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ABSTRACT

The research examined the impact of management upon employee outcomes (perceptions of discretionary power, wellbeing, engagement, and affective commitment), comparing public and private sector nurses in Australia, the United Kingdom, and Italy. Overall, 1945 nurses participated in a self-report survey within these core- and laggard-New Public Management countries. While management influenced employee outcomes for each country, there were significant differences between the public and private sectors, with private sector nurses reporting higher perceptions of outcomes. Importantly, nurses' engagement was affected by management practice for each country. This study raises important implications for nurse managers, especially public sector managers, described within.

INTRODUCTION

The importance of the management function is widely recognised because of its impact on employee outcomes (Cropanzano and Mitchell 2005). For example, Bloom, Genakos, Sadun and Van Reenen (2012) undertook a comparison of management practices across 20 countries in a variety of industries, to dentify the countries that manage the 'best', including whether there were management differences between the public and private sectors. Further, Bullock, Stritch and Rainey (2015) compared public and private employees' work motives, attitudes and perceived rewards across 30 nations, providing evidence for enhanced management practices.

In terms of which country is effectively managed by international standards, Bloom et al. (2012 14) found that 'US firms in retail and hospitals also appear to be the best managed internationally', based on performance monitoring, target setting, and people management. Within hospitals, Bloom et al. also compared management quality across

countries, because the health sector is expanding quickly, in most countries it is subsidised by the taxpayer, and efficiency and effectiveness are crucial in a context of increasing demand for services. They found significant differences in management quality between public and private organisations (with private sector organisations considered better managed) and that the biggest differentiator was people management and client outcomes (Bloom et al. 2012).

In this paper, we focus on comparing people management practices in the healthcare sectors across the public and private sector in three countries: Australia, UK and Italy. While the implementation of New Public Management (NPM) has been the impetus for the biggest public sector change agenda facing many managers for the past few decades (Kuipers et al., 2014), the resulting changes have not been homogeneous across countries, or even across organizations within the same country. To capture greater clarity about the depth and breadth of how different countries have implemented changes, Pollitt and Bouckaert (2011) categorised countries as either core-NPM countries (such as the USA, UK and Australia) or NPM-laggard countries (such as Germany, Italy and other Southern European countries). Further, there is emerging evidence that core-NPM countries are not a homogeneous group. Therefore, we compared two core-NPM countries (Australia and the UK) to identify whether differing increased discretionary power of public sector managers impacted upon employee outcomes. As further comparison, Italy was chosen as an example of a country that has implemented minimal changes in management practices (NPM-laggard).

Additionally, comparisons across only one sector, the healthcare sector, were chosen because previous research suggested the need to ensure valid comparisons of "apples with apples" and not "apples with oranges" (Lee 2016). The healthcare sector is similar to other social services provided by local government and other departments in

most OECD countries in that it has been similarly affected by multiple challenges including a growing demand for their services along with budget constraints driving change at various levels, especially in the past decade since the global financial crisis (Kuipers et al. 2014, 17). For example, while resource pressure was similar for local government employees in Australia with those in the USA, the Australian employees experienced a lower perception of Leader-Member Exchange (LMX), higher perception of resource inadequacy and lower engagement as a result and one explanation was the increased discretionary power of managers in Australia (Brunetto et al. 2015; Xerri, Farr-Wharton, Brunetto and Lambries 2016). Countries such as Australia, the United Kingdom (UK) and the United States of America (USA) have undertaken significant (but not the same) management reforms and have been labelled as core- New Public Management (NPM) countries, while others such as France and Italy have implemented far fewer reforms, and at a slower pace and therefore have been labelled NPM-laggards (Pollitt and Bouckaert 2011).

One strategy used in some core-NPM countries has been to increase the discretionary power of management to encourage public sector change, and there has also been a trend towards using autocratic management practices (Ackroyd Kirkpatrick and Walker 2007; Brunetto, Farr-Wharton and Shacklock 2011, Brunetto, Farr-Wharton, Shacklock and Robson 2012). These strategies are part of a bigger array of strategies used by managers across countries to different extents. While some aspects of organisational performance have improved, some employees (e.g., nurses, police officers, local government employees) in some core-NPM countries have experienced lower wellbeing in the workplace because of increased monitoring by management. The increased monitoring is also often coupled with inadequate staff levels (caused by a combination of reduced per capita resourcing as well as some poor management of existing resources) and reduced

discretionary power of employees (Diefenbach 2009; Brunetto et al. 2015a; 2015b). High discretionary power (i.e., the autonomy to make decisions in the workplace) has been identified as one of the most important workplace factors required by employees working within the context of staff/skill shortages, and where employees are expected to meet clients' needs and be resourceful with limited means (Scotti, Harmon and Behson 2007).

We compare the impact of supervisor-employee relationships because it appears to be a distinguishing factor in affecting employee outcomes across core- and laggard-NPM countries (Pollitt and Bouckaert 2011; Kuhlmann 2010; Brunetto et al. 2015a, 2015b). Social Exchange Theory (SET) is used to frame this study because evidence suggests effective workplace relationships apportion concrete and intangible positive benefits and outcomes for employees (e.g., access to resources, autonomy and respect), managers (e.g., support for managerial decisions) and organisational effectiveness (from increased employee commitment and engagement, leading to reduced turnover and increased performance) (Shore, Coyle-Shapiro, Chen and Tetrick 2009). As such, Cropanzano and Mitchell (2005) argued that SET is a useful framework which can explain much of the behaviour evident in workplaces. When SET is applied to this study, we argue that positive perceptions of management support and manager-employee relationships within workplaces are likely to result in employees perceiving adequate discretionary power to do their job and consequently, employee work outcomes also improve. A review of the extant literature revealed no studies that have examined the differences in impact of management on employee outcomes across the public –private sectors in Australia, Italy and the UK. Therefore, our study aims to contribute insight into public sector management across three countries, differing in the extent to which reforms have impacted workplace exchange relationships.

BACKGROUND

Social Exchange Theory

SET is a composite theory that helps explain how employees behave at work. Key contributors to the theory include Homans (1974), Blau (1964) and Cropanzano and Mitchell (2005). First, Blau (1964) argued that positive interactions with management generated feelings of obligations, goodwill, gratitude, helpfulness and trust (over time) by employees to return the behaviour sometime in the future, which later became known as mutual reciprocity. Later, Homans (1974) proposed that employee behaviour was based on the notions that rewards encourage, while punishments discourage certain behaviours, especially if the reward is valuable to an employee (although, the law of diminishing marginal utility does apply).

Cropanzano and Mitchell (2005) summarised previous SET research (assumptions, conceptualisations, theoretical extensions) and explained how SET had been used to conceptualise and explain variables such as LMX, perceived organisational support (POS) and affective commitment. They argued that the benefits of positive interactions in the workplace between managers and employees are based on the notion that, "social exchange comprises actions contingent on the rewarding reactions of others, which over time provide for mutually and rewarding transactions and relationships" (Cropanzano and Mitchell 2005, 891). In particular, while there is often no set timeframe in which reciprocation should take place, continuous under-reciprocation will lead to a breakdown of the social exchange relationship, in turn, negatively impacting management practices (Cropanzano and Mitchell 2005; Shore et al. 2009). In this study, we examine how two SET variables: POS (the relationship between the employee and the organisational support given by management), and LMX (the quality of the relationship between the employee and supervisor), impact upon employee outcomes in three countries (Australia, Italy, and

the UK). Each country has implemented differing levels of change to management practices, which we argue impacts on the quality of employee relationships with management (POS, LMX), thereby affecting the extent to which mutual reciprocity takes place, and as a consequence, employee outcomes are different. Australia is an example of where the discretionary power of managers has increased. Italy is an example of where managerial power has remained somewhat unchanged, while the UK represents countries where there have been some increases in the discretionary power of managers (Trinchero, Brunetto and Borgonovi 2013; Brunetto et al. 2012; 2014; 2015a; 2015b). We propose that the different management practices (even across core-NPM countries) are likely to result in employees (in this case, nurses) having differing outcomes.

Perceived Organisational Support

Perceived Organisational Support **(**POS) is a SET concept based on the notion of mutual reciprocity. That is, when employees perceive support from their organisation, they reciprocate by giving back high work outcomes (Cropanzano and Mitchell 2005). In contrast, when employees perceive that management continues to make decisions (e.g., policy and practices), which adversely affect them, they will perceive the organisation to be unsupportive, not value the work they do, and not care about their wellbeing (Allen, Shore and Griffeth 2003). Public sector workplaces reporting low POS have increased in number since the initial implementation of NPM in core-NPM countries. Diefenback (2009) and Brunetto et al. (2012; 2015a; 2015b) argued that, for some public employees (e.g., nurses, police, etc.), the focus on increased accountability and reporting without extra resourcing has contributed to a lowering of POS in these countries (e.g., Australia). Further, Zapf, Escartin, Einarsen, Hoel and Vartia (2011) identified that there is a higher incidence of poor management practices in the health and social sectors, especially in core-

NPM countries like Australia, New Zealand, and the UK. While there are reports of low levels of POS, past research indicates that, for different types of public and private sector employees, POS predicts affective commitment (Luchak and Gellatly 2007) and wellbeing (Brunetto et al. 2014).

In contrast, very little is known about the impact of management practices on employee outcomes within classical Continental countries, such as Italy. Following a review of the extant literature, no studies have been found comparing the impact of POS on the discretionary power of both public and private sector nurses working in the UK, Italy, and Australia. While we expect nurses' POS to be usually low, the expectation remains that POS will be positively related to discretionary power, engagement, wellbeing and commitment because as POS increases, so too do employee outcomes. However, we expect that if POS is reported to be low, employee outcomes (e.g., psychological wellbeing, engagement, affective commitment) will also be low. Hence we hypothesise:

H1: *Nurses' POS is positively associated with their perceptions of discretionary power.*

H2: *Nurses' POS is positively associated with their psychological wellbeing.*

H3: *Nurses' POS is positively associated with their affective commitment.*

Supervisors–subordinate relationships

Three key functions of an effective supervisor are to: (1) interpret organisational policies and directives from senior management, (2) mediate *demands* (performance targets) from management with the departmental *supply* (e.g., employees, equipment, resources), and (3) engage in 'helping behaviour' when needed (Beattie 2006; Brunetto et al. 2012; 2014). However, numerous researchers suggest that these functions may not be performed well by public sector supervisors because of poor training, especially in the health and social

sectors (Diefenback, 2009; Beattie, 2006; Ackroyd et al. 2007; Zapf et al. 2011). Research indicates that the higher an employee's level of satisfaction with their supervisor, the higher will be their perception of discretionary power, and subsequent organisational performance (Cropanzano and Mitchell 2005; Brunetto et al. 2012). It is therefore expected that nurses' perceptions of LMX will positively influence their discretionary power.

H4: *Nurses' perceptions of LMX are positively associated with their perceptions of discretionary power.*

Discretionary power

Discretionary power refers to the extent to which employees perceive that they have a choice and/or control to influence 'what' and 'how' they undertake tasks in the workplace (Gagné and Deci 2005). Discretionary power is often conceptualised within public sector literature in terms of the power of street-level bureaucrats. Further, Adler and Asquith (1993) conceptualised discretionary power in terms of 'rule', 'task' and 'value' discretion. In the case of nurses, 'rule' discretion has decreased their 'choice' because of 'administration, monitoring and communication' requirements (Butterfield et al. 2005, 338). Similarly, 'task' discretion has been curtailed as many nursing tasks have been standardised to benchmark performance and the use of resources (Bolton 2003; 2005). However, Scotti et al. (2007) argued that when resources are tight, employees need to have discretionary power to deliver an effective service to clients. The third type is 'value' discretion, which nurses seldom have because it occurs only in cases where patients require specialised care (a non-standardised clinical response) (Hupe and Hill 2007).

Regarding past research, discretionary power has been found to impact employees' perceptions of psychological wellbeing (Thompson and Prottas 2005) and engagement (Spence, Laschinger and Finegan 2005; Brunetto et al. 2014). Hence, it is expected that

discretionary power will positively impact upon engagement and psychological wellbeing for public and private sector nurses in Australia, Italy, and the UK, as hypothesised:

H5: *Nurses' perceptions of discretionary power are positively associated with their psychological wellbeing.*

H6: *Nurses' perceptions of discretionary power are positively associated with their engagement.*

Engagement

Managers care about employee engagement because it captures the extent to which employees have vigour (e.g., high energy and mental resilience), dedication (e.g., enthusiasm), and absorption (e.g., working happily) in the workplace (Schaufeli and Bakker 2004; Kular, Gatenby, Rees, Soane and Truss 2008). Past research has identified engagement as an important antecedent of affective commitment for nurses in Italy (Trinchero, Borgonovi and Farr-Wharton 2014) and Australia (Shacklock, Brunetto, Teo, and Farr-Wharton 2014), though no studies have been found for nurses working in the UK. We therefore expect that employee engagement will be positively correlated with affective commitment.

H7: *Nurses' engagement is positively associated with their perceptions of affective commitment.*

Employee Wellbeing in the workplace

Within the management literature, employee wellbeing is conceptualised as capturing employees' mental state (in terms of levels of satisfaction) with processes and practices in the workplace (Grant, Christianson and Price 2007). It differs from job satisfaction because

it not only refers to employees' attitudes and feelings about their job, but also to their satisfaction with tangible and intangible aspects of the work context.

Psychological wellbeing is important to examine because it provides insight into the mental state of employees regarding their workplace. Also, research suggests that psychological wellbeing is an antecedent of engagement for police officers and nurses (Brunetto et al. 2014), and has also been found to significantly correlate with their affective commitment (Rodwell et al. 2009). Hence, it is expected that psychological wellbeing will predict engagement and affective commitment.

H8: *Nurses' psychological wellbeing is associated with their perceptions of affective commitment.*

H9: Nurses' *psychological wellbeing is positively associated with their perceptions of engagement.*

Affective Commitment

Affective commitment is often used as a proxy for employee performance because it measures employees' identification and emotional attachment to an organisation (Allen and Meyer 1990). High affective commitment is associated with low turnover intentions because the emotional attachment that forms means that employees remain with the organisation because they feel obligated to support the organisation (Shore, et al. 2008). As previously argued for Hypothesis 3, we expect to find that high satisfaction with management is associated with high affective commitment.

Public versus Private sector employees across different countries

One factor affecting public sector management practices is the extent to which NPM reforms have been implemented (Pollitt and Bouckaert 2011). In NPM-laggard countries,

like Italy, France and Germany, changes to management practices were spasmodic and somewhat limited in impact (Ongaro 2008; Kuhlmann 2010). Even in core-NPM countries, management reforms have impacted differently with, for example, Australian local government employees perceiving lower satisfaction and support from management compared with those in the USA (Brunetto et al. 2015a). Reforms in Australia focused on increasing managerial control to achieve multiple government objectives (e.g., cost-cutting and professional accountability), whereas the UK approach was to separate policy development from service provision (Carroll and Steane 2002). There has also been a stronger movement of employees from the public to private sector hospitals in Australia, which has increased the pressure on the resourcing of public hospitals (Brunetto et al. 2011).

Earlier studies suggested no significant differences between public and private sector employees' values and practices (See Lyons et al. 2006; Buelens and Van den Broeck 2007). However, increasingly, empirical evidence has been identified of significant differences in employees' satisfaction with management and outcomes in the public and private sectors across numerous countries. Bloom et al. (2012) and Brunetto et al. (2015b) found differences between the public and private sector in Italy and Australia, and Farr-Wharton et al. (2016) found differences between police in USA and Malta. Additionally, Doiron, Hall and Jones (2008) found that nurse turnover was higher in the public sector in Australia and the UK. Hence, it is expected that private sector employees will have higher perceptions of POS, LMX, discretionary power, psychological wellbeing, engagement and affective commitment compared with public sector employees, especially in Australia (core-NPM country).

H10: *In the UK, Australia, and Italy, private sector nurses perceive higher levels of POS, LMX, discretionary power, wellbeing, engagement, and affective commitment than public sector nurses*.

H11: *Across Australia, UK, and Italy, there are differences in nurses' perceptions of POS, LMX, discretionary power, wellbeing, engagement, and affective commitment.*

[Insert Figure 1 about here]

METHODS

Sampling and Demographics: Three countries were chosen for this study based on specific criteria: two countries to represent core-NPM countries (we selected Australia and the UK) and one NPM-laggard (we chose Italy). We focussed on one type of employee (nurses) because healthcare management is a growing expense in every country (Bloom et al. 2012). In two states of Australia during 2011-12, we surveyed nurses working in public and private sector hospitals. In the public sector hospitals, we distributed 750 anonymous surveys and 250 useable surveys were returned (response rate of 33.3%). A further 1600 anonymous surveys were distributed to private sector hospitals and 510 useable surveys returned (response rate of 31.5%). In the UK, nurses working in public and private sector hospitals within Scotland and England were surveyed during 2011-12. In the public sector, we distributed 300 anonymous surveys and 92 useable surveys were returned (30.6% response rate), and in the private sector we distributed 800 anonymous surveys were distributed, and 290 useable surveys were returned (36% response rate). Having tested the surveys in Australia and the UK, we then replicated the study in Italy, having had the survey translated, back-translated and then tested in that country. During 2014, we

surveyed nurses working in Italian public and private sector hospitals within one region. In the public sector, we distributed 863 anonymous surveys and 535 useable surveys were returned (response rate of 62%). In the private sector, we distributed 626 anonymous surveys and 292 useable surveys were returned – (response rate of 46.6%). Table 1 presents the gender, age, and positions of the nurses involved in this study.

[Insert Table 1 about here]

Measures: We used previously validated scales to operationalise the constructs in the structural model. These were each measured on a six-point Likert-type scale, ranging from '1'=strongly disagree to '6'=strongly agree. *Perceived organisational support* was measured using the validated instrument by Eisenberger et al. (1997). Sample item includes, 'My organisation cares about my opinion'. The *leader-member exchange* (LMX) validated test-bank survey traditionally measures employees' satisfaction with the quality of the relationship with their supervisor-subordinate relationship (Mueller and Lee 2002). In this study, a seven-item unidimensional scale (LMX-7), developed by Graen and Uhl-Bien (1995), was used. A sample item includes, 'My nurse manager understands my work problems and needs'. To examine *discretionary power,* a three-item scale for 'Self-Determination' was used – a sub-set of a 12-item empowerment scale developed and validated in many studies by Spreitzer (1996, 1997). The following is a sample item, 'I can decide on my own how to go about doing my work'. The *employee engagement* nine-item scale was developed by Schaufeli and Bakker (2003). Sample items include, 'At my work, I feel bursting with energy'. *Psychological wellbeing* was measured using a four-item scale developed by Brunetto et al. (2011). A sample item is 'Overall, I am reasonably happy with my work life'. A*ffective commitment* was measured with an 8-item scale developed by Allen and Meyer (1990). A sample item is, 'I feel a strong sense of

belonging to my organisation'. We controlled for a number of relevant factors that may influence employee perceptions: type of employment, length of service, education level, and generation (age) (Sanders, Dorenbosch, and de Reuver 2008).

Data analysis: Analysis of Moment Structures (AMOS) software was used to conduct latent variable structural equation modelling (SEM) with Maximum-likelihood estimation. To test hypothesis 10, three analyses of variance (ANOVA) were conducted to compare the mean results between the public and private sectors for each of the three countries being examined. To test hypothesis 11, an ANOVA was used to compare the mean differences between the three countries, and Tukey's test was used to identify where the differences between the three countries were manifesting. To ensure a normal distribution of the data, 12 cases were removed from the Australian sample, which reduced the sample size from 772 to 760.

Validity and reliability: To manage common method bias, we followed prescriptions by Podsakoff et al. (2003) that the survey be anonymous and measurement of the endogenous and exogenous variables be separated psychologically. To test for common method variance, Harman's ex-post one-factor test and a common latent factor were used. The results provide additional confidence that common method bias is not a major concern in this study. There was an absence of cross-loadings, factor loadings were greater than 0.70, but none were greater than one (Kline 2011). As well, average variance extracted (AVE) exceeded 0.50, and composite reliability exceeded 0.70. There is also discriminant validity of the scales, for each of the samples, as the inter-correlations were less than any square root of the AVEs (see Table 2 to Table 5). Tables 2, 3 and 4 provide the descriptive statistics and correlations for the Australian, Italian and UK samples respectively. Table 5

provides the descriptive statistics and correlations for the public and private sector samples.

[Insert Tables 2, 3, 4 and 5 about here]

RESULTS

Confirmatory factor analysis: The hypothesised measurement model provided a poor fit to the data for the Australian, Italian, and UK samples (see Table 6). We removed one affective commitment item and two POS items from the model, due to low correlations. An examination of the modification indices also highlighted a large error covariance for the Australian, Italian and UK samples, between two POS items: 'Help is available from my organisation when I have a problem' and 'My organisation is willing to help me if I need a special favour'. Following the modifications, model fit was acceptable for the Australian, Italian, and UK samples (see Table 6).

To compare public and private sectors across the three countries, the country samples were each separated into their relevant public and private sectors. To test model fit, we began with the respecified measurement model. The respecified measurement models provided a good fit to the data for the public (χ^2/df = 2.70, CFI = .946, TLI = .940, RMSEA = .049) and private (χ^2/df = 2.41, CFI = .917, TLI = .908, RMSEA = .060) sector samples (see Table 6).

To ensure the distinctiveness of the structural model and to determine the best fitting model, two alternate models were tested. The addition of two paths to the hypothesised structural model (model 2) improved model fit substantially for the three samples (see Table 6). In model 3, a common latent factor was added to the structural model (Podsakoff, MacKenzie, Lee, and Podsakoff 2003), and model 3 fit the data well for all the samples. The standardised estimates for all hypothesised relationships found in

model 1 and 2 were significant in model 3, providing supporting evidence that, in the context of this study; common method variance is of little concern.

[Insert Table 6 about here]

Cross-validation: To confirm the results have not become sample specific, Byrne's (2010) invariance-testing strategy was used, applying the χ^2 difference test. The χ^2 difference test results show no statistically significant differences between the calibration and validation samples for the Australian measurement ($\Delta\chi^2 = 41.06$, $\Delta df = 25$, $p > .05$) and structural ($\Delta\chi^2 = 54.86$, $\Delta df = 34$, $p > .05$) models, Italian measurement ($\Delta\chi^2 = 36.21$, $\Delta df = 25$, $p > .05$) and structural ($\Delta\chi^2 = 58.10$, $\Delta df = 34$, $p > .05$) models, and the UK measurement ($\Delta\chi^2 = 40.08$, $\Delta df = 25$, $p > .05$) and structural ($\Delta\chi^2 = 58.11$, $\Delta df = 34$, $p > .05$) models.

Testing the hypotheses: Figure 2 indicates only two hypotheses (H5 and H9) were not supported across all countries. When comparing whether there were differences in management between public and private sectors (H10), only partial support was found for Australia and the UK, but H10 was not supported for Italy (see Table 7). Table 7 also shows significant differences between the combined countries for each variable in the study. However, while differences were found for each variable, results from Tuckey's test revealed no significant differences between Italy and Australia for LMX, affective commitment, and engagement. There were also no significant differences between the UK and Australia for wellbeing and discretionary power. Finally, there were no significant differences between Italy and the UK for POS or affective commitment.

However, Table 7 also illustrates that when there were differences between the public and private sectors, the private sector was reported as more effective in terms of the nurse outcomes measured, for each of the three countries. Importantly, employee engagement

was significantly different between the sectors for all countries, and in all three countries, private sector nurses reported higher perceptions of their work outcomes than did public sector nurses. Further, in Australia and the UK, there were significant differences between public and private results for both POS and LMX, yet in both countries, the private sector scored significantly higher for those outcomes. Moreover, in the UK, private sector nurses reported better outcomes than their public sector counterparts in all four outcome variables (discretionary power, wellbeing, engagement and commitment).

[Insert Table 7 about here]

[Insert Figure 2 about here]

DISCUSSION

This paper describes the similarities and differences found in the impact of workplace relationships with management (POS and LMX) upon employee outcomes (discretionary power, employee wellbeing, engagement and affective commitment) for public and private sector hospital nurses in Australia, Italy, and the UK. We found that workplace relationships with management did impact upon employees' perceptions of outcomes, although there were differences between the three countries examined, and also between the public and private sectors across the three countries. In particular, in terms of management, while there were significant differences across the three countries, there were also significant differences between the public and private sectors in the UK and Australia, but not Italy. These findings suggest that the different forms of management in each country depict differing influences upon social exchange relationships, and also upon employee perceptions of workplace relationships with management, discretionary power, and employee outcomes. One explanation for differences in the social exchange relationships could be the nature of the NPM and management reforms in each country.

Our findings build on and support previous research by Pollitt and Bouckaert (2011) and Diefenback (2009), comparing the impact of management practices between public-private sectors in core- and laggard-NPM countries. Importantly, our findings show that public sector nurses are barely satisfied with management in each country, although satisfaction with support was highest in Italy, and in the UK private sector. Satisfaction with supervisors was highest for the UK private sector, and similarly lower for Italy and Australia. There is certainly growing evidence in the literature of the need to improve management practices generally across countries and across both the public and private sectors (Beattie 2006; Brunetto et al. 2015b).

In terms of outcomes, nurses across the public and private sectors had perceptions of only some discretionary power, and only UK private sector nurses had significantly higher perceptions of discretionary than their public sector counterparts. Such a situation is likely not sustainable because many nurses operate within the context of staff/skill shortages, and poor perceptions of discretionary power do not enhance the ability to be resourceful with limited means, which Scotti et al. (2007) argued was necessary in such circumstances. One explanation for nurses perceiving only some discretionary power could be because of reforms aimed at standardising work processes and increasing accountability across the nursing profession generally (rather than NPM reforms) (see Ackroyd et al. 2007; Farr-Wharton et al. 2011; Brunetto et al. 2012). The new knowledge evident in this paper is that the nurses in Australia and the UK perceived more discretionary power than did those in Italy, which means that they perceived having greater power to be resourceful to cope with limited resources.

Further, there were significant differences in perceptions of wellbeing across the combined countries, and in the public and private sectors for the UK and Italy. The UK private sector nurses had the highest wellbeing in the workplace compared with the other

nurses - an important issue because wellbeing predicts both engagement and affective commitment. In terms of engagement, there were significant differences both across the three countries and between the private and public sectors, with engagement highest overall in the private sector. Nurses only just 'agreed' that they perceived having affective commitment in each country. Further, wellbeing was higher in the private sector in all three countries, though not necessarily significantly different. Overall, Table 7 reports that in each country, private sector nurses experienced significantly higher levels of at least one employee outcome (Australia) and for all four outcomes (UK). They reported being more engaged and committed, which also has positive implications for the outcomes of their patients. However, this assumption needs to be tested in further research.

Our research provides three main contributions to practice and theory, which are further discussed in the conclusions. First, it provides a snapshot in three countries, across the public and private sectors, of the impact of management practices. The results suggest that there is some room for improvement with employees' perceptions of management relationships and support, especially for the public sector when compared with the private sector, despite substantial (but different) management reforms in Australia and the UK. Second, our study contributes insight into the significantly better outcomes for nurses in the private sector. One explanation is that public sector management reforms have failed to improve employee outcomes. Finally, we contribute understanding to SET, that is, while perceptions of social exchange relationships significantly differed across the groups examined, the positive impact of these social exchange relationships were quite consistent across the groups. The limitations of this paper are that it focuses on nurses only, and further studies should include other types of employees. Also more international comparisons are required, perhaps also incorporating BRIC countries (Brazil, Russia, India, and China). Another limitation is the use of self-report data collected at one point in

time. However, following survey design prescriptions by Podsakoff et al. (2003) and the testing also prescribed, has reduced the chances that common method bias is affecting the findings of the study.

CONCLUSION

Within the context of resource-constrained environments, combined with increasing service demands, the search for successful and effective management practices continues. Our research examined the healthcare public and private sectors across three countries and provides evidence-based knowledge about the impact of management practices upon employees' perceptions of discretionary power, and in turn, their work outcomes. We know that effective workplace relationships result in concrete and intangible positive benefits and outcomes for employees (e.g., access to resources, autonomy and respect), managers (e.g., support for managerial decisions) and organisational effectiveness (from increased employee commitment and engagement, leading to reduced turnover and increased performance) (Shore, et al., 2009). Therefore, the reported levels of nurse perceptions and work outcomes in our study contribute some insight for managers in Australia, UK and Italy. In particular we found that, while there were differences between the countries, there is room for improvement in management practices, especially in the public sectors in each country.

In addition, such findings contribute to the theoretical understanding about the differences in perceptions between public and private sector nurses, and the varying impact that differing perceptions have upon employee work outcomes. Given that NPM has been implemented in the two core-NPM country public sectors (Australia and UK), which had the lowest reported nurse outcomes, it could be argued that NPM may be one explanation for the result.

Poor management is not sustainable because of the negative consequences for employee outcomes, the high cost of replacing skilled employees who leave, and the increasingly-tight external labour market. The findings from our study highlight several implications, including that improving management effectiveness means managers, in both the public and private sectors, could benefit from enhanced training to better understand the benefits of supporting, empowering, and developing high-quality relationships with their employees. Moreover, we found SET to be a useful theory to frame the research examining these relationships for nurses, and now suggest that SET theory might also be useful as a framework for the training of managers in how to enhance their management practices for improved nurse outcomes.

Our study contributes to the understanding of SET by adding insight into the differing perceptions of social exchange relationships between public and private sector nurses, and nurses in Australia, UK and Italy. Specifically, while perceptions of POS and LMX were significantly different across all groups examined in this study, the positive and significant impacts of social exchange relationships were reasonably similar across most of the groups. Such findings contribute insight into the stability of the positive impact of social exchange relationships, regardless of that relationship strength.

Considering the important role that both public and private sector employees play in providing public resources, public goods need to be managed effectively. Due to the fact that employees who provide public services have to be managed effectively, we recommend there is merit in training the managers to enhance management performance processes. For example, public employees, who typically seek more altruistic rewards than do private sector employees, could be reminded of the sense of purpose for being a nurse - the often not-insignificant impact that their work has on the health and wellbeing of those

they serve. Also, public management could identify and employ incentive systems that emphasize such motives and rewards.

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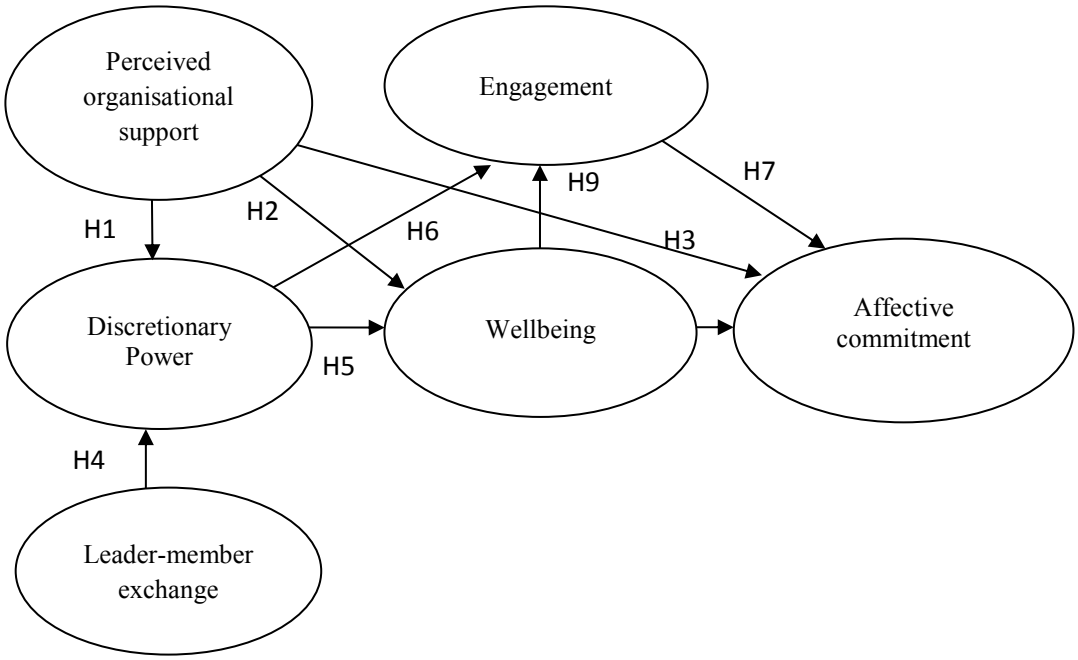


Figure 1. A conceptual model of the relationships between employee perceptions of workplace relationships, discretionary power, engagement, wellbeing, and affective commitment

Table 1. Demographics

	Australia		Italy		UK	
Gender	**N**	**%**	**N**	**%**	**N**	**%**
Male	74	9.7	188	22.7	113	31.6
Female	686	90.3	639	77.3	245	68.4
Age	**N**	**%**	**N**	**%**	**N**	**%**
=< 30 years	76	10	140	16.9	39	10.9
31-44 years	230	30.3	420	50.8	130	36.3
45+ years	454	59.7	267	32.3	189	52.8
Position	**N**	**%**	**N**	**%**	**N**	**%**
Nursing unit manager	40	5.3	47[a]	5.7	25	7
Clinical nurse	106	13.9	780[b]	94.3	6	1.7
Registered nurse	447	58.8			226	63.1
Endorsed enrolled nurse	107	14.1			14	3.9
Enrolled nurse	26	3.4			9	2.5
AIN	3	.4			4	1.1
Other	31	4.1			74	20.7

Australia: N = 760; Italy: N = 827; United Kingdom: N = 358
[a] = Coordinatore Infermieristico (CI), [b] = Infermiere

Table 2. Descriptive statistics and correlations – Australia sample

		C.R.	1	2	3	4	5	6
1.	Affective commitment	.78	(.77)					
2.	Employee engagement	.84	.597**	(.74)				
3.	Wellbeing	.83	.607**	.694**	(.76)			
4.	Discretion ary Power	.88	.308**	.271**	.323**	(.84)		
5.	POS	.76	.569**	.471**	.474**	.308**	(.74)	
6.	LMX	.89	.365**	.283**	.367**	.271**	.429**	(.81)
7.	Hospital Tenure		.152**	-.035	.033	.067	-.067	.027

**. Correlation is significant at the 0.01 level (2-tailed).

C.R. = composite reliability; square root of AVE on the diagonal

Table 3. Descriptive statistics and correlations – Italy sample

		C.R.	1	2	3	4	5	6
1.	Affective commitment	.71	(.82)					
2.	Employee engagement	.83	.646**	(.72)				
3.	Wellbeing	.86	.601**	.775**	(.71)			
4.	Discretionary Power	.75	.365**	.402**	.368**	(.81)		
5.	POS	.88	.470**	.395**	.454**	.385**	(.77)	
6.	LMX	.92	.329**	.333**	.393**	.362**	.529**	(.81)
7.	Hospital Tenure		-.058	-.008	-.032	-.042	-.075	-.065

**. Correlation is significant at the 0.01 level (2-tailed).

C.R. = composite reliability; square root of AVE on the diagonal

Table 4. Descriptive statistics and correlations – United Kingdom sample

		C.R.	1	2	3	4	5	6
1.	Affective commitment	.76	(.77)					
2.	Employee engagement	.76	.610**	(.75)				
3.	Wellbeing	.83	.593**	.690**	(.72)			
4.	Discretionary Power	.75	.462**	.442**	.496**	(.82)		
5.	POS	.87	.512**	.490**	.515**	.425**	(.73)	
6.	LMX	.93	.376**	.368**	.515**	.498**	.429**	(.80)
7.	Hospital Tenure		.322**	.098	.155**	.227**	.103	.091

**. Correlation is significant at the 0.01 level (2-tailed).

C.R. = composite reliability; square root of AVE on the diagonal

Table 5. Descriptive statistics and correlations – Public and private samples

		C.R. Private	C.R. Public	√AVE	√AVE	1	2	3	4	5	6
1.	Affective commitment	.76	.72	.75	.72	1	.643**	.619**	.371**	.499**	.341**
2.	Employee engagement	.85	.87	.73	.77	.597**	1	.716**	.383**	.439**	.323**
3.	Wellbeing	.83	.76	.75	.77	.603**	.741**	1	.370**	.473**	.432**
4.	Discretionary Power	.82	.86	.80	.84	.523**	.567**	.569**	1	.346**	.360**
5.	POS	.84	.87	.75	.77	.587**	.499**	.481**	.423**	1	.440**
6.	LMX	.89	.90	.81	.95	.428**	.356**	.417**	.373**	.495**	1
7.	Hospital Tenure					.224**	.054	.083	.185**	-.014	.015

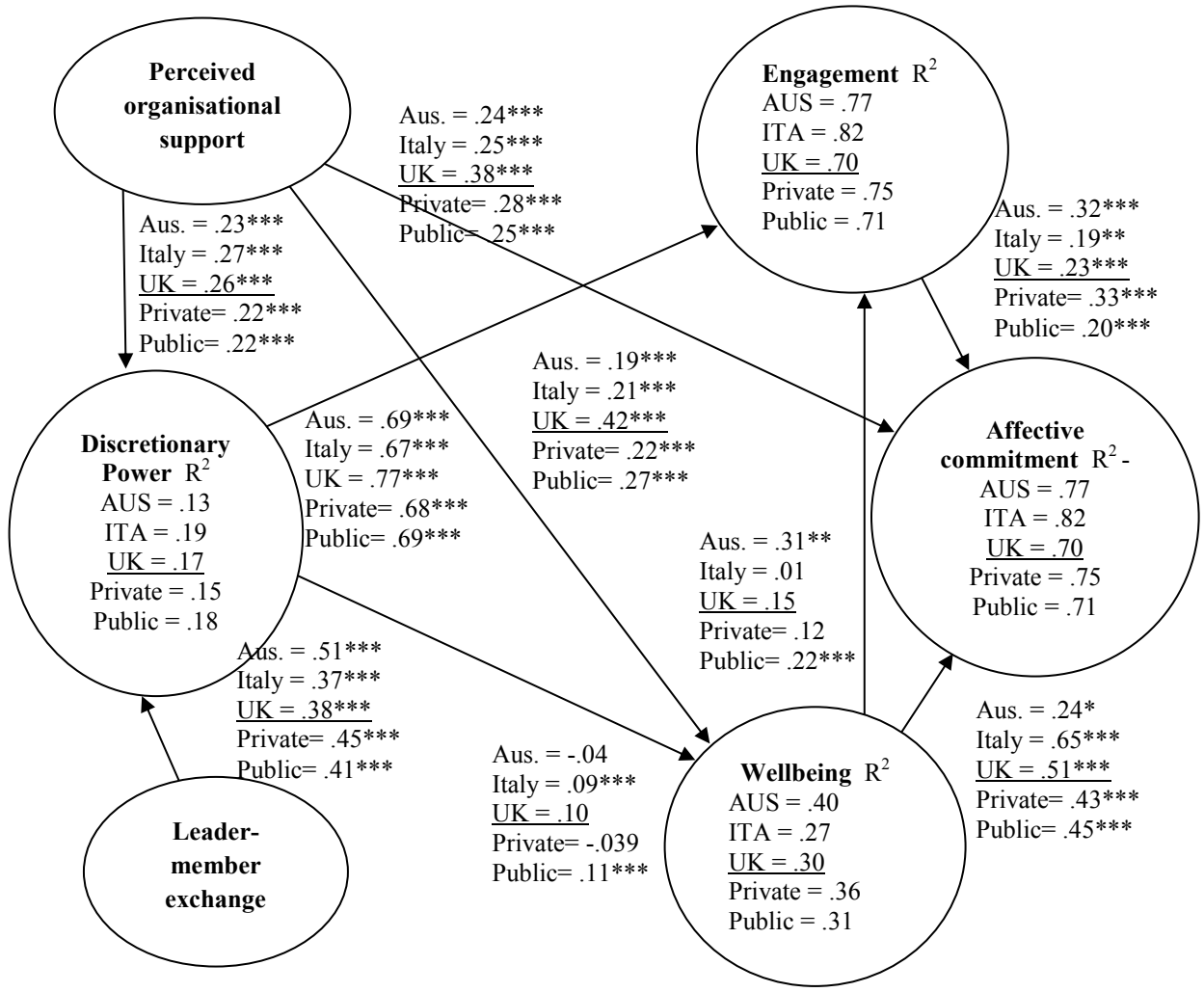
**. Correlation is significant at the 0.01 level (2-tailed).

C.R. = composite reliability; square root of AVE on the diagonal

Table 6. Results of model-fit

	χ^2 / df	CFI	TLI	RMSEA
Australia				
Measurement model	3.69	.908	.900	.060
Respecified measurement model	1.81	.915	.905	.060
Model 1: Structural model	3.16	.871	.860	.053
Model 2: Add two paths to the structural model (POS to wellbeing & affective commitment)	2.37	.918	.911	.043
Model 3: Add common method variable to structural model	2.20	.925	.916	.040
Italy				
Measurement model	3.74	.912	.905	.058
Respecified measurement model	2.37	.925	.917	.041
Model 1: Structural model	4.89	.889	.880	.069
Model 2: Add two paths to the structural model (POS to wellbeing & affective commitment)	2.94	.947	.942	.049
Model 3: Add common method variable to structural model	2.82	.951	.948	.044
United Kingdom				
Measurement model	3.01	.849	.836	.075
Respecified measurement model	2.13	.922	.914	.054
Model 1: Structural model	3.62	.882	.870	.066
Model 2: Add two paths to the structural model (POS to wellbeing & affective commitment)	2.71	.930	.925	.057
Model 3: Add common method variable to structural model	2.55	.936	.929	.049
Australia, Italy & UK – Private				
Respecified measurement model	2.41	.917	.908	.060
Model 1: Structural model	3.13	.866	.853	.076
Model 2: Add two paths to the structural model (POS to wellbeing & affective commitment)	2.54	.912	.903	.062
Model 3: Add common method variable to structural model	2.33	.940	.928	.054
Australia, Italy & UK – Public				
Respecified measurement model	2.70	.946	.940	.049
Model 1: Structural model	4.50	.902	.892	.066
Model 2: Add two paths to the structural model (POS to wellbeing & affective commitment)	2.83	.940	.934	.052
Model 3: Add common method variable to structural model	2.43	.955	.946	.048

Note: Private sector N = 899, Private sector N = 1046



*. Significant at the 0.05 level (2-tailed).
**. Significant at the 0.01 level (2-tailed).
***. Significant at the 0.001 level (2-tailed).

Figure 2. Path model of factors influencing work relationships in Australia, UK and Italy of hospital nurses in public and private sectors.

Table 7. Results from ANOVA testing difference between public and private sectors in Australia the United Kingdom (UK) and Italy

		POS	**LMX**	**Discret-ionary Power**	**Well-being**	**Engage-ment**	**Affective Commitment**
		Mean[#] SD	Mean[#] SD	Mean[#] SD	Mean[#] SD	Mean[#] SD	Mean[#] SD
Aust	**Public**	3.75 (1)	4.84 (.87)	4.5 (.94)	4.63 (.74)	4.29 (.8)	3.98 (1.2)
	Private	4.01 (1)	4.63 (1)	4.54 (.89)	4.75 (.81)	4.55 (.81)	4.09 (1.16)
	Significance	**11.04****	**7.62***	.251	3.469	**17.573****	1.58
UK	**Public**	3.64 (.85)	4.82 (.92)	4.2 (1.1)	4.35 (.94)	4.48 (.84)	3.73 (.85)
	Private	4.38 (.77)	5.11 (.63)	4.81 (.86)	4.93 (.59)	4.78 (.63)	4.55 (.95)
	Significance	**62.11****	**11.49****	**30.22****	**48.84****	**13.62****	**55.74****
Italy	**Public**	4.09 (.92)	4.74 (.86)	4.24 (.94)	4.54 (.82)	4.49 (.81)	4.12 (1.1)
	Private	4.2 (.87)	4.64 (.93)	4.15 (.91)	4.65 (.69)	4.67 (.67)	4.28 (.9)
	F score (Significance)	2.33	2.149	1.978	**4.105***	**10.134****	**4.42***
Total (All country comparison)	**F score (Significance)**	**28.22****	**19.26****	**36.35****	**9.80****	**9.45****	**7.79****

**. F score is significant at the 0.01 level, * F score is significant at 0.05 level.

[#] Scale: from 1 = strongly disagree, to 6 = strongly agree.