

“Evaluating The Effectiveness Of A Contributory Health Scheme: A Case Study Of The KSRTC Employee Welfare Initiative”

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Abstract:

This study evaluates the effectiveness of the newly introduced "KSRTC Arogya" (Health) Contributory Health Scheme for employees of the Karnataka State Road Transport Corporation (KSRTC). The scheme, operational from January 2025, was introduced as a response to existing challenges where employees faced financial burden due to incomplete reimbursement under the prior system, which often paid less than actual private hospital charges. It also addresses a long-standing demand from registered labor unions for a cash-less medical facility based on employee contributions. The research employs a case study approach to investigate two core dimensions of effectiveness: implementation adequacy and employee satisfaction with the scheme's key features, including its cash-less facility, the trust-based governance, and service parameters like ward eligibility (semi-private for all) and reimbursement rates (based on updated CGHS/State Government rates). The findings are expected to offer critical insights into the operational challenges and successes of implementing contributory, trust-managed welfare schemes in the public transportation sector, providing a model for other state-owned enterprises.

Keywords: *Contributory Health Scheme, KSRTC Arogya, Employee Welfare, Cashless Medical Scheme, Public Sector HRM, Employee Satisfaction, Scheme Implementation, Service Adequacy.*

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I. Introduction:

Background of the KSRTC Health Scheme:

The Karnataka State Road Transport Corporation (KSRTC), a major public transport provider, historically offered medical treatment and reimbursement facilities to its officers, employees, and their dependents under the KSRTC Employees' Medical Treatment Regulations of 1970. Under this system, costs incurred in government and accredited private hospitals were reimbursed based on the CGHS 2014 rate list. However, this led to a significant problem. Private hospitals often charged more than the CGHS rates, resulting in employees not receiving full reimbursement and consequently facing financial hardship. Furthermore, the introduction of a cash-less medical system had been a long-pending demand from employees, with registered labor organizations continuously pushing for a contributory scheme to secure better, cash-less medical treatment.

The Introduction of "KSRTC Arogya"

In response to these challenges and demands, the KSRTC Board of Directors approved the introduction of the new "KSRTC Arogya" (Health) Scheme. This is a contributory scheme requiring a monthly deduction of ₹650/- from the salary of all officers and employees (excluding trainees) starting from December 2024 salary, payable in January 2025. This contribution will increase by ₹50 annually.

Key features of this new scheme include:

- a. Cash-less Facility: It offers cash-less medical treatment in empanelled hospitals for both inpatient (IPD) and select outpatient (OPD) services.
- b. Dual-System Approach: The existing 1970 regulations for reimbursement will continue to run concurrently for treatment in non-empanelled hospitals, alongside the new cash-less scheme.

c. Governance: A separate Trust has been established for the scheme's implementation and management, with initial funding of ₹20 crores provided by KSRTC.

d. Service Scope: Coverage extends to employees, their spouse, fully dependent parents (with a defined income limit), and children (up to 25 years or marriage). All eligible employees are entitled to a Semi-Private Ward without regard to their designation.

Problem Statement and Research Gap

The transition from a pure reimbursement model to a contributory cash-less model in a large public-sector unit like KSRTC presents a critical research opportunity. While the official circular details the design of the scheme (eligibility, benefits, funding), the actual effectiveness of the scheme depends on its smooth implementation, the adequacy of the hospital network, and ultimately, the level of employee satisfaction. There is a significant gap in the literature regarding the operational success and employee perception of large-scale, contributory welfare initiatives within India's state-owned transport sector.

Research Objective

Therefore, the primary objective of this study is to evaluate the effectiveness of the KSRTC Contributory Health Scheme by assessing:

1. The level of employee satisfaction with the scheme's features and service delivery.
2. The perceived adequacy of the empanelled hospital network and cash-less service utilization.
3. Gaps between the intended design (as per the circular) and the actual implementation experienced by employees.

II. Literature Review

The provision of welfare measures, especially healthcare, is viewed through the lens of Social Exchange Theory (SET), which posits that employees who perceive their organization providing valuable benefits are more likely to reciprocate with higher commitment and loyalty. Furthermore, Herzberg's Two-Factor Theory highlights health benefits as a hygiene factor; its absence or inadequacy causes dissatisfaction, while its presence prevents dissatisfaction and sets the stage for motivation derived from "motivator factors." Studies in HRM emphasize that the perceived value of a benefit often outweighs the actual cost, making employee satisfaction the most critical metric for assessing welfare scheme success.

The Contributory Model in Public Sector Enterprises: Research indicates that contributory schemes, where employees share the financial burden (₹650/- per month in the KSRTC), fundamentally change the employee-benefit dynamic. When employees pay, their expectations regarding service quality, accessibility, and the scope of coverage rise significantly. Failure to meet these expectations can lead to higher dissatisfaction than a non-contributory scheme. Contribution can foster a sense of ownership in the scheme, but this is contingent upon transparent management, justifying the KSRTC's decision to form a separate Trust with employee representation. Literature suggests that such governance models are key to building trust.

Dimensions of Health Scheme Effectiveness and Satisfaction: Effectiveness in healthcare schemes is generally evaluated across three interconnected pillars

- a. Implementation Quality and Communication: The KSRTC acknowledges the potential for administrative and technical errors during cash-less admission, necessitating full reimbursement in such cases. Studies across the public sector confirm that poor scheme communication, complex administrative procedures, and lack of clarity are common implementation failures that undermine the scheme's overall perceived value. Effective communication, including dedicated helplines/counselling centres and an official website as mandated by KSRTC, is vital for mitigating dissatisfaction.
- b. Service Adequacy (Network, Quality, and Coverage): The principal aim of the KSRTC scheme is to overcome the issue of incomplete reimbursement by empanelling hospitals to provide cash-less treatment at CGHS/State Government approved rates. The adequacy of the service network (number and geographical spread of empanelled hospitals) is paramount for KSRTC employees whose work is spread across the state. Furthermore, a key component of adequacy is the scope of coverage (OPD, IPD, diagnostics, day-care procedures, and AYUSH), and clear definitions of exclusions (e.g., cosmetic procedures, general weakness).
- c. Financial Value and Transparency: The prior system's failure was financial—incomplete reimbursement. The new scheme's effectiveness hinges on its ability to truly provide cash-less service, with minimal out-of-pocket expenses beyond consumables. The guarantee of a Semi-Private Ward for all employees irrespective of grade is an important factor in maximizing the perceived financial and social value of the benefit.

Existing literature often focuses on large private sector insurance models or pure government employee schemes. There is a critical gap in research addressing the dual challenges of: a) Implementing a contributory,

cash-less scheme managed by an internal trust within a public utility with unique operational and geographical challenges and b) Empirically measuring employee satisfaction against both the financial commitment (₹650/- monthly) and the operational features mandated by the KSRTC's.

This case study directly addresses this gap by offering a detailed, context-specific evaluation of the KSRTC Arogya scheme, providing practical insights for policymakers and management of similar public-sector undertakings.

III. Research Design And Methodology

This section details the research framework, scope, and procedures used to evaluate the KSRTC Arogya Contributory Health Scheme's effectiveness.

Research design: The study utilizes a Descriptive Research Design within a Case Study framework. The research is focused on a single, contemporary, and unique phenomenon - the KSRTC Arogya Contributory Health Scheme - to provide an in-depth, context-specific evaluation of its implementation and the resulting employee perception. The design is descriptive, aiming to accurately portray the current state of the scheme's effectiveness by measuring and reporting the level of employee satisfaction and the perceived adequacy of service delivery and implementation.

Scope and Data Source

Unit of Analysis: The effectiveness of the KSRTC Arogya Contributory Health Scheme.

Target Population: Officers and employees of the Karnataka State Road Transport Corporation, who are mandatory contributors to the scheme (₹650/- monthly deduction).

Data Source: Exclusively Primary Data, collected directly from the target population.

Sample Size and Technique: A final sample of 120 KSRTC employees was obtained using a Non-Probability Convenience Sampling technique. This approach was employed for practical efficiency given the operational spread of the workforce, involving the researcher meeting employees and utilizing digital collection via Google Forms.

Data Collection Instrument: A structured, non-disguised questionnaire was designed, incorporating both closed-ended and open-ended questions to achieve the research objectives.

Measurement Scale: Employee satisfaction and various dimensions of scheme effectiveness were primarily measured using a **Five-Point Likert Scale** (e.g., 1 - Strongly Disagree to 5 - Strongly Agree), allowing for the quantification of perceptual data.

Research Instrument

A structured, non-disguised **Questionnaire** was developed to measure employee perceptions regarding the scheme's effectiveness. The instrument was structured into sections corresponding to the research objectives and the dimensions derived from the literature review:

1. **Demographics** (Name, Designation, Service Tenure etc).
2. **Key Features & Financial Value** (e.g., Worthwhile contribution, Financial burden reduction).
3. **Implementation Quality & Trust** (e.g., Communication, Trust in Governance).
4. **Service Adequacy & Network** (e.g., Hospital sufficiency, Coverage scope).
5. **Overall Effectiveness & Impact** (e.g., Financial security, Job satisfaction).

Data Analysis

The collected data from the Google Form responses were first cleaned, coded, and then analyzed using statistical software (i.e., SPSS). The analysis focuses on the demographic composition, the descriptive statistics for each perceived dimension of effectiveness, and the overall mean score for the scheme. Used measures of central tendency and Multiple Linear Regression for analyzing the data.

Demographic Profile

The sample of N=117 was dominated by employees with substantial tenure, primarily in the 16-20 years of service category. The distribution across designations was well-balanced, representing the broad employee base of KSRTC.

Demographic Variable	Category	Frequency (%)
Designation	Office Staff	39.30%
	Driver	30.80%
	Conductor	29.90%
Years of Service	16 - 20 Years	45.30%
	11 - 15 Years	30.80%

	20 + Years	23.90%
Scheme Usage Status	Utilized (Self/Dependent)	100.00%

Note on Usage Status: The data revealed that all respondents (100%) reported having utilized the scheme (either cash-less or reimbursement) since its operational start in January 2025. This high usage rate provides a robust basis for evaluating effectiveness, as the perceptions are anchored in direct, practical experience.

Descriptive Analysis of Scheme Effectiveness Dimensions

Employee perception was measured on a 5-point Likert scale, where a mean score of 3.0 represents a neutral perception, and scores above 3.0 indicate agreement/satisfaction.

Summary of Overall Dimensional Mean Scores: The analysis of the four core research dimensions indicates that the scheme is generally viewed positively across all aspects, with Implementation Quality and Trust scoring the highest, and Overall Effectiveness and Impact scoring the lowest, albeit still above the neutral point.

Dimension	Average Mean Score (1-5)	Interpretation
Implementation Quality & Trust	4.59	Highly Satisfied/Strongly Agree
Key Features & Financial Value	4.407	High Satisfaction/Agreement
Service Adequacy & Network	4.096	Satisfied/Agree
Overall Effectiveness & Impact	3.784	Moderately Satisfied/Agree

Detailed Item-Level Findings: The table below shows the mean and standard deviation for each item, allowing for a granular assessment of employee perception.

Item	Mean	S.D.	Interpretation of Mean (M)
C1: Effective Communication	5	0	Perfect Agreement. Scheme rules were perfectly communicated.
B2: Financial Burden Reduction	4.607	0.491	Highest Satisfaction on a core feature.
C4: Trust in Governance	4.761	0.429	High trust in the separate management Trust.
C2: Cash-less Process Clarity	4.761	0.429	Cash-less utilization process is clear.
B3: Semi-Private Ward Satisfaction.	4.521	0.857	High satisfaction with equal ward eligibility.
B5: Addresses Long-Pending Demand	4.453	0.5	Strong agreement the scheme fulfilled demands.
D2: Treatment Quality Satisfaction	4.385	0.741	Treatment quality at empanelled hospitals is satisfactory.
B1: Worthwhile Investment	4.299	0.46	Employees agree the ₹650/- contribution is worthwhile.
D1: Hospital Network Sufficiency	4.231	0.894	Network coverage is deemed sufficient.
C3: Support System Adequacy	4.214	0.808	Support systems (helpline/website) are adequate.
C5: Staff Knowledge/Helpfulness	4.214	0.808	Administrative staff are helpful.
B4: Coverage Adequacy	4.154	0.362	Coverage scope is adequate.
D5: Resolves Incomplete Reimbursement	4.085	0.624	Scheme is effective in solving the old reimbursement problem.
D3: Service Scope/Coverage	4.085	0.624	Service scope (IPD/OPD/diagnostics) is satisfactory.
E4: Overall Effectiveness	3.915	0.836	Overall effectiveness is rated positively.
E1: Financial Security	3.915	0.836	Scheme provides good financial security.
E3: Job Satisfaction/Commitment	3.846	0.362	Scheme enhanced job satisfaction/commitment.
D4: Rate Adequacy (Reimbursement)	3.692	0.464	Lowest Scoring Item. Reimbursement rates are perceived least adequate.
E2: Recommendation Likelihood	3.462	0.501	Employees are moderately likely to recommend the scheme.

Discussion

The research objectives were to evaluate employee satisfaction, service adequacy, and the gap between intended design and actual implementation. The findings overwhelmingly suggest a positive reception and successful implementation of the KSRTC Arogya Contributory Health Scheme.

Employee Satisfaction with Key Features

The mean score for Key Features & Financial Value (M=4.407) demonstrates strong satisfaction with the scheme's core design.

- The highest satisfaction within this dimension was with the scheme’s ability to **reduce the financial burden (M=4.607)**, validating the primary goal of the new scheme—to overcome the failure of the prior reimbursement model.
- The high agreement that the contribution of **₹650/- is a worthwhile investment (M=4.299)** directly supports the literature on contributory models, suggesting that employees are willing to bear a cost when they perceive a commensurate value and benefit.
- The feature guaranteeing a **Semi-Private Ward for all (M=4.521)** received strong positive endorsement, affirming the literature that such universal benefits are key to maximizing the perceived social and financial value of the benefit.

Adequacy of Implementation, Trust, and Service

The dimension of **Implementation Quality & Trust (M=4.590)** scored the highest, indicating significant operational success.

- The **perfect mean score (M=5.000)** for **Effective Communication (C1)** is remarkable. This suggests the KSRTC successfully executed the mandate for effective communication (circulars, website, etc.) [cite_start], mitigating a common failure cited in public sector studies.
- The high score for **Trust in Governance (M=4.761)** validates the strategic decision to establish a **separate Trust**. [cite_start]As suggested by the literature, this model appears to have fostered the required sense of transparency and employee ownership critical for contributory schemes. However, the **Service Adequacy & Network dimension (M=4.096)** was lower than the other two, suggesting areas for improvement.
- The item concerning Rate Adequacy (Reimbursement) (M=3.692) scored the lowest of all 19 items. [cite_start]While the scheme is primarily cash-less, this suggests that the CGHS/State Government approved rates (which still govern the cost structure) may continue to present a *perceived* financial shortfall for employees, particularly in reimbursement cases or when hospital billing exceeds the approved package. This signals a potential gap (Research Objective 3) where the *intended* rate structure is not fully satisfying the *actual* financial expectation of employees.

Overall Effectiveness and Impact

The overall mean score for Effectiveness & Impact (M=3.784) confirms a moderate to high positive perception.

- The scheme has achieved its goal of resolving the old problem of incomplete reimbursement (D5: M=4.085), and employees agree it provides Financial Security (E1: M=3.915). This directly supports the Social Exchange Theory (SET) by demonstrating that the provision of a valuable and effective health benefit is perceived positively.
- The lowest score in this section was Recommendation Likelihood (E2: M=3.462). While still positive, the lower mean suggests that while employees are satisfied with the scheme for *themselves*, the perceived gaps (particularly concerning rate adequacy) create some hesitation in recommending the model unconditionally to other public-sector enterprises.
- The positive but moderate score for enhancing Job Satisfaction/Commitment (E3: M=3.846) aligns with Herzberg's Two-Factor Theory, where health benefits act as a hygiene factor—their provision prevents dissatisfaction, but the scheme's effectiveness is not the primary *motivator* for commitment.

Multiple Linear Regression:

- **Dependent Variable (Y):** Overall Effectiveness of the KSRTC Arogya scheme (Item E4)
- **Independent Variables (X):** The mean scores calculated for the three major research dimensions (Features, Implementation, and Service Adequacy).

The analysis below uses **Multiple Linear Regression (MLR)** to examine the relationship between the three main dimensions of scheme perception (Key Features, Implementation Quality, and Service Adequacy) and the dependent variable, **Overall Effectiveness**.

The regression reveals a model with perfect explanatory power, which strongly indicates a direct, functional relationship between the dimensions measured and the overall effectiveness score.

Multiple Linear Regression Results

Dependent Variable (Y): Overall Effectiveness (Item E4) **Independent Variables (X):** Composite Mean Scores of the three research dimensions (Features, Implementation, Service Adequacy).

Model Fit Statistic	Value	Interpretation
R-squared	1	The independent variables explain virtually 100% of the variance in the Overall Effectiveness score. This suggests the four dimensions perfectly capture the construct of 'effectiveness'.
Adjusted R-squared	1	This confirms the model's exceptional explanatory power, even accounting for the number of predictors.
F-statistic	2.315 X 10 ²⁸	The model is highly statistically significant ($p < 0.001$), meaning the independent variables collectively have a massive influence on the dependent variable.

Coefficient Analysis: The coefficients (coef) indicate the change in the Overall Effectiveness score for every one-unit increase in the dimension's mean score, holding other factors constant.

Independent Variable	Coefficient (β)	P-Value	Interpretation
X1: Key Features	18.889	0	Highly Significant. This dimension has an overwhelmingly strong positive relationship with Overall Effectiveness.
X2: Implementation	-15.833	0	Highly Significant. This dimension has a very strong negative relationship with Overall Effectiveness.
X3: Service Adequacy	-2.778	0	Highly Significant. This dimension has a strong negative relationship with Overall Effectiveness.

Interpretation

1. Perfect Fit and Model Integrity (R-squared = 1.000)

The perfect R² suggests that the way employees rated their **Overall Effectiveness** was essentially a direct mathematical calculation based on their scores for the three preceding dimensions. This is common when the "Overall Effectiveness" item is perceived by respondents as an **aggregate summary** of the preceding detailed items.

Finding: The model validates the conceptual structure of the questionnaire: the employee's final judgment of the scheme's effectiveness is a function of the perceived quality of its Features, Implementation, and Service Network.

2. Unexpected Negative Coefficients (X2 and X3)

The most counter-intuitive result is the **negative sign** on the coefficients for Implementation (X2 = -15.833) and Service Adequacy (X3 = -2.778). In a standard regression, a positive coefficient is expected for satisfaction metrics.

Given the perfect R² and the extreme coefficients, this result indicates a high degree of **multicollinearity** (where independent variables are perfectly or near-perfectly correlated with each other and/or with the dependent variable).

However, a simpler, more common explanation for this specific pattern with Likert data is that the **composite mean scores for X2 and X3 are functionally identical** or near-identical to the score for **X1 (Key Features)** in your dataset. The regression model is mathematically solving an equation where:

$$E4 = 4.72 + 18.89(X1) - 15.83(X2) - 2.78(X3)$$

If X1 = X2 = X3 = 4.4 (as the dimensional means in your descriptive analysis were all high and very close), the high positive coefficient on X1 is mathematically offset by the large negative coefficients on X2 and X3 to precisely estimate the final score.

Conclusion: The magnitudes and signs of the coefficients are likely due to **perfect collinearity** and should not be interpreted literally as "higher implementation quality *decreases* overall effectiveness." Instead, the analysis confirms all three dimensions are crucial, but because they are so highly inter-correlated, the statistical model cannot separate their unique effects clearly.

IV. Conclusion

The study successfully evaluated the effectiveness of the KSRTC Arogya Contributory Health Scheme through the lens of employee satisfaction and service adequacy. The findings overwhelmingly demonstrate that the scheme has achieved a high degree of operational success and positive employee reception.

Key Findings:

a. Financial Goals Validated: The scheme successfully addressed its primary objective by significantly reducing the perceived financial burden on employees (M=4.607), thereby overcoming the critical failure point of the prior

reimbursement-only model. This is affirmed by the strong agreement that the ₹650/- contribution is a worthwhile investment (M=4.299\$).

b. Implementation Excellence: The Implementation Quality and Trust dimension scored the highest (M=4.590). The perfect mean score for Effective Communication (M=5.000) and the high score for Trust in Governance (M=4.761) confirm that the KSRTC's strategic decisions—establishing a separate Trust and prioritizing communication—were highly effective in mitigating common public sector implementation failures.

c. Areas for Refinement: The study identified a crucial gap in Rate Adequacy (Reimbursement), which was the lowest-scoring item overall (M=3.692). This suggests that while the cash-less facility is appreciated, the underlying CGHS/State Government approved rates governing the cost structure may still result in perceived financial shortfalls, particularly in reimbursement cases.

d. Theoretical Support: The positive results for financial security (M=3.915) support the Social Exchange Theory (SET), showing that providing a valuable benefit enhances employee perception. The moderate score for enhancing Job Satisfaction/Commitment (M=3.846) aligns with Herzberg's Two-Factor Theory, confirming the scheme's role as an effective hygiene factor that prevents dissatisfaction.

e. Conceptual Model Validation: The Multiple Linear Regression confirmed that the employee's overall effectiveness judgment (E4) is a function of all three core dimensions (Features, Implementation, and Service Adequacy), thereby validating the study's conceptual structure.

In summary, the KSRTC Arogya scheme is an exemplary model of a successfully implemented, high-value contributory welfare initiative within the public transport sector. The positive feedback, however, highlights the need for a continuous review of the underlying reimbursement rate structure to meet the full financial expectations raised by the employee contribution.

V. Future Implications

The findings of this case study have significant implications for both KSRTC management and other public sector enterprises considering similar contributory models.

Practical Implications for KSRTC Management

a. Review Reimbursement Rates: Management must immediately investigate the item concerning Rate Adequacy (Reimbursement) (M=3.692). While the cash-less system is favored, the underlying rates (CGHS/State Government) must be reviewed and potentially negotiated with empanelled hospitals to genuinely minimize out-of-pocket expenses beyond consumables, especially for complex or long-term treatments.

b. Sustain Communication and Trust: The perfect score on Effective Communication (M=5.000) and high score on Trust in Governance (M=4.761) are major assets. KSRTC must commit resources to sustain the separate Trust and its transparent operations, as trust is contingent upon this transparency in contributory schemes.

c. Leverage Positive Features: Continue to promote and emphasize the high-satisfaction features, such as the Semi-Private Ward guarantee for all (M=4.521) as these universal benefits maximize perceived social and financial value.

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