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The role of authentic leadership on healthcare Street-Level Bureaucrats’ well-being during the pandemic

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Abstract
This study uses Conservation of Resources Theory, to explain Street-Level Bureaucrats’ (SLBs) workplace behavioural responses to threats to their well-being. We examine whether authentic leadership within street-level organisations positively impacts employee well-being by increasing SLBs’ perception of personal resources, and reducing their perceptions of work harassment. The research design comprises a survey that solicited quantitative and qualitative data from 163 healthcare SLBs working in Australian hospitals during the pandemic in April 2020. Analysis of the means indicates low levels of satisfaction with leadership and low levels of well-being for SLBs. The structural equation modelling findings show that poor leadership is associated with higher levels of work harassment and lower levels of employee well-being. Qualitative data support these findings. As healthcare workers were already listed as over-represented in the stress-related workers compensation statistics, one strategy may be to improve the level of organisational support by upskilling managers in authentic leadership behaviours with the aim of...
increasing their perception of support so as to increase employee well-being. This will benefit employees and their families, and the community they service.

**KEYWORDS**
authentic leadership behaviour, psychological Capital, Street Level Bureaucrat’s well-being, work harassment

**Points for practitioners**
- Street-Level Bureaucrats (SLBs) have been increasingly experiencing the public sector gap (demand outstripping supply of resources) because of the dominance of the austerity-driven managerialist paradigm.
- The recent COVID-19 crisis amplified the severity and impact of the public sector gap causing increased perceptions of work harassment and reductions in SLBs’ well-being.
- However, SLBs with high levels of Psychological Capital had a natural buffer in place to protect their well-being, and as such, they perceived less work harassment and erosion of their well-being.
- The way forward is to complement the austerity-driven managerialist paradigm in management decision-making with authentic leadership behaviours focused on maximising the well-being of SLBs and the public.

**1 | INTRODUCTION**

Before the present crisis caused by COVID-19, Street-Level Bureaucrats (SLBs) delivering emergency, health, and social services were over-represented in stress-related workers compensation claims and subsequent stress-related illnesses (Safe Work Australia, 2021), and the main reason identified was the work conditions resulting in part from poor management practices (Riethof et al., 2019). SLBs are employees tasked with delivering services to the public, usually under conditions of demand exceeding supply, which then forces them to find coping measures as a way of rationalising who gets what, and importantly, who does not (Lipsky, 2010)—also called the public sector gap (Hupe & Buffet, 2014).

The intensification of demand-driven pandemic and post-pandemic circumstances continue to amplify the negative impact of poor work conditions on healthcare SLBs’ well-being worldwide, with many forced to undertake double shifts without adequate days off to recover (Brunetto...
et al., 2022). Similarly, Pappa et al. (2020) identifies one of the main causes of stress amongst healthcare SLBs across many countries as chronic levels of work harassment and intensity. Work harassment is defined as a negative work act driven by austerity-driven management practices directed at frontline employees under conditions of demand for services outstripping supply, leading to high work intensity and accountability, and is evident by increased workloads and longer shifts (Brunetto et al., 2016; Farr-Wharton et al., 2022). The pandemic has normalised increased workloads, longer shifts, and increased paperwork and patient assessments whether healthcare SLBs are working with COVID-19 patients or not (Brunetto et al., 2022). Over time, this has led to higher levels of physical and psychological distress (Farr-Wharton et al., 2022; van Roekel, et al., 2020). As a result, psychological injury, largely attributed to stress from overwork and pandemic-related work conditions, now constitutes one tenth of all stress-related workers compensation claims (SafeWork Australia, 2021).

The erosion of healthcare SLBs’ well-being is not sustainable. Over the past 2 years, many countries have struggled with, and at time, failed to adequately staff key positions within hospitals; hence, the impact of healthcare SLBs is not just impacting the individual SLB and their families, but it also has had a significant impact on the communities they serve. Healthcare in Australia receives approximately 68% of its funding from the government, although the service may be provided in a public, for-profit (FP), or not-for-profit (NFP) hospital or healthcare facility (AIHW, 2016). The remainder is funded by individuals. Since health is a public good, there is a legislative framework as well as professional standards that dictate many processes and practices undertaken by SLBs. However, once funding is allocated to each hospital, it is the organisational leadership that makes decisions about how the funding is allocated. Hence, this paper addresses a gap in the literature about how street-level organisations (SLOs) cope during a crisis (Brodkin, 2021; Dunlop et al., 2020), especially when crisis conditions are interwoven with austerity-driven management practices (Meza et al., 2021), further amplifying the public service gap for SLBs (demand exceeding supply) (Hupe & Buffett, 2014). The first step is to gain insight into leaders’ behaviour in managing the first line of defence during a crisis because it is SLBs who deliver services on behalf of SLOs and therefore the gap in the literature is in understanding the impact of organisational antecedents such as leadership on SLBs’ outcomes because it affects their delivery of public value (Brunetto et al., 2022).

According to Conservation of Resources Theory (CORT), employees are motivated based on how organisational actions and processes affect their health and well-being (Chen et al., 2016). It is management’s responsibility to adequately resource employees to ensure their health and well-being are not compromised (Hobfoll, 2011). This means that it is the responsibility of those leading hospitals to ensure that their SLBs have adequate organisational resources to cope. Past research shows that leaders’ behaviour (in terms of resourcing decisions and organisational support processes) can either erode or increase employee’s perception of personal support (Adendorff et al., 2021). Walumbwa et al. (2008, p. 84) defines authentic leadership as ‘a pattern of leader behavior that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalised moral perspective, balanced processing of information and relational transparency between leaders and followers’. When managers use authentic leadership behaviours in organisational decision-making and interactions with staff, past research about public sector employees indicates that it leads to increases in their personal resources, such as their Psychological Capital (PsyCap) (Adendorff et al., 2021). PsyCap is a variable from the field of Positive Organisational Behaviour and combines the attributes of hope, optimism, resilience, and self-efficacy (Luthans et al., 2006), and its value is that high levels of PsyCap is associated with lower stress and higher performance.
The question examined in this paper is whether authentic leadership within SLOs can provide a type of leadership behaviour that can positively impact employee well-being by increasing SLBs’ perception of personal resources (PsyCap) and reducing their perceptions of work harassment. Wang et al. (2014) found that when leaders use authentic behaviours (i.e. when they are self-aware, transparent in their workplace relationships, and engage in ethical and rational decision-making), the outcome is that employees perceive their supervisors as supportive and as a consequence, they perceive higher levels of PsyCap. Healthcare SLBs with high PsyCap are likely to have the psychological capacities required to cope when authentic leaders are in place, embedding authentic workplace relationships, making ethical decisions, and supporting staff with adequate protective equipment. Additionally, high PsyCap is associated with increased employee well-being (Brunetto et al., 2016). In contrast, if authentic leadership behaviours are minimal, employees will likely experience lower PsyCap, giving them fewer psychological resources to rely on when they need them. Also, they are unlikely to have the support in place to protect them against high work harassment and intensity, and over time, the outcome is likely to be low well-being.

The focus on employees’ well-being contrasts the perspective of traditional public administration researchers and managers (who were focused on SLBs’ outcomes) (Dunlop et al., 2020) and, instead, is more in line with Tummers’ (2017) call for research to examine the ‘effects of coping’ (p. 151). It is the sustained challenge associated with being an SLB delivering healthcare and emergency services that warrants research to examine a new way of managing them. Hospitals are only effective if they have the capacity to deliver healthcare services, and that requires SLBs with high well-being, since high well-being is associated with high performance (Brunetto et al., 2022). The research questions guiding the study are as follows:

**RQ1**: What is the impact of authentic leadership on employee well-being for Australian healthcare SLB during the pandemic?

**RQ2**: Do PsyCap and work harassment mediate the relationship between authentic leadership and employee well-being for Australian healthcare SLBs during the pandemic?

The contribution of the research is in understanding whether authentic leadership behaviours are associated with increased SLBs’ well-being. The argument is that when authentic leaders make more ethical decisions about workloads, it reduces SLB’s perception of work harassment, and provides support that builds employees’ personal resources—all of which results in high well-being for SLB’s. Hence, authentic leadership behaviours are likely to reduce financial, psychological, and emotional erosion of public value in the community. To answer these questions, we solicited quantitative data from 163 healthcare SLBs working in Australian hospitals during the first wave of the pandemic in April 2020. The survey also included three open-ended questions, furnishing respondents with the opportunity to provide free text responses about their well-being to add an ever-so-slight layer of depth to the quantitative data.

### 1.1 Conservation of Resources Theory

CORT is a theory about human motivation and argues that individuals are motivated to undertake those activities that improve their potential for achieving what they desire most from their lives. For most people, that means preserving or where possible, increasing their well-being (Hobfoll et al., 2018). According to CORT, if employees perceive adequate support resources (from the organisation or personally), they can maintain or, under the right conditions, even increase
their well-being and PsyCap. Two principles and two corollaries explain employees’ behaviour (Hobfoll, 2011). The first principle is that resource losses have a more significant impact than resource gains. In contrast, a loss of resources generates a negative combination of physiological, cognitive, emotional, and social responses. The second principle is that if employees want to develop or conserve resources, they must first invest some of their existing resources. For example, a doctor might devote time and effort into developing a friendly relationship with colleagues. Once he/she establishes a trusting relationship, he/she can ask for collegial support when he/she feels drained from excessive work intensity. The relevant corollaries are that employees with adequate resources cope better with challenges, and once employees perceive a loss of resources (such as reduced well-being because of working extra hours and not getting enough sleep), more losses are likely to follow because they begin their shifts feeling tired and run down.

Operationalising these principles and corollaries, we argue that if authentic leadership behaviours are evident, this is likely to enhance the healthcare SLBs’ perception of personal resources to cope (H1), which will likely generate positive physiological, cognitive, emotional, and social responses in the form of high well-being (H2, H3, H5, and H6) (Hobfoll, 2011). On the other hand, if healthcare SLBs are unable to preserve their resources, then their personal resilience and well-being will be compromised (H7), increasing the perception of work harassment (H4) and the likelihood of burnout (Chen et al., 2016). The next section provides the supportive narrative for each hypothesis.

1.2 | Factor 1: Authentic leadership

Leadership is a problem in the public sector because of a lack of skills in managing performance within the context of austerity (Brown & Head, 2019). It is also a problem specifically in health care (Daly et al., 2020). Leaders in public, NFP, or FP SLOs are all public leaders if they manage employees delivering public services. Additionally, Hartley (2018) argues that the relational context is an important element of leadership outcomes. Reviewing research examining the impact of authentic leadership on healthcare SLBs, Malila et al. (2018) found that when authentic leadership was evident, healthcare professionals had higher resilience and well-being. Authentic leaders’ behaviours develop supportive workplace practices that build personal resources for employees such as PsyCap. Similarly, a systematic review of research about healthcare workers found a consistent relationship between authentic leadership behaviours and positive outcomes for employees (Alilyyani et al., 2018). Further, Farr-Wharton et al. (2021) found that Italian police officers’ well-being was enhanced when their leaders displayed authentic behaviour because it positively enhanced the relationship between line managers and police officers.

1.3 | Factor 2: PsyCap (hope, self-efficacy, optimism, and resilience)

As stated, PsyCap is a higher order variable that comprises four sub-variables: resilience (ability to bounce back), along with hope (flexibility in achieving goals), optimism (positive perspective on life), and self-efficacy (confidence in the ability to achieve goals) (Luthans et al., 2006). Past research shows that efficacious employees tend to be resilient employees (Sezgin & Erdogan, 2015; Yu et al., 2019) and hopeful employees are also resilient employees (Roesch, & Vaughn, 2006); hence, combining the variables offers a powerful concept capturing a broad range of psychological resources. Individuals have varying levels of PsyCap depending on their DNA, childhood, family,
and community experiences, along with subsequent significant events that either supported them in building their personal resources or compromised and eroded their resources. High PsyCap provides a buffer against stress and is associated with high performing employees (Brunetto et al., 2021) and better adherence to safety accreditation procedures in the case of medical practitioners (Trinchero et al., 2020). High PsyCap also reduces the impact of red tape (Dudau et al., 2020).

### 1.4 Factor 3: Work harassment

The widespread use of austerity-driven funding models dominating health, social, and emergency services delivery, especially in core new public management (NPM) countries (Pollitt & Bouckaert, 2017), has negatively impacted SLBs’ ability to cope (Tummers, 2017). One reason for the decline in their well-being is the use of management models that increase work harassment (Brunetto et al., 2016), in turn normalising overwork (Xerri et al., 2021). As stated, work harassment is a negative workplace act involving large numbers of frontline staff experiencing chronic levels of high work intensity coupled with increased accountability and red tape (Farr-Wharton et al., 2019). Farr-Wharton et al. (2022) found evidence of work harassment for nurses across the United Kingdom and the United States, and Xerri et al. (2019, 2021) found evidence of work harassment in Bangladeshi and U.S. healthcare SLBs. SafeWork Australia (2021, p. 15) detailed the incidence of stress-related workers compensation claims, identifying a sharp rise in the number of cases, a majority of mental health claims originating in the public sector, and work harassment as a significant contributing factor.

### 1.5 Outcome: Employee well-being

There are multiple definitions of well-being. Forgeard et al. (2011) and Brunetto et al. (2011) conceptualise employee well-being as comprising a hedonic dimension (moods and emotions) and a eudaimonic dimension (the extent to which work tasks are consistent with their values)—the intentional component. Low well-being amongst healthcare SLBs caused by high work harassment and intensity has been an emerging problem for at least a decade as the degree to which it affects their physical and psychological well-being has been identified (Riethof et al., 2019). The pandemic has amplified the pressure that SLBs perceive, with Pappa et al. (2020, p. 1) reviewing the outcomes for 33,000 healthcare professionals and finding approximately one-fifth reported lower well-being in the form of depression and anxiety, caused by ‘... increased workload, physical exhaustion, inadequate personal equipment ... and the need to make ethically difficult decisions on the rationing of care may have dramatic effects on their physical and mental well-being’.

In contrast, when authentic leaders demonstrate genuine support for SLBs—evident in their ethical decision-making in relation to staffing and workloads so as to preserve their well-being—hospitals have the capacity to deliver services to the public. However, according to Inceoglu et al. (2018, p. 179), previous research about the impact of leadership behaviours (i.e. authentic leadership) on well-being is limited by the focus on performance, which has restricted both the debate and examination of longer term implications. Additionally, approximately half of the studies reviewed by Nelson et al. (2014) link low management support with increasing numbers of employees with high blood pressure (Li et al., 2015). Prolonged periods of high blood pressure are associated with circulatory diseases such as myocardial infarction, stroke, angina, and hypertension. The increasing incidence of these diseases is a growing concern for most
governments responsible for operating healthcare systems. Such workplaces are empirically linked to approximately a third of all deaths annually across the globe (Gilbert-Ouimet et al., 2014).

1.6 Hypotheses development

Accordingly, this paper considers whether authentic leadership (Walumbwa et al., 2008) provides the behaviours required to generate such outcomes as reducing stress and increasing well-being for SLBs. According to the second principle of CORT, when leaders spend time and energy developing authentic, supportive relationships with employees, the employees are likely to become more resilient, experience more positive emotions, and ultimately improve productivity and other work outcomes. Hence, we expect that when authentic leadership is high, then PsyCap is also likely to be high. The hypothesis is as follows:

**H1**: High authentic leadership is associated with high PsyCap for healthcare SLBs.

Reviewing the impact of leadership (on employees), Rudolph et al. (2020) found that positive leadership behaviour is associated with respectful expectations, improved employee outcomes, and high well-being. This suggests that authentic leadership is one way of creating working conditions where SLBs feel that they have the resources required to do their job.

**H2**: Authentic leadership behaviours are associated with low work harassment.

Employees with high well-being do not emerge in an organisational vacuum. Instead, in terms of COR, effective leadership is a pivotal organisational lever required to embed a supportive culture promoting well-being (Chen et al., 2016). In terms of CORT, this means that authentic leadership is likely to ensure work conditions promote employees’ ability to enhance their well-being. We expect the following:

**H3**: High-quality authentic leadership behaviour is associated with high well-being.

Without adequate psychological and physical resources, employees are likely to respond by either withdrawing energy in the workplace to preserve their well-being or experiencing burnout with subsequent negative medical implications.

**H4**: Low work harassment is associated with high well-being.

Employees with high PsyCap perceive low stress and have high well-being (Harms et al., 2018). In terms of COR, effective leadership can help to build SLBs’ PsyCap (Adendorff et al., 2021) and to embed a supportive culture promoting growth in well-being (Chen et al., 2016). We expect to replicate the same relationship.

**H5**: High PsyCap is associated with high well-being.

Research about nurses found that even relatively new graduates perceive lower levels of emotional exhaustion and high well-being when leaders behave authentically (Laschinger &
Hence, we anticipate that authentic leadership affects well-being, both directly and indirectly by increasing PsyCap.

**H6:** PsyCap mediates the relationship between authentic leadership and well-being.

In contrast to authentic leadership, austerity-driven management models are likely to normalise work harassment (Xerri et al., 2021), whereas Farr-Wharton et al. (2021) found that authentic leadership enhanced the well-being of police officers in England and Italy. Hence, we expect work harassment to mediate whether authentic leadership impacts well-being:

**H7:** Work harassment mediates the relationship between authentic leadership and well-being.

These hypotheses guide the data collection and analysis.

## 2 METHOD

### 2.1 Design and context of the study

This study is predominantly quantitative, although supported by the responses to three open ended questionnaires included in the survey, aimed at soliciting insight into the factors driving well-being. The sample includes all SLBs because the Australian federal and state governments formed a national cabinet, and then introduced significant changes to healthcare delivery suspending elective surgery and persuading all private sector hospitals to adopt the national priorities and become part of the extended public health network (Parliament of Australia, 2020). Irrespective, even during ‘normal periods’, government-funded health care occurs in public, FP, and NFP hospitals via PPPs and contracting out (AIHW, 2016).

Using QUALTRICS software, healthcare professionals in Australia were invited to complete a survey (in April 2020) using screening parameters to ensure genuine responses during the heart of the pandemic’s first wave, and 163 completed surveys were useable; a total of 20 were incomplete and discarded. The useable surveys comprised a cohort of 30 medical practitioners, 85 nurses, and 48 allied health professionals, of which 52 were males and 71 were females. In terms of the hospital types, 85 worked in public sector hospitals, 45 worked in FP hospitals, and 28 worked in NFP hospitals (with five giving no response). In terms of age, 59 were aged 48 years or older and 54 were aged less than 33, with the remainder (n = 50) aged between 33 and 48. Many of the respondents (n = 72) worked full time, and the rest were either part-time or casual.

### 2.2 Measures

Validated scales were used to operationalise the constructs in the path model, using statements rated on a 6-point Likert-type scale, ranging from 1 = strongly disagree to 6 = strongly agree. In terms of the instruments used to collect the data, *Authentic leadership* was measured using the eight-item scale developed by Walumba et al. (2008). A sample item includes ‘My manager seeks feedback to improve interactions with others.’ *PsyCap* was measured using Luthans et al.’s (2006) short PsyCap scale (12-items) including, ‘I can think of many ways to reach my current work goals’.
Work harassment was measured using the Dick (2010) three-item instrument. A sample item was ‘Management sets unrealistic work targets.’ Employee well-being was measured using Brunetto et al.’s (2011) four-item scale. A sample item is ‘Overall, I am reasonably happy with my work life.’ To gain slightly richer and more nuanced information about the impact of the pandemic on SLBs, we included a qualitative component to the survey. This part of the study involved participants completing questions relating to their stress levels and well-being. The survey included three open-ended questions requiring a written word response: (1) ‘How has your stress level changed during the pandemic’? (2) ‘List the top three ways this pandemic has affected you’. (3) ‘How has your well-being changed during the pandemic’?

2.3 | Analysis

For the quantitative data, Anderson and Gerbing’s (1988) two-step structural equation modelling (SEM) approach in Analysis of Moment Structures (AMOS) software was used to test the hypotheses, and bootstrapping within AMOS was used to test for mediation between the four variables. AMOS is a statistical package explaining the relationship between multiple variables, by combining a measurement model with the structural model into a simultaneous statistical test (Mudalige et al., 2012). Covariance-based structural equation modelling estimates the theoretical structural model and examines the causal relationship between constructs and measures model feasibility and confirms according to empirical data. The absolute fit model was used for the current study (see Tables 4 and 5 for the model fit indexes). The criteria for the goodness of fit (GOF) measurement (Hair et al., 2014) are categorised into:

- Absolute fit indices: chi-square fit statistics/degree of freedom (CMIN/DF) < 5; goodness of fit index (GFI) 0–1; root mean square error of approximation (RMSEA) .05–.08;
- Incremental fit indices: adjusted goodness of fit index (AGFI) 0–1; Tucker–Lewis index (TLI) 0–1; normed fit index (NFI) 0–1;
- Parsimonious fit indices: 0–1; parsimony normed fit index (PNFI) 0–1; parsimony goodness-of-fit index (PGFI) 0–1.

Although sample size is a critical issue in SEM, there is debate regarding what is an appropriate sample size. Most statisticians agree that a sample size of above 150 is adequate especially if the number of variables examined is limited (Anderson & Gerbing, 1988; Tabachnick & Fidell, 2001). In the case of multi-group modelling, a sample size of over 100 is sufficient (Kline, 2005). In addition, sample size is mainly considered based on the numbers of observed variables. Bentler and Chou (1987) suggested that for normally distributed data, a minimum of five cases per variable is appropriate, which is aligned with our study.

Next, the data were manipulated using AMOS. Both direct and indirect path testing was undertaken to assess the hypotheses, utilising the bootstrapped bias-corrected standardised effect test (undertaken at a 95% confidence level, bootstrapped to 4000 samples). Table 1 shows the correlation coefficient table, coefficient of variation (CV), and AVE. Table 2 shows the comparative means for authentic leadership, PsyCap, work harassment, and employee well-being across the three cohorts. Table 3 shows the direct and indirect effects and the squared multiple correlation scores ($R^2$). The model fit scores for the hypothesised path models are displayed in Tables 4 and 5. Figure 1 shows the SEM approach to test hypotheses—particularly whether high level of authentic leadership impacts healthcare SLBs’ perception of personal resources (H1), resulting
TABLE 1  Descriptive statistics and correlations

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>CR</th>
<th>AVE</th>
<th>$R^2$</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Authentic leadership</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>.53</td>
<td>1</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2. PsyCap</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>.23</td>
<td>.4a</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>3. Work harassment</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>.20</td>
<td>–</td>
<td>-.05</td>
<td>1</td>
</tr>
<tr>
<td>4. Well-being</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>.65</td>
<td>.69a</td>
<td>.37a</td>
<td>-.197b</td>
</tr>
</tbody>
</table>

Scale: 1 = Strongly disagree; 2 = Disagree; 3 = Somewhat disagree; 4 = Somewhat agree; 5 = Agree; 6 = Strongly agree.

Abbreviations: AVE, square root of the average variance extracted; CR, composite reliability; SD, standard deviation.

aCorrelation is significant at .001 (two-tailed)
bCorrelation is significant at .05 (two-tailed).

TABLE 2  A comparison of means for medical practitioners, nurses, and allied health

<table>
<thead>
<tr>
<th>Variables</th>
<th>Medical practitioners Mean (SD)</th>
<th>Nurses Mean (SD)</th>
<th>Allied health Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authentic leadership</td>
<td>2.4 (.87)</td>
<td>2.61 (.67)</td>
<td>2.72 (1.08)</td>
</tr>
<tr>
<td>Psychological capital</td>
<td>2.5 (1.2)</td>
<td>2.63 (1.2)</td>
<td>2.29 (1.08)</td>
</tr>
<tr>
<td>Work harassment</td>
<td>3.2 (.95)</td>
<td>3.75 (1)</td>
<td>3.5 (1.3)</td>
</tr>
<tr>
<td>Employee well-being</td>
<td>2.2 (1)</td>
<td>2.1 (.5)</td>
<td>2.43 (1.1)</td>
</tr>
</tbody>
</table>

Scale: 1 = Strongly disagree; 2 = Disagree; 3 = Somewhat disagree; 4 = Somewhat agree; 5 = Agree; 6 = Strongly agree.

TABLE 3  Direct and indirect results (standardised)

<table>
<thead>
<tr>
<th></th>
<th>Direct effect</th>
<th>Indirect effect</th>
<th>Total effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsyCap mediates Authentic Leadership (AL) onto well-being (H6)</td>
<td>.50 ($p &lt; .000$)</td>
<td>.27 ($p &lt; .000$)</td>
<td>.67</td>
</tr>
<tr>
<td>Work harassment mediates AL onto well-being (H7)</td>
<td>-.33</td>
<td>.27 ($p &lt; .000$)</td>
<td>-.18</td>
</tr>
<tr>
<td>PsyCap → Well-being</td>
<td>.37 ($p &lt; .05$)</td>
<td>.57 ($p &lt; .000$)</td>
<td>.37</td>
</tr>
<tr>
<td>AL → Well-being</td>
<td>.42 ($p &lt; .05$)</td>
<td>.25 ($p &lt; .000$)</td>
<td>.80</td>
</tr>
<tr>
<td>Work harassment → Well-being</td>
<td>-.17 ($p &lt; .05$)</td>
<td>–</td>
<td>-.20</td>
</tr>
<tr>
<td>AL → Work harassment</td>
<td>-.15 ($p &lt; .5$)</td>
<td>–</td>
<td>.15</td>
</tr>
<tr>
<td>AL → PsyCap</td>
<td>.51 ($p &lt; .000$)</td>
<td>–</td>
<td>.67</td>
</tr>
<tr>
<td>AL → Well-being</td>
<td>.44 ($p &lt; .000$)</td>
<td>–</td>
<td>.80</td>
</tr>
</tbody>
</table>

in higher well-being (H5, H6), and whether low authentic leadership disabled SLBs’ to preserve their resources, compromising their well-being (H7), and increase work harassment (H4). We also tested whether PsyCap and work harassment acted as mediators between authentic leadership and well-being. The signs (+) and (–) indicate the positive and negative impacts between variables, respectively.

TABLE 4  Structural equation modelling (SEM) model fit indices

<table>
<thead>
<tr>
<th></th>
<th>CMIN/DF</th>
<th>CFI</th>
<th>RMSEA</th>
<th>TLI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1: Default/proposed model</td>
<td>2.191</td>
<td>.759</td>
<td>.096</td>
<td>.719</td>
</tr>
</tbody>
</table>

Abbreviations: CFI, comparative fit index (0–1); CMIN/DF, chi-square fit statistics/degree of freedom (<5); RMSEA, root mean square error of approximation (.05–.08); TLI, Tucker–Lewis index (0–1).
### TABLE 5  Structural equation modelling (SEM) model fit indices

<table>
<thead>
<tr>
<th>Fit indices</th>
<th>Model fit</th>
<th>Cut-off point</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMIN/DF</td>
<td>2.191</td>
<td>CMIN/DF: &lt;5</td>
</tr>
<tr>
<td>CFI</td>
<td>.759</td>
<td>GFI: 0–1</td>
</tr>
<tr>
<td>TLI</td>
<td>.719</td>
<td>TLI: 0–1</td>
</tr>
<tr>
<td>RMSEA</td>
<td>.096</td>
<td>RMSEA: .05–.08</td>
</tr>
<tr>
<td>N</td>
<td>163</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CFI, comparative fit index; CMIN/DF, chi-square fit statistics/degree of freedom; GFI, goodness of fit index; RMSEA, root mean square error of approximation; TLI, Tucker–Lewis index.

### FIGURE 1  Structural equation modelling (SEM) of the hypothetical model.

With regard to the qualitative phase of the study, a total of 160 out of 163 answered the three qualitative questions. The semantic approach to thematic analysis was used for analysis, starting with the semantic level identifying the surface meaning of what participants suggested, and subsequently resulted in more in-depth analysis moving back and forth over the data until ‘meaning-making’ occurred (Harding & Whitehead, 2013). The data was transcribed, tabulated, and analysed using Yin’s (2011) five phases (compiling, disassembling, reassembling, interpreting, and concluding) to identify the emerging themes. A thematic map was provided throughout the analysis for a visual understanding of the interconnectedness and pattern between the key themes (Harding & Whitehead, 2013).

### 3  RESULTS

#### 3.1 SEM findings

Using SEM analysis (see Tables 4 and 5), the findings confirmed significant relationships (correlation at the 0.01 level) between (a) authentic leadership and PsyCap (H1: $\beta = .51^{**}$) (confirming RQ1); (b) authentic leadership and work harassment (H2: $\beta = .15^{**}$) (new knowledge); (c) authentic leadership and well-being (H3: $\beta = .44^{**}$); (d) work harassment and well-being (H4: $\beta = .17^{**}$); and (e) PsyCap and well-being (H5: $\beta = .42^{**}$). Table 3 shows the direct and indirect effect of the variables (e.g. authentic leadership, PsyCap, work harassment, and well-being), indicating that two thirds of the variance of PsyCap can be accounted for by authentic leadership and over three quarters of employee well-being can be explained by authentic leadership. Both PsyCap
and work harassment mediate the relationship between authentic leadership and employee well-being (confirming RQ2), with PsyCap enhancing the relationship and work harassment detracting from the relationship.

Overall, there were not any significant differences across the demographic variables, including settings. For example, as Table 2 shows, authentic leadership was low across different health disciplines including medical practitioners, nurses, and allied health.

3.2 Qualitative findings

Overall, in response to two open-ended questions about how the pandemic affected them, the following findings emerged. Firstly, 21 respondents suggested that there was no change or were ‘unsure’ about how the pandemic affected them, whereas the majority (135) responded that there had been a negative impact. The key themes are increased work harassment, health and well-being, and lack of support. The strongest emerging theme was ‘work harassment’.

3.2.1 Work harassment

Fifty-four work harassment responses were mainly related to an increased level of workload, exposure to the virus at work, uncertainty/change, loss/reduction of staff, and the ambiguity of working from the office or home. Participants highlighted the role of management/leadership in improving the situation and/or adjusting to the crisis in a smoother way. Some of the statements supporting the mentioned issues are as follows: ‘Management bully staff’; ‘My stress level is higher as a result of higher demand and changes in work settings’; ‘Unreasonable boss’; ‘My company will not supply PPE’; ‘More stress due to less staff with the cancellation of booked surgeries unnecessary’; and ‘Continual updates, meetings, and interference to the working day. Increase procedures and less use of casual staff resulting in a higher patient/client load’.

3.2.2 Physical and mental health/well-being

Although a total number of 51 respondents suggested that there was no change to their health and/or they are ‘unsure’, the majority of participants (101) responded that there had been a negative impact. The two strongest emerging themes were physical and mental health/well-being (28 responses). The physical and mental health/well-being themes were mainly related to anxiety, stress, pressure, restrictions on exercise, diet, and lack of sleep. Some of the direct statements supporting these issues are ‘My well-being has changed because my mental anxiety has increased’; ‘More eating less exercise less time alone’; and ‘Being socially isolated, less physical outside activity, don’t sleep as well’. A few participants suggested that this crisis was an opportunity for them to evolve and improve their well-being: ‘Less cluttered lifestyle, fitter, [but] bored’ and ‘Made me appreciate the simple things in life, to realise how fragile life is, and it is a huge wakeup call to all’.

3.2.3 Lack of support

Participants suggested that they perceived a low level of support during the crisis. The lack of support was related to emotional, informational, and financial support. They felt scared and angry.
due to the situation and were not in a good position to spend more quality time with family. This resulted in the feeling of social loneliness/isolation and lack of trust in others. Some direct quotes in the support of these issues are as follows: ‘Feeling isolated, unsure of the future, desperate for a solution’ and ‘Reducing my social contact, missing planned holiday trips, stuck at home’. On the other hands, some participants suggested that they changed the way they approached the connection to others to make the most out of it: ‘Enjoying new hobbies at home, enjoyed regular zoom catch-ups with friends’. However, it was also suggested that although online catching up was good, it was still not replaceable with face-to-face catch-ups particularly with beloved ones (families and relatives)—‘Not being able to go to hug many of my loved ones or destress with after-work coffee and friends’.

4 | DISCUSSION

This paper examined whether authentic leadership within SLOs could provide a type of leadership behaviour that would positively impact employee well-being by increasing SLBs’ perception of personal resources (PsyCap), and reducing their perceptions of work harassment.

SLBs have been experiencing the public sector gap for at least two decades (Hupe & Buffet, 2014) because of the dominance of the austerity managerialist paradigm (Bryson et al., 2014). The recent crisis simply amplified the public sector gap (Meza et al., 2021), which then further increased the burden on SLBs. The new information addresses a call from scholars such as Brodkin (2021) and Dunlop et al. (2020) to better understand the impact of management practices within SLOs during the pandemic crisis. Additionally, it addresses calls for research by Meza et al. (2021) and Brunetto et al. (2022) to investigate how SLBs responded to austerity-driven management practices during the COVID-19 crisis when the public service gap increased. In particular, the paper examined the impact of leaders’ behaviour on SLBs’ perception of work harassment and their subsequent well-being.

This study found that authentic leadership behaviour did positively impact SLBs’ well-being by reducing their perception of work harassment and increasing PsyCap (see Table 3). The analysis of the qualitative data provides greater insight into the quantitative results, notably in the SLBs perceptions of the impact of management/leadership practices on well-being. Hence, in terms of CORT, authentic leadership provides the type of organisational support resources likely to build in SLBs, giving them more personal resources to cope with the stress of working under difficult conditions (Chen et al., 2016). It is not human nature to continue to do that which does not sustain their well-being (Hobfoll et al., 2018). In particular, effective authentic leadership behaviours provide the type of support likely to ensure SLBs’ well-being, rather than erode it, which allows them to productively deliver healthcare services to the public. The findings are also an example of the ‘effects of coping’ (Tummers, 2017, p. 151), because it shows that authentic leadership enhances SLBs’ ability to cope by building their PsyCap, leading to higher well-being. In terms of practical implications for SLOs, this is important because PsyCap is developmental, which means that upskilling SLBs will increase their PsyCap. The qualitative data reveal some of the ways in which SLBs are using their reserves of PsyCap, affording them extra personal resources to cope with the stress of difficult working conditions (Brunetto et al., 2020).

At the individual level, healthcare SLBs appear to have to cope with crises regularly, not simply because of the pandemic, but also because of natural disasters such as fires and floods that affect large areas of Australia regularly. SLOs that focus on building employee well-being are likely to provide a platform from which they can pursue improved organisational outcomes. Whilst CORT conceptualises PsyCap and well-being as personal resources that SLBs can use for
support (Chen et al., 2016), the United Nations, the World Health Organization, and the new Work Health and Safety (WHS) legislation point to the importance of organisations taking responsibility for contributing positively to employee well-being. Since Safe Work Australia (2021) identifies poor management decision-making leading to overwork and work harassment as a cause of rising stress claims, it seems likely that building employee well-being is one pathway to ensuring that SLOs have the necessary staff in place to continuously deliver services during and after a crisis. No SLO is resilient to crises when those delivering services perceive that their well-being is low because they become more susceptible to disease (Li et al., 2015).

The cross-sectional research design limits generalisability. However, according to Avey et al. (2010), the PsyCap variable is subjective and therefore is suited to self-reporting. Additionally, the sample comprised only healthcare SLBs, although the findings are generalisable to SLBs delivering social and emergencies who share similarly low levels of well-being. The study was undertaken only in Australia. Further research should consider replicating this study in other countries. In terms of the qualitative design, there is a possibility that the high frequency of responses regarding harassment and well-being may be due to a priming effect as questions on these constructs were also included in the quantitative section of the survey. However, the open-ended responses regarding the constructs emerged only after multiple reviews through the analytical process described above.

4.1 Implications

This paper used CORT to examine whether authentic leadership provided an appropriate management approach likely to increase SLBs’ PsyCap, and decreased their work harassment, thereby preserving their well-being. The findings show that authentic leadership is a more effective leadership for building SLBs’ personal resources so as to protect well-being as argued by CORT (Hobfoll et al., 2018). However, the means show little evidence of authentic leadership behaviour which is the type of leadership likely to underpin SLOs’ ability to deliver high-quality services to the public. The findings indicate that the present pandemic and post-pandemic crises have placed extraordinary strains on healthcare professionals’ well-being, at a time when the well-being of healthcare SLBs is paramount in ensuring healthcare services to the public. This aligns with past research showing that when authentic leadership behaviours are present in the workplace, healthcare professionals’ PsyCap and well-being are reinforced and provide the conditions for enhancing well-being (Laschinger & Reid, 2016). Conversely, poor leadership negatively affects well-being. The implications of the findings are that authentic leadership behaviour is likely to enhance SLBs’ well-being and maximise public value by ensuring that public services continue to be delivered to the public and stress-related claims and illnesses are minimised. The responsibility for upskilling managers will be pivotal in determining employee well-being and preparing organisations for future crises.

In terms of practical implications, Table 2 indicates that there is an absence of authentic leadership. The low means for authentic leadership, PsyCap, and employee well-being indicate that poor leadership negatively impacts healthcare SLBs’ well-being. SafeWork Australia (2021) indicates that the present leadership practices are a financial burden on the individuals affected, their families, and taxpayers. One strategy for improving well-being is to upskill leaders in PsyCap. Past research shows significant increases in PsyCap, well-being, and performance from such training (Brunetto et al., 2020; Luthans et al., 2006). Hence, a way of improving SLB’s resources is to develop PsyCap capabilities amongst leaders.
There are organisational and legislative implications about how SLOs are managed in the austerity-led post-pandemic crisis. Leaders who choose to use efficiency as the only driver of their management decision-making negatively impact SLBs’ well-being (Bryson et al., 2014; Farr-Wharton et al., 2022), and those costs are presently bore by the tax-paying public in the form of higher stress-related workers compensation claims. Dunlop et al. (2020) question the logic of pursuing an austerity-led managerialist paradigm when faced with the growing evidence about long-term negative outcomes for employees and the public. Additionally, international policies are now beginning to spur changes in legislation, including within Australia, which will reposition the burden of poor management decision-making onto organisational management.

For example, the International Standards Organisation (ISO) released a new standard in 2021 (ISO 45003, Occupational health and safety management—Psychological health and safety at work—Guidelines for managing psychosocial risks). The new ISO standard offers guidance for organisations about how to manage risk better and prevent physical and psychological injuries as a way of achieving higher levels of employee well-being in the community (https://www.iso.org/news/ref2677.html). Accordingly, most Australian state and federal WHS legislation is now under review. The reason for the change is that the third Sustainable Development Goal of the United Nations is ‘good health and well-being’ (SDG3), and the WHO has shown that there are negative long-term health implications for employees experiencing low well-being. The present austerity-driven managerialist-informed management may appear cost effective in the short term; however, it is damaging for individuals, their families, and communities (because it compromises service delivery) and therefore must change (Dunlop et al., 2020, p. 271). For this reason, Dunlop et al. (2020) urge practitioners and scholars alike to question the continual use of the managerialist cost-driven paradigm.

5 | CONCLUSION

CORT provided a useful lens for understanding the impact of poor leadership behaviours on employees’ access to resources and their subsequent well-being (Chen et al., 2016). Previous research showed that SLBs’ stress was amplified predominantly because of poor organisational leadership behaviour (Brunetto et al., 2021). During the pandemic, poor healthcare leadership cost the U.S. government approximately $200 billion (Coe et al., 2020). This study showed that leadership behaviours that increase work intensity expectations under already adverse conditions result in a compounding of the pre-existing work pressures of delivering health care. The media coverage across many countries demonstrates the increasing exodus from health care because of continual work harassment, especially in countries such as the United Kingdom and Australia, leaving increased burden on the existing workforce or reduced services from existing public facilities.

The reason for the exodus is explained best using CORT (Hobfoll et al., 2018), which argues that there is a point at which employees no longer have their reservoir of resources (both personal and organisational) to continue to cope without negative consequences. A continual loss of resources generates a dangerous combination of negative physiological, cognitive, emotional, and/or social responses. It seems likely that the first CORT corollary holds, that is, a loss of resources will affect employees with inadequate emotional resources. When employees begin to perceive a loss of resources (such as reduced well-being because of working extra hours and not getting enough sleep), more losses are likely to follow. To mitigate the losses, SLOs can invest more resources in
building authentic leadership to prevent further declines in PsyCap and well-being. However, a different paradigm would be required to address the present austerity-led managerial mode in line with the changing international policy agenda (UNDP, 2016; ISO, 2021).

The implications for healthcare SLOs are that without positive leadership, unethical decision-making (such as inadequately resourcing SLBs) is exacerbating, with work harassment negatively impacting employee well-being. Under pandemic and post-pandemic conditions, low levels of employee well-being in healthcare SLOs are already compromising their ability to deliver health services across the globe. The way forward is to build PsyCap from the bottom up. This requires positive leadership that promotes ethical decision-making, likely to enhance relational transparency. It is a public value proposition to embrace repositioning employee well-being as a foundational component of building resilient SLOs.

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CONFLICT OF INTEREST STATEMENT
The opening sentence explicitly refers to Anderson and Gerbing (1988) and yet the author, in response to editorial comment, has asked that the reference be removed from the List of References. Given the authors actually use the modelling approach these authors recommend the reference needs to be reinstated. Please confirm with the author and either insert into the List or References or revise the relevant sections.

DATA AVAILABILITY STATEMENT
The data for this research are available on request.

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REFERENCES


