analysis: The Summary of Empirical Studies on Work-life balance, employees well-being and work behaviours

<table>
<thead>
<tr>
<th>No</th>
<th>Authors</th>
<th>Independent Variable(s)</th>
<th>Dependent Variable(s)</th>
<th>Research Method(s)</th>
<th>Settings/ Country of Study</th>
</tr>
</thead>
</table>
| 01. | Scandura & Lankau (1997) | • Gender  
• Family responsibility  
• Flexible work hours | • Organizational commitment  
• Job satisfaction | Quantitative method  
• Survey | • Service, Manufacturing, Government, Retailing, Small business  
• United States |
| 02. | Saltzstein, Ting & Saltzstein (2001) | • Job and family involvement  
• Work and family demands  
• Employee characteristics  
• Family – friendly programs and practices | • Job satisfaction  
• Satisfaction with work – family balance | Quantitative method  
• Survey | • Federal Government ‘white – collar’ employees  
• United States |
| 03. | Clark (2001) | Work culture  
• Flexibility of working hours  
• Operational flexibility  
• Supportive supervision | **Dependent Variable**  
• Work – family balance  
**Moderating Variable**  
• Work – family characteristics | Quantitative method  
• Survey | • Universities students  
• Northwest United States |
<table>
<thead>
<tr>
<th>No.</th>
<th>Author(s) (Year)</th>
<th>High performance practices</th>
<th>Work – life balance</th>
<th>Quantitative method</th>
<th>Country</th>
</tr>
</thead>
</table>
• Working hours  
• Employers ‘high performance’ practices  
• Flexibility and choice in working time  
• Individual pressure: Financial pressure and home time | Work – life balance  
• Negative job – to – home spillover | Survey | Great Britain |
• Involvement – balance  
• Satisfaction – balance | Dependent variable  
• Quality of life | Survey | American Institute of Certified Public Accountants  
• United States |
• Work – role overload  
• Work – role ambiguity  
• Family responsibility | Mediating variables  
• Work – family conflict  
• Stress  
Mediating variables  
• Work – family conflict (WFC)  
• Family – work conflict | Survey | Furniture manufacturers  
• United States |
• Family – to – work conflict (FWC) | Dependent variable  
• Organizational commitment  
• Job satisfaction  
• Life satisfaction  
• Health | Meta-analysis | |
<table>
<thead>
<tr>
<th>No.</th>
<th>Author(s) (Year)</th>
<th>Study Title</th>
<th>Dependent Variables</th>
<th>Moderating Variable</th>
<th>Methodology</th>
<th>Industry/Country</th>
</tr>
</thead>
</table>
• Role environment comprising role experiences  
• Role involvement | • Gender  
• Career satisfaction  
• Work – life balance  
• Burnout (emotional resilience and personal accomplishment) | Quantitative method  
• Survey | Financial services, manufacturing and telecommunications industries  
• India |
| 09. | Keeton, Fenner, Johnson & Hayward (2007) | Dependent Variables | Demographic factors  
• Age  
• Gender  
• Specialty | Career satisfaction  
• Work – life balance  
• Burnout (emotional resilience and personal accomplishment) | Quantitative method  
• Survey | Healthcare (Physician – Obstetrician & Gynecologist)  
• United States |
| 10. | Sun (2009) | Perceptions of work – family balance policy | • State benefits and workplace rights  
• Paid maternity and paternity leave  
• Government financed leaves  
• Individual protection from dismissal on the grounds of leave of absence  
• Right on shorter and flexible working hours | Job satisfaction | Qualitative method  
• Semi structured interviews | Women samples  
• Singapore |
| 11. | Morganson, Major, Oborn, Verive & Heelan (2010) | • WLB support  
• Workplace inclusion  
• Main office  
• Client location  
• Satellite office  
• Home | • Job satisfaction | Quantitative method  
• Survey | Non – for – profit engineering and technology organizations  
• United States |
• Organizational | Quantitative method  
• Survey | Academics of Public Higher Education Institution  
• Malaysia |
<table>
<thead>
<tr>
<th></th>
<th>Author(s)</th>
<th>Demographic factors</th>
<th>Work – family conflict</th>
<th>Quantitative method</th>
<th>Other details</th>
</tr>
</thead>
</table>
| 13. | Mahpul & Abdullah (2011) | **Demographic factors**  
- Region  
- Stratum  
- Ethnicity  
- Age  
- Employment  
- Occupation  
- Children  
- Childcare  
- Child (7 – 12 years old)/ (13 – 24 years old) | **Commitment** | **Quantitative method**  
- Survey |  
- Female workers  
- Professionals, Agricultural, Fishery & Elementary workers  
- Malaysia |
| 14. | Hassan, Ibrahim & Lim (2011) | **Demographic factors**  
- Gender  
- Age  
- Highest Education Level  
- Current CGPA  
- School type  
- Work sector preference  
- Previous experience | **Commitment** | **Quantitative method**  
- Survey |  
- Undergraduate students  
- Malaysia |
<table>
<thead>
<tr>
<th></th>
<th>Study</th>
<th>Dependent variable</th>
<th>Quantitative method</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Sanchez-Vidal, Cegarra-Leiva &amp; Cegarra-Navarro (2012)</td>
<td>availability of WLB practices</td>
<td>Dependent variable: Use of WLB practices by employees</td>
<td>Metal industry &amp; Spain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mediating variable: Perceived availability of WLB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|   | Cegarra-Leiva, Shancez-Vidal & Cegarra-Navarro (2012) | WLB cultures • WLB practices | Dependent variable • Turnover intentions  
Mediating variable • Job satisfaction | Quantitative method • Survey | SMEs of metal industry • Spain |
|---|-----------------------------------------------------|-------------------------------|---------------------------------|-------------------------------|-------------------------------|
|   | Haar (2013)                                          | Work – family conflict • Work – family enrichment | Dependent variables • Job satisfaction  
Life Satisfaction • Emotional exhaustion • Anxiety and depression  
Mediating variable • Work – life balance | Mixed method • Initial exploratory interviews  
Survey | Various sectors of employees • New Zealand |
|   | Kuo (2013)                                           | Recreational sport involvement | Mediating variables • Work stress  
Quality of life • Leisure sport coping strategy | Quantitative method • Survey | Taiwan |
<table>
<thead>
<tr>
<th>No</th>
<th>Authors</th>
<th>Independent Variable(s)</th>
<th>Dependent Variable(s)</th>
<th>Research Method(s)</th>
<th>Settings/ Country of Study</th>
</tr>
</thead>
</table>
• Life satisfaction  
• Comparison between full – time, part – time employees and non – employed students | Quantitative method  
• Survey questionnaires | • Full time employees: Personnel managers of engineering company, university faculty staffs, local schools, banks, churches  
• Part – time employees and non – employed students: university students  
• United States |
| 02. | Tang (2007) | • Income  
• The love of money  
• Job satisfaction | Dependent Variable  
• Quality of Life  
Moderating Variable  
• Income  
• Happiness  
• Life satisfaction | Quantitative method  
• Survey questionnaire | • Personnel managers of engineering company, university faculty staffs, local schools, banks, churches  
• United States |
| 03. | Paul and Guilbert (2012) | • Income  
• Working hours | Time series analysis  
• (2001 – 2005) data from Household Income and labour Dynamics in Australia (HILDA) | | • Australia |