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International Journal of Health Governance (IJHG) is oriented to serve those at the policy and governance levels within government, healthcare systems or healthcare organizations. It bridges the academic, public and private sectors, presenting case studies, research papers, reviews and viewpoints to provide an understanding of health governance that is both practical and actionable for practitioners, managers and policy makers.

Policy and governance to promote, maintain or restore health extends beyond the clinical care aspect alone. Formerly published as Clinical Governance: An International Journal, the journal's new title reflects an expansion in coverage. As well as including papers on clinical governance, which seeks to continuously improve and safeguard the quality of clinical services and patient care, the journal will now incorporate the broader domain of health governance, which encompasses the actions and means of organizing the promotion and protection of the health of a population. That comprehensive breadth, inclusive of public health, social determinants of health, population health systems and the full range of healthcare settings is our journal's focus.

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Civic engagement in the Indonesia health sector

The role of religiosity, empathy, and materialism attitude

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Abstract

Purpose – The purpose of this paper is to understand the impact of religiosity on civic engagement in the health sector through giving advocacy for people with AIDs, mental health, cancer and disability.
Design/methodology/approach – The authors achieve this aim by proposing a structural equation model, which was derived based on literature. The data collection involved an on-line purposive sampling survey, which targeted young people who intend to work in the health sector. The survey asked about the experience and perception of 610 respondents in Indonesia.
Findings – The results indicate that the respondents with high religiosity were identified to be more caring towards those who suffer from mental health, AIDs, cancer and disability. However, the highly religious were less motivated by empathy in conducting civic engagement in the health sector. In this study, the impact of religiosity on civic engagement was found to be stronger for those who identified with low materialism.
Originality/value – The study contributes to the discussion on altruistic theory by challenging the widespread assumption that feelings of empathy drive civic engagement. The results extend the discussion on how to promote civic engagement in the health sector for young people with high materialism attitude.

Keywords Emerging health economies, Emerging healthcare delivery structures, Cancer, Quantitative research, Political strategy, Behavioural social or mental health issues, One health movement

Paper type Research paper

Introduction

Community engagement is an essential element for the public health sector, especially in developing countries, where there is a need of remarkable resilience to deal with an issue of great complexity. The concept of community engagement in the health sector has been paved the way to a core strategy of the WHO framework since the Alma Ata Declaration in 1987 (World Health Organization, 2017). This action needs partnership, which calls for great socio-political empowerment and sense of community through encouraging social networks and communication (Ramey *et al.*, 2018).

Many developing countries line up behind the ambitious agenda of sustainable development goals due to lack of human capital investment in the health, education, and nutrition of people. Among those countries, Indonesia attempts to end the communicable diseases by fostering community engagement (UNDP, 2017). The practices of civic engagement in health service challenges acceptability, adaptability, quality and non-discrimination in public health services (Pratono and Maharani, 2018). As the tradition proposition indicates that religiosity makes people more generous, another study suggests that Indonesian physicians keep religious practices when caring for patients (Lucchetti *et al.*, 2016).

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Religious beliefs may become the primary antecedent to the civic engagement in voluntary contribution in health movement (Charsetad, 2016). The studies supporting the proposition that being religious is associated with the generosity of the people may face the inequality of relationships, which take more than policy pronouncements (Sablosky, 2014). Hence, the partnership between development agencies and faith communities have also multiplied (Deneulin and Zampini-Davies, 2017). On the other hand, religiosity often results in a barrier to community engagement, especially when religiosity generates an exclusive community (Lowicki and Zajenkowski, 2017).

Research on responses to community engagement has described the struggles of citizens to deal with various health issues. Silke *et al.* (2018) highlight the needs to understand how and why adolescents' empathy and prosocial responding in various social context with different social targets, including participation in the health sector. Previous studies discuss how the exchange theory examines the willingness to engage in community services (Jha and Bhalla, 2018). A study in Asian context argues that the social paradigm is related to the dimensions of materialism (Polonsky *et al.*, 2014). Prosocial behaviour highlights the exposure to individual values (Silke *et al.*, 2018), which may involve materialism attitude to improve their social class image (Khare, 2014).

This study seeks to examine the impact of religiosity on civic engagement in the health sector through giving advocacy for people with AIDs, mental health, cancer and disability. We achieve this aim by proposing a model, which explains the relationship between religiosity and community engagement under a various level of materialism behaviour. The model also identifies the mediating effect of empathy. The following sections discuss the literature review on civic engagement in the health sector, hypothesis development that mainly concerns on the relationship between religiosity and engagement in the health sector, the research method of the on-line survey, empirical results, and discussion on both theoretical and managerial contributions related to the theory of materialism.

Literature review

Civic engagement in the health sector

Civic engagement refers to a process of developing relationships that enable stakeholders to work together to address health issues and promote well-being to achieve positive health impact and outcomes (World Health Organization, 2017). Improving population health often requires policy changes that spring from complicated advocacy efforts. Information exchanges among researchers, advocates and policymakers are paramount to policy interventions to improve health outcomes (Tabak *et al.*, 2015). The main reason for utilising community engagement in public services may come from the decreasing boundary critique from the population and especially preventing later conflict between stakeholders in the area (Konsti-Laakso and Rantala, 2018). Incorporating research to support advocacy work in public health needs to understand the skills and resources required for advocacy (Smith and Stewart, 2017).

The materialism theory highlights the initiative to build a relationship under dynamic context by creating innovative action (Lupton, 2019). The excellent public awareness in health sector warrants advocacy on the part of health advocacy groups and healthcare professionals (Pearson *et al.*, 2015). Information exchanges among the citizens may include evidence on what works well for whom and cost-effective strategies to improve outcomes of interest, but the information is not easily communicated (Tabak *et al.*, 2015). Hence, the advocacy demonstrates not only increasing recognition of mental health people, cancer, and disability but also legitimation through strengthening the voice and legal advocacy (Newbingging and Ridley, 2018).

Civic engagement demonstrates not only personal involvement in activities but also motivation to promote participation as well as the efficacy of participation (Schulz *et al.*, 2010).

The need of participatory governance and stakeholders is essential for the general public sector, where the stakeholders are shaping the implementation and influencing the relationship between the service providers and beneficiaries (Komendantova *et al.*, 2018). Public health researchers, policymakers and advocates acknowledge the role of engagement in public health, which involves advocacy and lobbying activities (Smith and Stewart, 2017). Effective knowledge-driven advocacy demonstrates the capability of citizenship to access various conceptual resources through sharing group to make sense of their experience (Newbingging and Ridley, 2018) and adapting the diverse interests of targeted groups and stakeholders (Adonteng-Kissi and Adonteng-Kissi, 2017).

The cancer advocacy groups take substantial time to cultivate through community support and grassroots activism (Maxwell, 2015). Transnational advocacy networks play a pivotal role to deal with global HIV and AIDS governance by involving global governance with local articulations through routed systems (Marx *et al.*, 2012). The initiative to promote civic engagement in their broader community and awareness-raising and advocacy efforts around sexual orientation has been emerging (Poteat *et al.*, 2018). However, there have been few adaptations of effective interventions from high-income countries and few high-quality evaluation studies in low- and middle- income countries, beyond those in sexual and reproductive health (Patton *et al.*, 2016). The barrier to support disabled people may spring from stigma, discrimination and the hidden nature of negative attitudes (King *et al.*, 2019).

Hypothesis development

This study concerns with four constructs, i.e. religiosity, civic engagement in the health sector, empathy, and materialism. Hence, we propose four hypotheses:

H1. Religiosity positively affects the engagement in health care services.

Religion has been acknowledged as an alternative medicine technique or through a psychosocial coping mechanism (Goss and Bishop, 2018). Religious attendance positively correlates with volunteering, charitable giving, as well as informal activities such as helping and supporting friends, family and neighbours (Lewis *et al.*, 2013). The religious beliefs of workers in the health sector affect the interaction with that demonstrates patient care (Bjarnason, 2007). The religious beliefs also become the primary antecedent to the attitude towards blood donation as considerable prosocial activities (Charsetad, 2016). Religious activities play a pivotal role to increase the acceptability of health services with support from local volunteers (Pratono and Maharani, 2018).

Religiosity refers to ritual and ceremony that show socially based beliefs and traditions, which may contribute to a value of belonging and acceptance (Dein *et al.*, 2010). The initiatives in the health sector include matching community engagement with the age and stage of the family with modifiable recruitment and retention practices (Kulig *et al.*, 2018). Religion may promote social change independently from the level of development and modernisation (Autiero, 2018). Since religiosity encourages empathy, some studies argue that there is no relationship between empathy and discrimination (Silke *et al.*, 2018).

The engagement in the health sector needs support from the local religious leaders due to their role as opinion shapers, especially when protecting people's health and caring for the environment become religious objectives or ways of honouring God (Deneulin and Zampini-Davies, 2017). Religious leaders see themselves as health promoters as their belief is translatable into a successful health programme, which could be part of the religious-based information materials (Lumpkins *et al.*, 2013). The stigma of having a curse or punishment from God may spring from the religious people, who prejudice against the HIV/AIDs patients from a religious perspective (Muturi and An, 2010). Promoting religious tolerance is more about encouraging people to accept other religious beliefs and practices

rather than discouraging them from having any objections towards things that contradict one's sacred beliefs (Verkuyten and Yogeeswaran, 2017):

H2. Religiosity positively affects empathy.

Religiosity has a strong relationship with empathy through enhancing the capability to attribute mind to another human being. Lack of empathy prevents not only social interaction but also religiosity (Lowicki and Zajenkowski, 2017). Integral emotions are elicited in response to a target stimulus and therefore offer the opportunity to shape the feelings evoked. Religious practice is related to the higher perceived threat and lower empathy, while the religious practice is essential to sensibilities (Bilali *et al.*, 2018).

The initiative of praying with patients has been the subject of contentious debate. It will be helpful for some patients by strengthening the therapeutic alliance; the response may call for sensitivity (Dein *et al.*, 2010). Empathy is essential for health care services, especially when patients consider the compassionate of healthcare providers for service delivery (Kemp *et al.*, 2017). However, empathy may have severe limitations. Empathy may occur with ingroup bias, such as religious, race and attractiveness (Bloom, 2017). The lack of empathy may play in conferring risk for conduct problem. Socio-environmental processes empathy development is associated with cognitive and socio-environmental processes (Moul *et al.*, 2018).

The religiosity is part of the service of self-enhancement, which demonstrates socially desirable responding (Sedikides and Gebauer, 2010). The prejudice in moralised entities and activities leads to avoidance rather than toleration (Verkuyten and Yogeeswaran, 2017). The intention to buy products of people with a health problem may demonstrate initiative of consumers with high religiosity (Kuo and Kalargyrou, 2014). A negative association between religiosity and AIDs is related stigma, which shows those who are affected by HIV/AIDs (Muturi and An, 2010):

H3. Empathy and community engagement in health care services.

Empathy refers to a natural socio-emotional need to understand the others who deal with an unfortunate situation (Bloom, 2017; Kemp *et al.*, 2017). In the narrow sense, empathy becomes a positive force for good by motivating us to care about and help that person (Bloom, 2017). However, the transition from the agrarian societies to the industrial ones contributes to the shift from traditional values and orientation towards materialist, rational and secular values (Autiero, 2018).

There is a growing consensus that community development needs to cultivate not only a greater sense of empathy but also to realise the greater social well-being (Silke *et al.*, 2018). Empathy and moral obligation contribute to the feasibility of starting a civic engagement, including voluntary in health service (Hockerts, 2015). Empathy is an emotional appeal, which influences the way people view their relationship with an unfortunate person, and thus help build stable relationships (Kemp *et al.*, 2017).

Expression of empathy among young people is related to their exposure to critical environmental process as well as individual values (Silke *et al.*, 2018). Community engagement may evoke an empathic response that plays in not only imparting traditional clinical skill-based knowledge but also facilitating the interpersonal skills (William *et al.*, 2012). The empathic concern becomes predictive of prosocial behaviour (Decety *et al.*, 2018). Working with community members encourage volunteers to confront unfamiliar issues and feel emotions, including greater empathy for others (Tremblay and Harris, 2018):

H4. Materialism moderate the relationship between religiosity and civic engagement in health care services.

Materialism is an essential element for those who lay their value to material goods in general, which distinguishes it from consumption itself (Polonsky *et al.*, 2014). Silke *et al.* (2018)

identify that civic engagement is associated to the exposure of the adolescents to the key environmental processes (extra-curricular activities) as well as the individual values (self-efficacy). Both key environmental processes and individual values entail materialism attitude in which individuals become more susceptible to pronounce their performance by acquiring valuable brands to improve their social class (Khare, 2014; Pratono and Tjahjono, 2017). Consumers with materialism behaviour seek to fulfil through material possessions (Segev *et al.*, 2015). Possession helps materialistic individuals in improving self-identity, which becomes central to happiness (Khare, 2014). Hence, religiosity with materialism attitude may lead to better outcomes in life satisfaction (VanderWeele, 2017).

A country in post-materialism experiences that religiosity foster altruistic and community engagement behaviour (Mostafa, 2016). They may consider that materialism is not seen as the road to individual well-being (Polonsky *et al.*, 2014). Those who are materialistic and utilitarian orientation use religion as a means of achieving mundane goals, which show lack of sensitiveness to community engagement issues (Islam and Chandrasekaran, 2016). Materialism influence the relationship between credibility and intention to charity decreases (Pratono, 2019).

The citizen with strong religious believes that donation to international charities can help them to gain recognition from employers and co-workers (Teah *et al.*, 2014). The religiosity and materialism were inversely related, whereby religious people tend to become less materialistic (Bakar *et al.*, 2013). Value from financial success is different from the feminine value that is related with modesty, caring, harmony and a focus on improving the quality of life (Steel *et al.*, 2018).

Research method

Model

This study puts forward a structural equation model to explore the complicated relationship between religiosity and civic engagement. The structural equation model involves four latent variables, engagement in the health sector, religiosity, empathy, and materialism attitude, which are related to each other. The model analysis of each construct and the relationship between them, which represent the hypotheses.

This study determines the hypotheses for the relationship between the constructs in the structural equation model following the concept. The model consists of two elements: the structural model and the measurement models. The structural model explores the relationship between religiosity and community engagement, while the measurement models explain the relationship between the latent variables and the indicators.

Introducing a mediating variable helps the study to explore the complicated process by which religiosity influences engagement in the health sector. The path model shows the direct effect and indirect effect. The direct impact explains the immediate impact of religiosity on community engagement. Hence, the indirect impact explains the relationship that entails a sequence of relationship with empathy as an intervening construct to clarify the relationship between religiosity and engagement in the health sector.

A moderating variable explains the interaction between the religiosity and engagement in various level of materialism attitude. With moderation, the construct of materialism attitude directly influences the relationship between the religiosity and engagement at a high level, moderate level and low level of materialism attitude. The distinction between moderating and mediating variables is that moderating variable does not depend on the predictor variable.

The measures

According to the measurement theory, the outer models involve the reliable or valid relationship between constructs and their corresponding indicator variables (Hair *et al.*, 2014). This study uses questionnaires by adapting from previous studies. The measures of civic

engagement were adapted from Schulz *et al.* (2010). This study adopts the constructs of religiosity, which involves motivational constructs and religious cognitive-emotional systems (Joseph and Diduca, 2007). This study also adopts the measure of empathy from Hockerts (2015) and the measure of materialism from Khare (2014). Table AI provides detail measures.

Table I shows the measure of engagement represents in the four relative items, P04, P05, P06 and P7, which related to the following survey questions: "my social activities include involvement and advocacy for people with AIDs", "involvement and advocacy for people with AIDs, "involvement and advocacy for people with cancer", and "involvement and advocacy for people with disability". Respondents are encouraged to express the level of agreement to each statement on a seven-point scale from 1 = entirely disagree to 7 fully agree.

Similarly, religiosity is operationalised by four items (R01, R02, R03, R04) that indicated the degree which they agree with each statement on the seven scales. The measures are related to the questions in the survey: "Religion is more important to me than what is happening in national politics", "religion helps me to decide what is right", "religious leaders should have more power in society", and "religious should influence people's behaviour toward others".

Data collection

The data collection involves an on-line purposive sampling survey, that asked about the experience and perception of respondents with engagement in the health sector. Purposive online samples enhance the probability samples through participant observation of online discussion to access hidden population (Barratt *et al.*, 2015), which is also called as non-random sample selection (Wojtys *et al.*, 2018) The survey sent an invitation to the groups of young people in five cities in Indonesia: Medan, Jakarta, Bandung, Semarang, and Surabaya. We found the groups in social media that expose their community engagement in the health sector.

This study encouraged the respondent to be generous in answering the questionnaire by promising to cover their private information and profile of the organisations. The survey attempted to maintain respondent confidentiality. Privacy and confidentiality become the main reason for low response rates (Buchanan and Hvizdak, 2009). The internet survey is applicable to cluster sampling for targeted discussion groups in the health community and to sample users within the group (Fricker, 2011). By protecting the confidential information, the survey can avoid confidentiality dilemmas that might otherwise lead them not to tell the truth (Kaiser, 2009).

Table I. The measures

Code	Items	VIF
CP4	I intend to get involved in advocacy for people with mental health	1.895
CP5	I intend to get involved in advocacy for people with AIDs	2.092
CP6	I intend to get involved in advocacy for people with cancer	2.232
CP7	I intend to get involved in advocacy for people with disability	1.629
Materialism		
M2	My dream in life is to be able to own expensive things	1.699
M3	People judge others by the things they own	1.857
M4	I buy some things that I secretly hope will impress other people	1.532
Religiosity		
RE1	Religion is more important to me than my national politics	1.709
RE2	Religion helps me to decide what is right	2.202
RE3	Religious leaders should have more power in society	1.499
RE4	Religious should influence people's behaviour toward others	1.885
Empathy		
E1	I don't care how people feel who live on the margins of society (R)	1.436
E2	Seeing socially disadvantaged people triggers an emotional response in me	1.488
E3	I do not experience much emotion when thinking about social excluded people (R)	1.681

Data collection was carried over six months in 2018 that results with 610 respondents or sample size. The respondents are young people with age between 18 and 25-year old, which 70 per cent of respondents aged 18 and 20. Based on the religious profile, the majority of respondents are Muslim with 60 per cent of the samples, followed by Christian (30 per cent) and others (10 per cent). The survey asked the respondents' financial profile, only 33 per cent provided information about their daily expenditure. The monthly income of the respondents was US$6,000 on average, which represents the middle-class income in Indonesia.

Data analysis

This study uses partial least square to test the hypothesis by explaining the variance or the prediction of the construct. The SmartPLS 3.2.4 software is used to execute all the PLS-SEM analysis. The algorithm estimation involves path coefficients that explain the variance of the dependent constructs. The variables represent individuals with the measurements taken from the survey. The outer models explain how these variable constructs are measured. The reflective model has arrows pointing from the constructs to obtain validity and reliability of the constructs.

Results

The first model assessment focusses on the measurement models by evaluating the reliability and validity of the construct measures. Table II shows the traditional criteria for internal consistency relies on the coefficients of Cronbach's α, which indicate that all constructs are reliable with coefficients higher than 0.75. The coefficients of composite reliability also suggest that the observed constructs meet the standard for internal consistency reliability with values ranges from 0.851 to 0.882.

Table II provides convergent validity for measuring that correlation between alternative measures of the same construct. The coefficient of average variance extracted (AVE) are higher than 0.64, which indicates the construct explains more than half of the variance of its indicators. The convergent validity is also available at the Appendix, which shows the outer loadings on each construct is significant (Table AI). The results indicate that the coefficients of the outer loadings are higher than 0.708 (Table AII). Overall, the results show the high commonality of each construct.

Table III shows the discriminant validity with the Fornell-Larcker criterion to evaluate the reflective measurement models. The diagonal indicates the square root of each

Constructs	Cronbach's α	rho_A	Composite reliability	Average variance extracted (AVE)
Engagement in health service	0.829	0.871	0.882	0.652
Materialism attitude	0.789	0.976	0.862	0.678
Religiosity	0.816	0.867	0.877	0.642
Empathy	0.750	0.838	0.851	0.656

Table II. Construct validity and reliability

Constructs	Empathy	Engagement	Materialism attitude	Moderating effect	Religiosity
Empathy	0.810				
Engagement in health service	0.160	0.807			
Materialism attitude	0.468	−0.119	0.823		
Moderating effect	0.105	0.117	0.165	1	
Religiosity	0.146	0.392	−0.032	−0.046	0.801

Table III. Discriminant validity

construct's AVE, while the non-diagonal elements show the correlation between the latent variables. The values of the square root of the AVE of each construct at the diagonal are more significant than 0.8, while the non-diagonal values are less than 0.4. The results show that the discriminant validity meets the Fornell-Larcker criterion, which indicates the high levels of convergent validity.

After examining the constructs' reliability and validity, this analysis continues with the assessment of the structural equation model. This step requires to explore the model for collinearity since the estimation uses the OLS regressions that each endogenous latent variable relates to the predecessor constructs. Table I shows the outer VIF with the CP6 has the highest VIP value, while inner VIF values are less than 1.3. All of the VIF values are below the threshold value of 5.0 (see Table IV). The results indicate that the collinearity does not an issue for estimating the model.

For the goodness of fit, Table V shows that the standardised root means square (SRMS) is less than 1.0, which indicates no discrepancy between the implied model and the observed correlation. The results suggest that the model fits for the empirical data. The coefficient of determination or R^2 value shows that the three constructs explain 51 per cent of the variance of the endogenous construct. The values indicate the amount of variation in the endogenous constructs described by all exogenous constructs at a moderate level.

The PLS uses a bootstrapping approach to examine whether the path coefficients are significant or not. Table VI shows that all of the empirical *t*-values are larger than the critical value of 1.85 with a significant level of 5 per cent. The exogenous construct of religiosity significantly contributes to explain the endogenous variable of engagement with *t*-value 6.114 and probability of error is close to 1 per cent. This result indicates that *H1* is

Table IV. VIF inner

Constructs	Empathy	Engagement
Empathy		1.170
Materialism		1.173
Moderating Effect		1.049
Religiosity	1.000	1.108

Table V. Goodness of fit

Measures	Saturated model	Estimated model
χ^2	487.928	572.42
NFI	0.687	0.632
SRMR	0.088	0.137
d_G1	0.357	0.425
d_G2	0.282	0.351
d_ULS	0.810	1.957

Table VI. Path coefficient with bootstrapping approach

Path	Original sample (O)	Sample mean (*M*)	SD (STDEV)	*t*-Statistics (|O/STDEV|)	*p*-values
Materialism→ Engagement	−0.224	−0.21	0.099	2.259	0.024
Moderating effect	0.151	0.136	0.08	1.894	0.050
Religiosity → Engagement	0.363	0.364	0.059	6.114	0.000
Religiosity → empathy	0.146	0.161	0.055	2.638	0.009
Empathy → Engagement	0.196	0.186	0.091	2.143	0.033

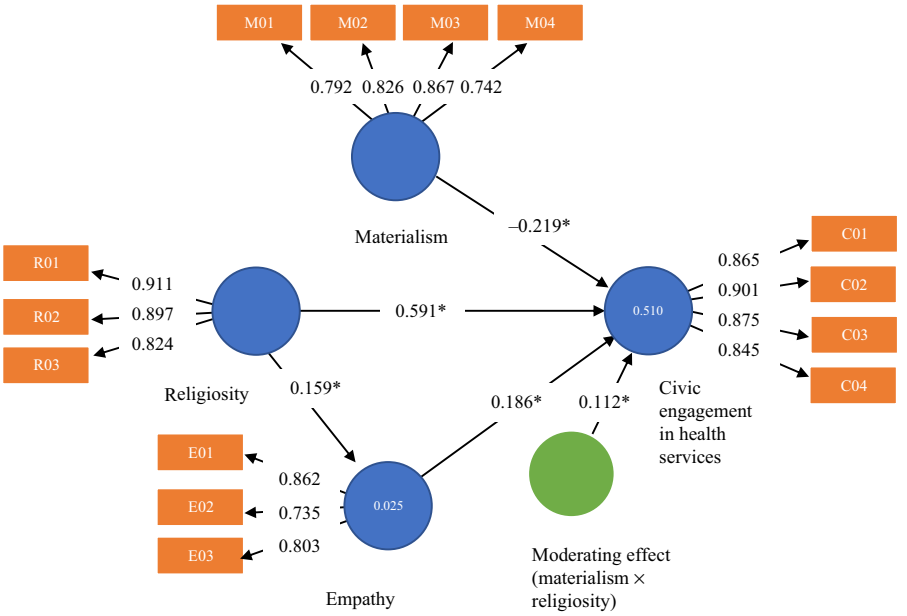
acceptable, which support the argument that religiosity brings civic engagement in helping friends, family, and neighbours (Lewis *et al.*, 2013). This result also confirms that supporting people's health and caring for the environment become religious objectives or ways of honouring God (Deneulin and Zampini-Davies, 2017).

Figure 1 provides the results from the PLS-SEM algorithm, which represent the hypothesis relationship among the latent variables. The path coefficients have a positive relationship except for the moderating variable of materialism. The results also confirm that *H2* and *H3* are acceptable with positive and significant coefficients, which affirms that religiosity enhances the capability to understand the feeling of another (Lowicki and Zajenkowski, 2017; Bilali *et al.*, 2018). The results also gain support from the previous study, which argues that compassionate encourages for voluntary (Kemp *et al.*, 2017).

The impact of religion on engagement has the most substantial coefficient (0.591), while the weaker relationship occurs in the relationship between religion and empathy (0.159). Table VI also indicate the indirect effect between religiosity and engagement via the mediating construct of empathy. The indirect impact is the product of two effects $0.159 \times 0.186 = 0.029$. The total effect is 0.621, which springs from $0.591 + 0.159 \times 0$. When we removed the mediating variable, the direct effect of religiosity on civic engagement is 0.630. Table VII also provides the coefficient of total effects, which combination of direct effect and indirect effect.

Table VIII shows that the size f^2, which indicates that religiosity provides a substantial effect on the civic engagement variable's R^2 value. Besides, materialism and empathy have a smaller impact on engagement than religiosity. However, the effect of materialism is slightly higher than the effect of empathy. The result of blindfolding analysis shows that Q^2 is greater than 0, which indicates that the model provides relevance prediction (Table IX).

Figure 1 shows that the interaction between religiosity and materialism positively affects civic engagement with a coefficient value of 0.112, *t*-value of 1.89, and $p = 5$ per cent, which



Note: *Significant at alpha 5 per cent

Figure 1.
Path analysis

confirms the *H4*. Figure 2 shows that the slope of religiosity on civic engagement is slightly higher for respondents with high materialism than for respondent with low materialism. However, at the same level of religiosity, the respondents with weak materialism tend to have greater civic engagement than respondent with high materialism. The results support the *H4*.

Discussion

Theoretical implication

This study challenges the altruistic theory by asking the effect of religiosity on civic engagement. The results indicate that religiosity is an essential element to civic engagement

Table VII.
Total effect

Path	Original sample (*O*)	Sample mean (*M*)	SD	*t*-Statistics |O/STDEV|	*p*-values
Materialism → Engagement	−0.224	−0.212	0.099	2.251	0.025
Moderating effect	0.151	0.136	0.085	1.789	0.074
Religiosity → Engagement	0.391	0.392	0.055	7.077	0.000
Religiosity → empathy	0.146	0.159	0.058	2.525	0.012
Empathy → Engagement	0.196	0.192	0.086	2.286	0.023

Table VIII.
f^2 matrix

Constructs	Empathy	Engagement
Empathy		0.060
Materialism		0.083
Moderating effect		0.027
Religiosity	0.026	0.643

Table IX.
Blindfolding analysis

Constructs	SSO	SSE	Q^2 (=1−SSE/SSO)
Empathy	813	805.546	0.009
Materialism	1,084.00	1,084.00	
Moderating effect	271	271	
Religiosity	813	813	
Engagement	1,084.00	708.539	0.346

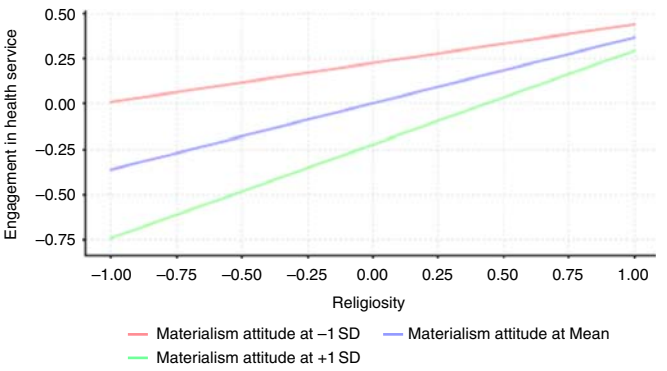


Figure 2.
Moderating effect of materialism attitude

in the health sector. The respondents with higher scores in religiosity tend to be more caring towards those who suffer from mental health, AIDs, cancer and disability. The results confirm previous studies, which argue that religiosity people are encouraged to support health sector through volunteering, charitable giving and other informal supporting activities (Lewis *et al.*, 2013; Deneulin and Zampini-Davies, 2017; Goss and Bishop, 2018; Pratono and Maharani, 2018).

This study indicates that civic engagement in the health sector is less motivated by empathy than the findings at the previous studies. This results are different to previous studies, which argue that religious fuels empathy (William *et al.*, 2012; Bilali *et al.*, 2018) and young religious people who are altruistic tendencies tend to get involved at civic engagement (Decety *et al.*, 2018). In comparison with materialism attitude, empathy and religion do not have a strong relationship, and the belief is partly responsible for the lack of empathy in Indonesia people. The results indicate that religiosity has a more significant effect on civic engagement than empathy and materialism. Religiosity influences on empathy do not account for more than 3 per cent of the variance.

Religiosity drives the materialism people to be more generous in supporting those who suffer from mental health, AIDs, cancer and disability. Understanding how materialism works in the positive outcome is essential to promote and encourage civic engagement, especially when materialists are less concerned with the environment (Segev *et al.*, 2015). In this study, the relationship between religiosity and civic engagement was found to be higher for respondents who identified as low materialism than for those with high materialism. This study recognises that for high materialism people, the religiosity is critical to whether they will support those who suffer from the health problem. The results challenge the widespread assumption that empathy is a driving force to civic engagement (Bloom, 2017; Pratono, 2018).

Practical implication

Our findings provide essential inputs for the health sector governance, especially in the low- and middle-income countries with a democratic system. Civic engagement is crucial for establishing good governance as it allows people to deliver their voice and to contribute to the policy-making of their society (Bhargava *et al.*, 2015). In a country with a democratic system, civic engagement shapes the institutions that govern people's lives. Beyond the formal health system, health sector governance collaborates with other sectors, including civil society, to promote and maintain population health (World Health Organization, 2015).

This study encourages that civic engagement needs to be careful when an attempt to gain from networks of participation. Receiving inattention from the community, AIDs, mental health, and diffable issue may become a continuous problem in the community. O'mara-Eves *et al.* (2015) show that interventions using community engagement in the field of public health help the community gain greater health outcomes. Networks of participation deepen involvement within the community because someone they trust suggests it (Pratono and Ratih, 2019).

Indonesia is a multicultural country with more than 300 ethnic groups, 750 languages and dialects, and numerous religions. Hence, policy to improve health status among Indonesians should be sensitive to religious and cultural norms. Different religious groups have diverse forms and norms about healthcare and medicine, including maternal and child health. For example, mothers in Nanggroe Aceh Darussalam province, which have a strong Islamic background, believe that death due to childbirth is a "fate" and part of life destiny (Susanti, 2013).

Research limitation

The empirical evidence indicates that religiosity plays a pivotal role in civic engagement. Empathy and prosocial behaviour become valuable resources for a developmental

perspective at young ages. The conclusion needs to consider some limitations. First of all, research indicates that on-line interviews target only specific types of individuals who spend time on the internet. This study may not be able to get responses from a cross-sectional mix of respondents. Second, the PLS-SEM allows the study to examine the mediating role of empathy and the moderating part of materialism attitude. The PLS SEM algorithm requires a recursive model and cannot handle the circular relationships between the latent variables (Hair *et al.*, 2014).

This study adopts the concept of civic engagement from Schulz *et al.* (2010), which mainly concern the intention to support people with mental health, AIDs, cancer and disability. Future studies are encouraged to explore more cases, which may have different support from the communities. The initiative to develop a new construct should meet the principle of the reliability and validity from the measurement theory, which examines the relationship between constructs and the corresponding indicator variables (Hair *et al.*, 2014).

Last, this study focussed on a cross-section survey to understand the attitudes and beliefs of young people in the Indonesia context regarding participatory in the health sector. The data collection involves an on-line interview, which may ignore the young people who have no access to the internet. Also, peer relationships and institutional context were not examined in this particular study, which may bring an additional limitation which needs to be addressed in future studies. We suggest the future studies adopt various data collection, such as face-to-face interview, offline survey, and telephone interview for civic engagement in the health sector. Different survey methods need to be tested, which may provide different results.

Conclusion

This paper contributes to the discussion on altruistic theory by challenging a widespread assumption that the feeling of empathy drives civic engagement. The effect of religiosity on generosity become weak for those who have high materialism. The results are different from the tradition proposition, which argues that religion makes people more generous. This study recognises that for top materialism people, the religiosity is critical to whether they will support those who suffer from the health problem.

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Appendix

Table AI. Finite mixture (FIMIX) segmentation

Constructs	Empathy	Engagement
Empathy		−0.032
Materialism		−0.130
Moderating effect		0.118
Religiosity	0.397	0.963

Table AII. Outer loading with bootstrap approach

Path	Original sample (*O*)	Sample mean (*M*)	SD (STDEV)	*t*-Statistics (|O/STDEV|)	*p*-values
C01 ← engagement	0.865	0.863	0.021	40.331	0.000
C03 ← engagement	0.901	0.900	0.015	61.549	0.000
C04 ← engagement	0.875	0.872	0.020	44.090	0.000
C05 ← engagement	0.845	0.843	0.027	31.080	0.000
E02 ← Empathy	0.862	0.854	0.084	10.250	0.000
E08 ← Empathy	0.735	0.717	0.107	6.890	0.000
E10 ← Empathy	0.803	0.782	0.085	9.455	0.000
IR03 ← Religiosity	0.911	0.911	0.014	64.078	0.000
IR04 ← Religiosity	0.897	0.894	0.021	42.311	0.000
IR05 ← Religiosity	0.824	0.825	0.035	23.409	0.000
M02 ← Materialism	0.792	0.783	0.062	12.778	0.000
M03 ← Materialism	0.826	0.814	0.051	16.199	0.000
M04 ← Materialism	0.867	0.866	0.038	23.064	0.000
M06 ← Materialism	0.742	0.719	0.095	7.774	0.000
Religiosity × materialism ← Moderating effect	1.055	1.059	0.087	12.146	0.000

	Empathy	Materialism attitude	Engagement	Religiosity
E01	0.756			
E02	0.881			
E03	0.788			
M02		0.723		
M03		0.826		
M04		0.911		
P04			0.815	
P05			0.747	
P06			0.838	
P07			0.826	
R01				0.758
R02				0.854
R03				0.719
R04				0.864

Table AIII.
Outer loadings

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