

Job demands, authentic leadership, job satisfaction, and intention to leave in public healthcare

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COMMENTS

The reader is reminded of the following:

- The editorial style and references as prescribed by the Publication Manual (6th Edition) of the American Psychological Association (APA) were followed in this mini-dissertation.
- The use of the APA style in all scientific documents is in line with the policy and the Programme in Industrial Psychology of the North -West University since January 1999.
- This mini-dissertation is submitted in the form of a research article.

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In memory of my Dad, who is – even after his passing – still a source of inspiration to me.

DECLARATION

I, Loshni Pillay, hereby declare that “Job Demands, authentic leadership, job satisfaction, and intention to leave in public healthcare” is my own work and all references have, to the best of my knowledge, been correctly reported.

I further declare that the content of this research will not be handed in for any other qualification at any other tertiary institution.

Loshni Pillay

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SUMMARY

Title:

Job demands, authentic leadership, job satisfaction, and intention to leave in public healthcare

Keywords:

Job demands, authentic leadership, job satisfaction, intention to leave, public healthcare, turnover, nurse shortage, doctor shortage

The public health sector faces major challenges to produce, recruit and retain skilled nurses and doctors. Budgetary constraints further exacerbate this situation affecting the healthcare environment and skills shortage. This leaves an already fragile health system even more vulnerable by adding to the pressure on the remaining workforce to meet the country's ever-growing healthcare demands.

In a bid to retain brilliant medical professionals, nurses and doctors are often fast tracked into senior positions by management. This practice not only strips these capable individuals of clinical expertise and the opportunity to specialise, but it also thrusts them into leadership positions they are not appropriately skilled to manage. Poor leadership practices cause burnout and decrease job satisfaction, ultimately affecting quality of care, customer service, attrition, intention to leave, turnover and patient satisfaction. The need for authentic leadership is critical as it contributes to the growth and development of a healthy work environment through leaders who are transparent, support followers, are objective in decision-making and are guided by ethical values. An authentic leader-follower relationship allows followers to be inspired and develop due to the interaction with the leader, and is essential to increase job satisfaction levels and retention of nurses, doctors and other public healthcare workers.

The objective of this study was to investigate the relationships between job demands, authentic leadership, job satisfaction, and intention to leave. A cross-sectional survey design with a non-probability convenient sample ($n = 633$) was obtained. The measuring instruments are the Questionnaire on Experience and Assessment of Work (QEEW), the Authentic Leadership Inventory, the Job Satisfaction Scale, and the Intention to Leave Scale. Structural equation modelling was used for developing measurement and structural models to test the study hypotheses. The measurement models were used to determine correlations and factor analysis, whilst the structural model was used to determine regression amongst the variables, as well as moderating and indirect effects.

The results confirm correlations in the expected directions between the variables. Authentic leadership did not have a moderating effect on the relationship between job demands and job satisfaction. Authentic leadership did not have a moderating effect on the relationship between job demands and intention to leave. The indirect effects were significant as job demands had a significant effect on intention to leave through job satisfaction.

Findings suggest that public healthcare institutions can focus on developing authentic leadership skills within the organisation, fostering a values-based climate and further, seek to understand those variables that promote employee motivation towards job satisfaction.

CHAPTER 1

INTRODUCTION

The focus of this mini-dissertation is to determine whether there is a relationship between job demands, authentic leadership, job satisfaction, and intention to leave amongst public healthcare employees in the South African public healthcare sector. Chapter 1 focuses on the problem statement, research objectives, and research methodology. The chapter commences with a problem statement, the research method follows with an explanation of the research design, participants, measuring instruments, and the statistical analysis. Chapter 1 concludes with an overview of the chapters that comprise this mini dissertation.

1.1 Problem Statement

The efficiency of the healthcare workforce in South Africa has gradually deteriorated since the 1990s (Bateman, 2007; Bauman, 2007; Blecher, Kollipara, De Jager, & Zulu, 2011; Breier, 2009). The public healthcare services provide primary and secondary healthcare in South Africa, servicing 84% of the country's population (Department of Health [DoH], 2015; Engelbrecht & Crisp, 2010). From the 2015/2016 projections on the national scarce skills list, experts within the South African healthcare sector have described the immediate shortage of nurses, doctors and public healthcare managers as "intensely distressing" (Health and Welfare Sector Education and Training Authority [HWSETA], 2015). The public healthcare sector is under-resourced, it is predominantly nurse-based due to shortages of doctors, and requires nurses to have the competence and expertise to manage the country's substantial burden of disease and growing user population (Bauman, 2007; DoH, 2011b; Engelbrecht & Crisp, 2010; Lloyd, Sanders, & Lehmann, 2010). There are fewer doctors, nurses and other medical personnel than required in the public sector for multiple reasons, such as, professional institutional training and recruitment has not kept abreast of population growth, attrition of staff due to turnover, competing job demands, work overload (emotional and physical), lack of formal jurisdiction and control over resources, lack of or outdated job descriptions and lack of support from superiors (HWSETA, 2015; Matsotso & Fryatt, 2013).

By government's own admission, the well-documented poor standards of infrastructure, the skills shortages, poor staff attitudes, low levels of patient satisfaction and incompetent management that characterises much of the public health sector makes it extremely challenging to turn around an establishment of this size, with the public sector's current resources. Hence, given the extent of the problems, the human resources agenda of the South African healthcare system has to focus on accelerated training and development of professional nurses and doctors, leadership skills, management skills and retention strategies to improve operational efficiency within the public healthcare sector (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; DoH, 2011a; HWSETA, 2015; International Council for Nurses [ICN], 2015; Matsotso & Fryatt, 2013).

In the public sector, health budgets are a major determinant of both the number of positions created and salary levels, thereby influencing the ability of institutions to attract and retain staff (Blecher et al., 2011). Public sector spending on health services increased from R99.4 billion in 2009/2010 to R154.1 billion in 2014/2015. This grew by 7% in 2016 (National Treasury, 2016), with salaries and wages comprising more than 60% of this total budget in 2016, Government recognises that given competing demands for resources, it will be unable to absorb large increases in the health budget (National Treasury, 2016). It is for this reason that the public healthcare sector will have to improve efficiencies and human resource management (such as skills development, leadership development, retention and talent management) to improve its services and coverage (DoH, 2011c; Engelbrecht & Crisp, 2010).

Higher job demands and lower job resources has had a dire effect on the quality of service delivery and staff morale within public healthcare (Coovadia et al., 2009; Etchells, Mittmann, & Koo, 2012). In an international study conducted amongst nurses in a public healthcare facility (Asegid, Belachew, & Yimam, 2014), nurses who were not satisfied with their work due to higher demands and lower resources, were found to distance themselves from their patients and their nursing chores, resulting in suboptimal quality of care. A South African study conducted by Ramasodi (2010), indicated that 79.6% of healthcare participants were not satisfied in their jobs. Further, research indicates that apart from poor job performance and lower productivity, dissatisfaction with work resulted in intention to leave and staff

turnover within the healthcare sector, and was costly to organisations (Asegid et al., 2014; Wong & Laschinger, 2013).

Retaining medical personnel is a critical concern in today's resource constrained healthcare environments. Globally, intention to leave and turnover are due to various factors, such as a large contingent of the current medical workforce that approaches retirement age (Asegid et al., 2014; Buerhaus, Staiger, & Auerbach, 2003; Nooney, Unruh, & Yore, 2010), and job demands, such as difficult working conditions that cause considerable stress amongst employees, leading to job dissatisfaction (Laschinger, Wong, & Grau, 2012a). The scarcity of healthcare personnel in South Africa is one of the biggest challenges to the country's aim of eventually providing equitable universal access to healthcare for all its citizens (Coovadia et al., 2009).

The job demands-resources (JD-R) model will be used as a framework to study the relationship between all the proposed variables. The JD-R model considers the impact of job demands and job resources on employee outcomes (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). In this model, job demands include time pressure and emotional and physical demands associated with workload; while job resources include social support, support from supervisors, innovative and social climate, and autonomy and control (Bakker & Demerouti, 2007; Hakanen, Bakker, & Schaufeli, 2006). The JD-R model indicates the existence of two different underlying psychological processes, a strain process related to negative outcomes and a motivational process affecting positive outcomes (Bakker & Demerouti, 2007). It postulates that a greater amount of job demands leads to negative outcomes, like job strain or burnout, while the availability of job resources, such as supervisory support leads to positive outcomes, such as employee engagement which leads to job satisfaction (Bakker & Demerouti, 2007; Hakanen et al., 2006).

Effective and efficient leaders have been identified as being synonymous with creating safe patient care environments (Thompson et al., 2011; Laschinger, Wong, & Grau, 2012b; Van den Broeck, Van Ruysseveldt, Vanbelle, & De Witte; 2013). Kouzes and Posner (2002) found that an important component of effective leadership is leaders treating their employees authentically, thereby winning the employees' trust.

In this study, authentic leadership, will be seen as a job resource, work overload and emotional demands (job demands), job satisfaction (job outcomes) and intention to leave (organisational outcome) are included in the JD-R framework (Bakker, Demerouti, De Boer, & Schaufeli, 2003; Halbesleben & Buckley, 2004). Literature indicates that the JD-R model proposes that job resources serve as a buffer to ease the negative effects of job demands (Bakker & Demerouti, 2007; Bakker, Demerouti, & Euwena, 2005). The model indicates that significant negative association exists between job satisfaction, and intention to leave (Van den Broeck, Vansteenkiste, De Witte, Soenens, & Lens, 2010).

Empirical studies have shown that work-related attitude and behavioural outcomes, such as job satisfaction, and intention to leave are significantly influenced by how employees feel about their jobs (Harter, Schmidt, & Hayes, 2002; Penger & Černe, 2014). Studies further show that job resources have a positive relationship with motivational processes (Bakker & Demerouti, 2007; Hakanen et al., 2006; Wong, Laschinger, & Cummings, 2010) and Saks (2006) found that this had a positive relationship with employees' job satisfaction, and a negative correlation with intention to leave. Motivation is the compulsion within a person that affects the direction, intensity and perseverance of voluntary behaviour (McShane & Von Glinow, 2010). Work motivation brings about a state of balance or equilibrium within the individual and it can lead to job satisfaction (Bruno, 2010; Luthans, 1998). Although motivation is not a construct within this study, its relativity to job satisfaction makes it essential to mention in this discussion. Hence, it is expected that job resources (authentic leadership) as described in this study, will be positively associated with job satisfaction.

This study explores the types of job demands and resources that are relevant to this healthcare sector and occupational context. The study approach focuses on the role of authentic leadership as a moderating variable, in which it is assessed whether job demands and resources were associated with job satisfaction thereby linking these job-related factors with turnover intention.

Prior research has shown the strong reciprocal and inverse relationship between job satisfaction and the employees' intention to leave an organisation (Egan, Yang, & Bartlett, 2004; Lambert, Hogan, & Barton, 2001; MacIntosh & Doherty, 2010; Schwepker, 2001;

Silverthorne, 2004). In other words, it is improbable that satisfied employees will seek out a new job, with a new employer.

With the ensuing challenges faced by employees in the South African public healthcare sector, it became necessary to conduct this study. A number of hospital-based studies in western countries have explored the constructs of authentic leadership, job satisfaction, and intention to leave within healthcare in varying contexts (Asegid et al., 2014; Baker, Norton, & Flintoft, 2004; Bamford, Wong, & Laschinger, 2012; Isaksson et al., 2003). To date, limited research using these constructs were found within the South African public healthcare sector. The theory of authentic leadership suggests that authentic leaders are able to enhance motivation and satisfaction of followers by strengthening their follower identification with the leader and the organisation, thereby promoting hope, trust, optimism and positive emotions. Through a clear understanding of the variables that influence and impact on job demands, job satisfaction, and intention to leave amongst employees in this South African public healthcare sector, the ultimate goal of this study was to investigate the relationships and the effects between the constructs of authentic leadership, job demands, job satisfaction, and intention to leave. Based on the review of the literature, the research model of this study is graphically depicted in Figure 1.

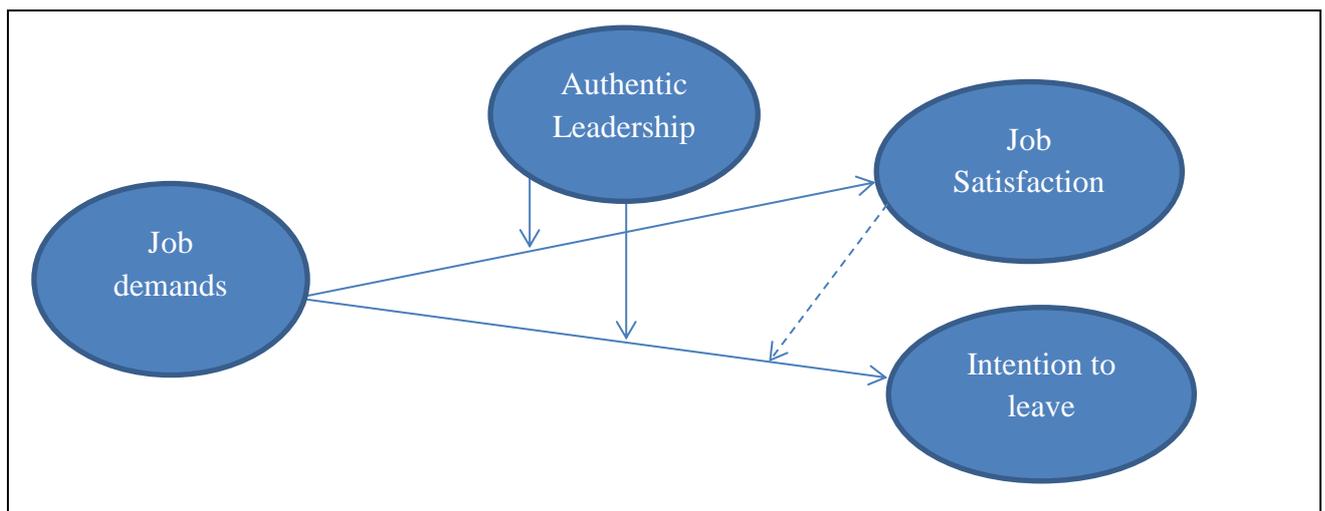


Figure 1. Job demands, authentic leadership, job satisfaction, and intention to leave

1.2 Research Questions

Based on the preceding problem statement, the following research questions arise:

- What is the relationship between job demands and job satisfaction?
- What is the effect of authentic leadership on the relationship between job demands and job satisfaction?
- What is the effect of job satisfaction on the relationship between job demands and intention to leave?
- What is the relationship between job demands and intention to leave?
- What is the effect of authentic leadership on the relationship between job demands and intention to leave?

1.3 Research Objectives

Based on the introduction and problem statement above, the following general and specific objectives are set.

1.3.1 General Objective

The general objective of this study was to investigate the relationships between job demands, authentic leadership, job satisfaction, and intention to leave amongst public healthcare employees in South Africa.

1.3.2 Specific Objectives

The specific objectives of the research were to:

- Conceptualise job demands, authentic leadership, job satisfaction, intention to leave and, the relationship between these constructs in literature.
- Study the relationship between job demands and job satisfaction.

- Determine the effect of authentic leadership on the relationship between job demands and job satisfaction.
- Determine the effect of job satisfaction on the relationship between job demands and intention to leave
- Study the relationship between job demands and intention to leave.
- Determine the effect of authentic leadership on the relationship between job demands and intention to leave.

1.4 Research Design

The research method consisted of a literature review and an empirical study. The results obtained from the study are presented in the form of a research article.

1.4.1 Literature Review

The literature review focused on job demands, authentic leadership, job satisfaction, and turnover intention. A comprehensive literature review of the constructs was undertaken through articles relevant to this study, published from 1978 – 2017, obtained via computer searches and internet data bases, such as Academic Search Complete, Africa-Wide Information, Business Source Complete, EbscoHost, EconLit, Emerald, Health Source – Consumer Edition, Health Source: Nursing/Academic Edition, Humanities International Complete, Nexis, ProQuest, PsycArticles, PsycInfo, SACat, SAePublications, and Science Direct. Journals that were consulted, due to their relevance to this study were *Journal of Organizational Behavior*, *Career Development International*, *American Journal of Nursing*, *Journal of Public Economics*, *South African Journal of Human Resources*, *European Journal of Public Health*, *Journal of Occupational and Organisational Psychology*, *International Journal of Employment Studies*, *Work and Occupations*, *Journal of Management*, *Journal of Vocational Behavior*, *Advances in Developing Human Resources*, *Journal of Managerial Psychology*, *Business Ethics Quarterly*, *Journal of International Business Research*, *Human Resource Development Quarterly*, *South African Journal of Psychology*, *Psychological Reports*, *Human Relations*, *International Journal of Training and Development*, *Personnel Psychology*, *International Journal of Manpower*, *Career Development International*, *Journal*

of Applied Psychology, Academy of Management Journal, Journal of Business and Psychology, and International Journal of Human Resource Management.

1.4.2 Empirical Study

The empirical study consists of information pertaining to the research design, participants, measuring battery and, statistical analysis. This includes information gathered from participants through the questionnaires. This study was part of a bigger project for which the data was already gathered.

1.4.3 Research Method

The study followed a quantitative design approach. Gravetter and Forzano (2012) have observed that quantitative research is a conclusive type of research that involves large representative samples and follows a structured data collection process. A survey design was used to achieve the research objectives. This specific design was cross-sectional (Maxwell & Cole, 2007), and information collected was a snapshot in time. This design is useful to describe interrelationships among variables within a population at a specific point in time. The research approach was appropriate for the objective of this study, which was to determine the relationship between the constructs without a controlling effect (Gravetter & Forzano, 2012). This study constituted descriptive research. The design was ideally suited to the descriptive and predictive functions associated with correlational research (Gravetter & Forzano, 2012; Strydom, 2011).

1.4.4 Research Participants and Procedure

The employee population of the Sedibeng District public healthcare sector was selected and engaged for the purpose of this study. This included the district's public healthcare hospitals and clinics. Availability sampling technique was utilised. The sample is ($n=633$). The sample for this study included all employees who work at the targeted public healthcare institutions, who fulfilled the inclusion criteria. The criteria dictated that only employees with a diploma or higher qualification, with more than six months of job experience could be included in the study. The experience level of the sample also varied.

The research formed part of a bigger project that investigated the work-related experiences and well-being of employees in the public healthcare sector within the Sedibeng district in Gauteng. Permission to conduct the research was obtained from relevant authorities at the Department of Health as well as from the management of the specific public healthcare sector. A meeting was held with the managers of the various health services entities to inform them of the purpose of the project. The organisation granted permission for the questionnaires to be completed at the workplace. A pilot group completed the questionnaire and it was determined that it took approximately 45 minutes to complete. Suitable participants were identified and informed of the study. A letter containing information and requesting consent for participation was attached to questionnaires. The information letter explained the importance of the study as well as the objectives of the study, and informed participants of the voluntary nature of the research. Participants were informed that anonymity and confidentiality was assured. Participants of the study completed a consent form and returned it to the project leader. Questionnaires and information letters were distributed in envelopes. Participants were afforded the opportunity to direct their enquiries and questions to the project leader who availed himself throughout the process. Completed questionnaires were collected and safely kept in a storeroom within the School of Behavioural Sciences at the University.

1.4.5 Measuring Instruments

The following measuring instruments were used in the empirical study:

Authentic leadership inventory (ALI) (Neider & Schriesheim, 2011). The authentic leadership inventory (ALI) measures four different perceived leader behaviours. The ALI scale was used to measure the employees' perception of their direct supervisor or manager as an "authentic leader". The leadership construct consisted of the following four factors: self-awareness (S), relational transparency (R), balanced processing (B) and internalised moral perspective (M). The ALI consisted of 14 items and examples included: "My leader uses his/her core beliefs to make decisions", and "My leader encourages others to voice opposing points of view." The questions were scored on a five-point Likert scale, in which 1 denotes strong disagreement (disagree strongly) and 5 denotes strong agreement (agree strongly). The

scale is reliable as indicated by Cronbach's alpha of 0.74 to 0.85 (Neider & Schriesheim, 2011).

Questionnaire on experience and assessment of work (QEEW) (Van Veldhoven, Meijman, Broersen, & Fortuin, 1997) also known in Dutch as Vragenlijst Beleving en Beoordeling van de Arbeid (VBBA). The job characteristics (demands and resources) were measured through the QEEW. This instrument consists of 27 subscales of which 14 were used in this study. The job demands questions used in this study consisted of three subscales with 25 items. The subscales used are as follows: mental load, emotional load and pace and amount of work. Mental load consisted of seven items, for example "Does your work require a lot of concentration?". Emotional load consisted of seven items, for example "Does your work put you in emotionally upsetting situations?". Pace and amount of work consisted of eleven items, examples are, "Do you have too much of work to do?" and "Do you have to work very fast?". The QEEW was scored from 1 (Never) to 4 (Always) on a four-point frequency rating scale. Internal consistency of 0.77 to 0.95 was found (Van Veldhoven, Meijman, Broersen, & Fortuin, 2002).

Job satisfaction (PSYCONES) (Isaksson et al., 2003). Job satisfaction was measured using four items. Examples are, "I find enjoyment in my job" and "Most days I am enthusiastic about my job". The items were scored on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Cronbach's alpha coefficients of 0.78 indicated that the scale is reliable (Van der Vaart, Linde, & Cockeran, 2013).

Intention to leave (PSYCONES) (Isaksson et al., 2003). The intention to leave refers to the intent or predisposition to leave the organisation where one is presently employed, or the employees' plan or intention to leave their present job with the expectation of finding another job in the near future (Elangovan, 2001). This was measured using four items with assessment of attitudes on the current job and reasons for leaving in the past. The question is scored on a five-point Likert-type scale in which 1 denotes strong disagreement (strongly disagree) and 5 denotes strong agreement (strongly agree). When individual study participants score below the overall mean, they are considered as having an intention to leave.

Cronbach's alpha coefficients have shown that the scale is reliable (Coomber & Barriball, 2007; Van der Vaart et al., 2013).

1.4.6 Statistical Analysis

The collected data was analysed using the Mplus 7.4 statistical program (Muthén & Muthén, 1998-2016). Techniques utilised include descriptive and inferential statistics, (for example, correlations). Descriptive statistics refer to the measurement of central tendency, (for example, mean) and measurement of variance, (for example, standard deviation and variance) as well as kurtosis and skewness of the collected data. These techniques organise large quantities of quantitative data in order to get a summary of the tendencies observable from the collected data (Heiman, 2011). Confirmatory factor analysis (CFA) was used to determine whether the sample yields factorial validity of the measuring instruments (Muthén & Muthén, 1998-2016). The reliability of the measuring instruments was assessed using Raykov's rho coefficients. Proposed relationships between the study variables were measured using Spearman's correlation coefficients. Practical significance of results was determined by effect sizes (Cohen, 1988). The cut-off point of 0.30 (medium effect) and 0.50 (large effect) was set for the practical significance of the correlation coefficients (Cohen, 1988). To evaluate the statistical significance, the confidence interval level was set at the value of 95% ($p \leq 0.05$) and 99% ($p \leq 0.01$).

Structural equation modelling (SEM) as implemented by Mplus 7.4 is a preferred statistical technique and it was used to test the measurement and structural models. The following indices produced by Mplus 7.4 were used: The Chi-square statistic (χ^2), which is the absolute fit for the model, the standardised root-mean residual (SRMR) the root-mean-square error of approximation (RMSEA), and the comparative fit index (CFI). Non-significant (χ^2) values, values larger than or equal to 0.90 for goodness of fit (GFI) and CFI, and RMSEA values smaller than or equal to 0.08 (Byrne, 2012), indicated an acceptable fit of the model. Comparative and parsimonious fit indices were used to test the model fit to the data. The Bayes information criterion (BIC), which provides an indication of model parsimony (Kline, 2010) and the Akaike information criterion (AIC) were used. The AIC is a comparative

measurement fit and is meaningful when different models are assessed. The lowest AIC model is the best fit.

The bootstrapping method was used to test mediation in this study. The method was set at 5000 draws (Hayes, 2012). The bias corrected confidence levels was set at 95%. It can be concluded that the indirect effect is significantly different from zero at $p < 0.5$, when zero is not in the 95% confidence level.

Stepwise hierarchical moderated regression analysis was used to analyse moderation effects in this study. Regression models were used to determine the moderating effect of authentic leadership on the independent variable and the dependant variables. In order to counter the probability of a type 1 error, the significance value was set at the 95% confidence interval level ($p \leq 0.05$) (Pallant, 2007).

1.5 Ethical Considerations

The ethics application was submitted for approval to the Ethics Committee of the North-West University's (NWU) Ethics Review Board for permission to use the primary data of project Bophelo. The primary researchers ensured that ethical considerations of the study were adhered to, to ensure that the participants were fully informed of the voluntary nature of the study. Written consent was obtained. It was essential for the success of this project to conduct research that was fair and ethical. Confidentiality and privacy was adhered to (Salkind, 2009). In order to ensure that the research was conducted in a fair and ethical manner, the purpose of the study as well as the voluntary nature thereof was explained to the research participants. The primary researchers refrained from causing harm to the participants. The original ethics application for the project, through which the primary data was collected, was approved (NWU-HS-2014-0146).

1.6 Expected Contributions of the Study

1.6.1 Contribution for Industrial-Organisational Psychology Literature

A job can provide structure to a person's life, a sense of meaning, satisfaction and productivity that stems from completing purposeful tasks, a feeling of belonging to a valued reference group, a basis for self-esteem and personal identity, and a way to earn one's economic place in society (Coomber & Barriball, 2007). Research indicates that employee dissatisfaction with work can lead to poor job performance, lower productivity, illness, burnout, intention to leave, turnover and, ultimately culminate in higher costs to organisations (Asegid et al., 2014).

Seligman (2002) argued in the late 1900s that it was time for science to understand that positive emotions build strength and virtue and provide a beacon for finding what Aristotle referred to as "the good life". In 2002, Turner, Barling, and Zacharatos acknowledged that a more positive workforce could improve the financial bottom line and develop healthy people (Northhouse, 2013). Tarnowski in 1943 (Northhouse, 2013), pointed out that in order to stay competitive, improving the calibre of workplace life will become necessary in the future. This research sets out to explore the relationships between the constructs of job demands, authentic leadership, job satisfaction, and intention to leave amongst employees in the public healthcare sector, thereby ultimately contributing to positive outcomes for public healthcare employees, the organisation and the country – making a positive difference. According to Seligman (2002), Industrial psychologists could make a positive difference by investigating ways in which we can optimise employees' whole life experience instead of just researching the negative impact that different variables have on the employee and organisation. There is a significant gap in literature regarding authentic leadership as it is still in its infancy stage (Stander, De Beer, & Stander, 2015). This study will therefore contribute to literature regarding authentic leadership, within the realms of Industrial Psychology.

1.6.2 Contribution for the Individual

Many public healthcare workers are employed within bureaucratic structures in which they pursue routine anticipated tasks, feel isolated and futile, work long hours tending to the sick who are also at times irritable and too demanding, thereby making service delivery physically and emotionally draining for these healthcare workers (Laschinger, 2012). Globally, nursing and medical associations and unions report on the deteriorating quality of work life for medical personnel (ICN, 2015; Wong & Giallonardo, 2013). A large government study in Canada revealed that nurses' rate of illness-related absenteeism was 58% higher than that of the overall labour force (Laschinger, Wong, & Grau, 2012b). Other studies have shown high levels of burnout amongst hospital nurses and doctors (Cho, Laschinger, & Wong, 2006; Greco, Laschinger, & Wong, 2006; Laschinger, Finegan, & Wilk, 2009; Uncu, Bayram, & Bilgel, 2006). Burnout amongst healthcare personnel not only affects their own lives negatively (Peterson, Demerouti, & Bergström, 2008; Sa & Fleming, 2008; WHO, 2013), but also represents a threat to the quality of care patients receive, and to organisational performance as a whole. This study will offer the perspective of the public healthcare personnel themselves. Due to the staff shortages and the high turnover within the public healthcare sector (Coovadia et al., 2009; DoH, 2011c), the information gathered will possibly serve to contribute towards retention and job satisfaction of the employees, by highlighting their needs (leadership support and working conditions). According to the South African Occupational Health and safety Act Number 85 of 1993 (RSA), organisations have a legal obligation to attend to the mental and physical health of their employees (Deacon & Kew, 2005). Therefore, resulting benefits from possible company implemented interventions arising from recommendations, or awareness due to this study could be experienced as the promotion of a fair, equitable, productive, respectful, and supportive work environment.

1.6.3 Contribution for the Organisation

Patient care and safety has received considerable public, research, and political attention in the past decade because adverse outcomes are a major challenge to quality patient care (Wong & Giallonardo, 2013). Adverse patient outcomes are defined as unintended injuries or complications caused by healthcare management, leading to disability or prolonged hospital stay (Baker et al., 2004). It was estimated that adverse events cost the Canadian healthcare

system billions of dollars (Etchells et al., 2012). Given the cost of adverse events, President Zuma's expectations of the public healthcare system for improved delivery, becomes understandable (Zuma, 2011). South Africa spends 8.5 percent of its gross domestic product (GDP) on healthcare – a figure that is proportionately higher than the five percent recommended by the World Health Organisation (WHO) (McIntyre & Thiede, 2003). The aim of this research is to contribute to institutional capability, through awareness and knowledge pertaining to leadership selection and training. Healthy public healthcare work environments are essential to ensure patient safety, enhance staff recruitment and retention, and maintain the organisation's financial viability. Inattention to leadership issues, the factors affecting job satisfaction, and resulting in intention to leave or turnover, poses a serious obstacle to creating and sustaining a positive public healthcare environment. This then makes the healthcare journey to service excellence impossible.

1.7 Chapter Division

The chapters in this mini-dissertation are presented as follows:

Chapter 1: Introduction

Chapter 2: Research article

Chapter 3: Conclusions, limitations and recommendations

1.8 Chapter Summary

This chapter provided a discussion of the problem statement and research objectives. The research method and measuring instruments were explained, followed by a brief overview of the chapters that will follow.

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CHAPTER 2

RESEARCH ARTICLE

Job demands, authentic leadership, job satisfaction, and intention to leave in public healthcare

ABSTRACT

Orientation: The constructs of job demands, authentic leadership, job satisfaction, and intention to leave have been researched within varying contexts internationally; however, not much research has been done on these constructs within the South African public healthcare sector.

Research Purpose: The objective of this study was to investigate the relationships between job demands, authentic leadership, job satisfaction, and intention to leave.

Motivation for the study: Although empirical research and literature review provides evidence that job demands, job satisfaction, and intention to leave may be influenced by authentic leadership, there seems to be paucity of research examining the interaction effects between these variables within the South African public healthcare sector. Healthcare is a highly specialised industry and the scarcity of healthcare professionals in South Africa is one of the major threats to the country's vision to eventually roll out equitable universal access to healthcare to all its citizens, Hence, it becomes crucial to understand the factors that influence attraction and retention within the public healthcare sector.

Research design, approach and method: A cross-sectional survey design was used with a sample (n=633) of employees within the public healthcare sector. Participants' experience level ranged from six months and higher. Education levels and qualifications also varied. The authentic leadership inventory (ALI), Questionnaire on experience and assessment of work (QEEW), PSYCONES Job satisfaction scale and PSYCONES Intention to leave scale were administered. Structural equation modelling was performed using the Mplus 7.4 statistical programme to achieve the objective of the study.

Main findings: Job demands are negatively correlated with job satisfaction. Job demands have a positive correlation with intention to leave. Emotional demands had a significant effect on intention to leave. Job satisfaction plays a mediating role in the relationship between job demands and intention to leave. Authentic leadership did not have a moderating effect on the relationship between job demands and job satisfaction, and job demands and intention to leave.

Practical or managerial findings: The results provide management with insight into the impact of job demands, especially emotional demands on job satisfaction, and intention to leave. The importance of cultivating an authentic leadership culture by developing authentic leaders and followers has been highlighted. Leaders play a key role in imbuing authentic leadership qualities and thereby promoting job satisfaction through trust, ethical conduct, openness, and engagement.

Contribution or value added: The study contributes to authentic leadership literature within the South African context. The study contributes to existing literature by confirming the relationships between the constructs of job demands, job satisfaction, and intention to leave.

Key terms: Job demands, authentic leadership, job satisfaction, intention to leave, public healthcare nurses, turnover, nurse shortage, doctor shortage

INTRODUCTION

The 2015/2016 projections outlining the shortage of healthcare professionals in South Africa was estimated at approximately 66 000 (Department of health [DoH], 2015). The private sector, which serves 16% of the country's population, enjoys 70% of the service of the country's healthcare professionals (DoH, 2015). The remaining 84% of the South African population uses public healthcare, which has access to only 30% of the country's doctors and nurses. This vast discrepancy in the ratio of healthcare professionals within the private and public health sector leaves a burden on the shoulders of the healthcare workers within the public healthcare workforce (DoH, 2015; Engelbrecht & Crisp, 2010). South Africa's public healthcare workforce is predominantly nurse-based. The Health and Welfare Sector Education and Training Authority (HWSETA) (2015) and the South African department of health have described the country's nursing and doctor shortage as dire (Blecher, Kollipara, De Jager, & Zulu, 2011; Breier, 2009; DoH, 2011c).

Shortage of nursing and medical staff, lack of resources, high workload, long hours, inefficient leadership, working beyond their scope of practice, and exploitation in the workplace are common factors for employees in the public health sector (DoH, 2011a; International Council for Nurses [ICN], 2015; Matsotso & Fryatt, 2013) and are some of the many challenges and barriers that contribute to the inefficiencies within the public healthcare system (Bauman, 2007; DoH, 2011a; Engelbrecht & Crisp, 2010; Lloyd, Sanders, & Lehmann, 2010). International and local studies conducted amongst employees in public healthcare facilities indicated that higher job demands and lower job resources had a detrimental effect on quality of service delivery and staff morale (Asegid, Belachew, & Yimam, 2014; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Etchells, Mittmann, & Koo, 2012; White, Phakoe, & Rispel, 2015), increasingly causing public healthcare employees to seek, or consider seeking employment in the private sector or overseas (Bateman, 2007; Bauman, 2007; Matsotso & Fryatt, 2013).

The job demands - resources model (JD-R) is used a theoretical framework in this study to examine how job demands (emotional and physical) are related to the job outcome of intention to leave. The central theme of the JD-R model is that job demands give rise to an

energy depletion process and availability of job resources induces a motivational process. For instance, high job demands (such as work overload, and emotional demands) may exhaust employees' mental and physical resources and ultimately culminate in health problems, intention to leave, and turnover itself (Bakker, Demerouti, De Boer, & Schaufeli, 2003).

The South African study by White et al. (2015) indicates that in addition to their competing job demands, frontline public healthcare workers are faced with disrespectful patient behaviours and attitudes on a regular basis. These conditions are exacerbated by lack of proper administration and management support, as leaders and managers continuously blame nurses and other employees for difficulties, despite the evidence of health system inefficiencies and severe staff shortages. The lack of appropriate leadership support in public healthcare can be ascribed to various factors, including the fact that in most circumstances clinical specialists or administrative staff are allocated leadership positions because of their expertise to multi-task (Munyewende & Rispel, 2015; White et al., 2015). The knowledge and abilities clinical specialists develop from years of intensive and committed medical training have prepared them to meet the medical complications experienced by their patients. However, they often lack the skills and training to adequately manage themselves and their environments (Shanafelt, Sloane, & Habermann, 2003), which could arguably affect their well-being, in addition to the well-being of their subordinates and their patients. Research shows that many tasks performed by these managers or leaders were of short duration, fragmented, unplanned, and sometimes required them to step in and perform clinical tasks in addition to their management responsibilities (Armstrong, Rispel, & Penn-Kekana, 2015). The lack of appropriate leadership skills to manage complex environments successfully leaves such leaders focused on their fiscal and logistical responsibilities and not the relational and developmental responsibilities towards their staff (Armstrong et al., 2015).

Effective leadership and guidance are viewed as imperative to the creation of safe patient care environments (Thompson et al., 2011; Van den Broeck, Van Ruysseveldt, Vanbelle, & De Witte, 2013) as such leaders are crucial in developing roles and managerial expectations of employees, which directly affects their job satisfaction (Abramis, 1994). Hence, it is imperative that leaders display integrity, core values, and the ability to develop enduring organisations through the inspiration and motivation of their employees (George, 2003).

Ethical and performance challenges within organisations and institutions have signalled the need for a new approach to leadership (Avolio & Gardner, 2005; George, Sims, McLean, & Meyer, 2007). Studies have shown that when leaders' actions reflect their true selves manifesting in behaviours, such as being honest with themselves, being sincere with others, and behaving in a way that shows their personal values, it is referred to as authentic leadership (Leroy, Ansel, Gardner, & Sels, 2012; Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). Authentic leadership has emerged within the academic field in recent years as a central component in positive leadership studies (Hassan & Ahmed, 2011; Avolio, Gardner, Walumbwa, Luthans, & May, 2004; George, 2003; Walumbwa et al., 2008). The study by Clapp-Smith, Vogelgesang, and Avey (2009) has shown that authentic leadership (AL) leads to trust in management thereby positively affecting team performance towards common goals and objectives (Kouzes & Posner, 2002). When employees get support from colleagues in terms of encouragement and sponsorship, they are better able to deal with emotional demands (for example, taking care of dying patients) (Happell et al., 2013).

Theoretical conceptualisations have also suggested that AL may positively affect employee attitudes and behaviours, giving rise to job satisfaction (Avolio et al., 2004; Gardner, Avolio, Luthans, May, & Walumbwa, 2005; George, 2003; Ilies, Morgeson, & Nahrgang, 2005). Job satisfaction describes how content employees are with their job, implying that the happier people are with their jobs, the more satisfied they are said to be (Asegid et al., 2014). AL is seen to promote subordinates' trust in the leader (Hassan & Ahmed, 2011). Jensen and Luthans (2006) purport that employee's perception of their leaders' authentic behaviour served as the strongest single predictor of employee job satisfaction (Laschinger, Wong, & Grau, 2012a).

Previous studies have explored the constructs of authentic leadership, job satisfaction, and intention to leave amongst employees, from different perspectives. Almost all of the health sector research comes from hospital-based studies in international contexts (Asegid et al., 2014; Baker, Norton, & Flintoft, 2004; Bamford, Wong, & Laschinger, 2012; Isaksson et al., 2003), with limited research studies having investigated authentic leadership in the South African healthcare service (Stander, De Beer, & Stander, 2015). The aim of this study was to examine the relationship between job demands, authentic leadership, job satisfaction, and

turnover intention amongst employees in the public healthcare sector in the South African environment, as this has not been investigated previously. The challenges faced by public healthcare employees are amplified against the backdrop of South Africa's political past, cultural diversity, the lack of basic resources, lack of effective leadership, and the emotional and physical demands of the job. This study seeks to determine the effect of authentic leadership on the relationship between job demands, job satisfaction, and intention to leave, and to build on existing empirical data.

Literature Review

Job Demands

The job demands-resources model (JD-R) is a leading job stress model (Bakker & Demerouti, 2007) and is used as a theoretical framework in this study to examine the impact of job demands (emotional and physical) on the job outcome of intention to leave. The JD-R model asserts that job characteristics of an organisation can be separated into the categories of job demands and job resources (Bakker, Demerouti, De Boer, & Schaufeli, 2003; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). Job demands refers to “those physical, psychological, social, or organisational aspects of the job that require sustained physical and/or psychological efforts and are therefore associated with certain physiological and/or psychological costs” (Bakker & Demerouti, 2007, p. 312).

The main proponent of the JD-R model is that job demands elicits an energy depletion process and job resources instils a motivational process (Bakker & Demerouti, 2007; Xanthopoulou, Bakker, & Fischbach, 2013). The JD-R model assumes that an equilibrium between positive (resources) and negative (demands) job characteristics contributes to better and happier lives for the employees (Bakker & Demerouti, 2007). It further assumes that any demand or resource may affect employees' well-being. This means that the JD-R can be applied to various work settings allowing for the inclusion of potentially all job characteristics (Schaufeli & Taris, 2014).

JD-R research reveals that job demands lead to high risks of burnout, disengagement, and dissatisfaction when resources are insufficient or simply absent (Bakker & Demerouti, 2007; Van den Broeck, De Cuyper, De Witte, & Vansteenkiste, 2010; Xanthopoulou et al., 2007). The JD-R researchers suggest that perpetual job demands, specifically emotional demands, cognitive demands, and work overload, lead to the depletion of energy, thus resulting in poor health and absenteeism (Demerouti, Bakker, Jonge, Janssen, & Schaufeli, 2001; Demerouti et al., 2001). Work overload is defined as excessive work performance required in a job within a short time frame (Iverson & Maguire, 2000). According to Schaufeli and Bakker (2004), work overload refers to pressures and amount of work. Emotional demands are viewed as an important source of job strain arising from emotionally involved interactions at work (Totterdell & Holman, 2003). Cognitive demands are the potential psychological and behavioural outcome of perceived mental workload (Taub, Morin, Goldrich, & Benjamin, 2006).

Previous studies demonstrate a negative relationship between emotional demands, cognitive demands, and work well-being (Bakker, Van Veldhoven, & Xanthopoulou, 2010; Llorens, Bakker, Schaufeli, & Salanova, 2006; Xanthopoulou, Bakker, & Fischbach, 2013). As cited by Mowday, Porter, and Steers (1982) earlier research by Steven et al. (1978) demonstrates that work overload distinctly decreases the level of job satisfaction (Iverson & Maguire, 2000); while it has a significant and positive association with voluntary turnover (Dore, 2005) and consistently shows a correlation with burnout (Maslach, Schaufeli, & Leiter, 2001; Schaufeli & Bakker, 2004; Weise, Rothmann, & Storm, 2003). Public healthcare employees experience emotional, cognitive and physical demands as part of their routine tasks, therefore, emotional demands (emotional workload), cognitive demands (mental workload) and pace and amount of work as part of work overload are important variables to be included in this investigation.

Bakker and Demerouti (2007) have asserted that work overload has frequently been examined by the JD-R researchers, as it has been identified as a key factor causing the depletion of energy and increasing the magnitude of cynicism and dissatisfaction, ultimately leading to intention to leave or turnover. According to the JD-R model, high job demands, such as work overload and emotional demands are strong predictors of job outcomes (Bakker,

Hakanen, Demerouti, & Xanthopoulou, 2007). Examples within healthcare are high work pressure, long hours, unfavourable physical environment, and emotionally demanding interactions, such as ethical dilemmas or dealing with service providers, patients or their families (death, dying, depression) (Bakker, Demerouti, Taris, Schaufeli, & Schreurs, 2003). Further examples include concern over disease control, advances in technology and equipment, and preparedness for timeous and speedy diagnosis with human life at stake (Taub et al., 2006). Previous research by Meijman and Mulder (1998) concluded that job demands may not necessarily be negative. They purported that job demands may become negative stressors if these demands required high effort from the employee who perhaps did not have adequate resources, such as the necessary skills, abilities and support, at hand.

Job resources refer to those physical, psychological, social, or organisational aspects of the job that are effective in achieving work goals; reduce job demands and the associated physiological and psychological costs; stimulate personal growth, learning, and development (Bakker & Demerouti, 2007). Hence, resources are not only necessary to deal with job demands, they are also important in their own right (Bakker & Demerouti, 2007). The JD-R model proposes that job resources serve as a buffer to mitigate the negative effects of job demands (Bakker & Demerouti, 2007; Bakker, Demerouti, & Euwena, 2005). Not having appropriate job resources at hand exhausts employees' mental and physical resources, thereby leading to health problems, demotivation and higher levels of absenteeism (Demerouti et al., 2001; Lee & Ashforth, 1996; Van der Colff & Rothmann, 2009). These health issues ultimately culminate in turnover ideation (thoughts of leaving) as they may increase the awareness that time spent outside the work environment is valuable and more worthwhile (Moore, 2000; Schreurs, De Cuyper, Van Emmerik, Notelaers, & De Witte, 2011).

Empirical research shows that job demands sharply decrease the level of job satisfaction (Bakker et al., 2010; Cummings et al., 2010; Iverson & Maguire, 2000; Llorens et al., 2006; Xanthopoulou et al., 2013) and have a significant positive association with intention to leave and voluntary turnover (Jourdain & Chênevert, 2010; Mueller et al., 1994).

Authentic Leadership

The current conceptualisation of authentic leadership has emerged from the field of positive psychology (Avolio & Gardner 2005; Luthans & Avolio, 2003). Authentic leaders are described as being deeply aware of how they think, behave, and are perceived by others as well as being aware of their own and others' values or moral perspectives, knowledge and strengths. They are aware of the situations within which they function; and are seen to be confident, hopeful, optimistic, resilient, and of high moral character (Gardner et al., 2005; Walumbwa et al., 2008). Myrick and Yonge (2005) postulated that for leadership to be effective there must be an authentic connection, which characterises the relationship between leader and subordinate.

The concept of being authentic is founded in ancient Greek philosophy (Erickson, 1995) and it has evolved to encompass leadership, where the leader is seen as possessing authenticity as one of his core attributes. The dictionary defines authentic as being "real and true", not a copy of something, not false or fake (Oxford South African School Dictionary, 2015). The working definition of authenticity refers to owning one's personal experiences, such as thoughts, emotions, needs, preferences, or beliefs (Gardner et al., 2005). Authentic persons feel the priority to align their behaviours, emotions, and feelings to their inner core or self, this is aptly reflected in Shakespeare's words, captured in 1901, "to thine own self be true" (Avolio & Gardner, 2005).

Building on previous research (Avolio & Gardner, 2005; Gardner et al., 2005; Gardner et al., 2005; Ilies et al., 2005; Kernis, 2003) the current conceptualisation of authentic leadership consists of four substantive components, namely self-awareness, internalised moral perspective, balanced processing, and relational transparency (Walumbwa et al., 2008). Self-awareness refers to the extent to which the leader understands his own strengths and motives, and others' perceptions of his leadership (Gardner et al., 2005; Neider & Schriesheim, 2011). Leaders being true to themselves are particularly important, in that they know exactly how to align their behaviours, emotions and feelings with their inner self (Luthans & Avolio, 2003; Neider & Schriesheim, 2011). Having high levels of self-awareness gives healthcare leaders insight into their own strengths and limitations, thereby allowing them to develop

relationships that are more honest with the employees within their units/organisation. This would further encourage the employees or teams to be open and accepting of one another (Avolio & Gardner, 2005; Gardner et al., 2005).

Internalised moral perspective refers to the leader that embeds a consistent value system within him or herself and is always navigated by these values despite external pressures (Gardner, et al., 2005; Neider & Schriesheim, 2011). This is an important component of authentic leadership. Once leaders become aware of their true self by internalising their identities, values, emotions, and goals in their daily perspective, they are more likely to be authentic (Laschinger & Smith, 2013). They are able to engage in ethical and transparent decision-making using their own moral capability and resilience to navigate ethical dilemmas and take appropriate moral decisions (Walumbwa et al., 2008).

Balanced processing refers to the leader's ability to assess and analyse all relevant information before making important decisions (Gardner et al., 2005; Neider & Schriesheim, 2011). These leaders are able to process information objectively with little tendency to be biased towards negative outcomes, because such leaders are not ego-centred and vulnerable to self-esteem problems (Giallonardo, Wong, & Iwasiw, 2010). Within a hospital setting, balance processing will involve the leader requesting input and ideas from the employees prior to making important decisions.

Finally, relational transparency refers to the leader's behaviour to promote trust among his followers through self-disclosure and openly sharing information (Walumbwa, Luthans, Avey, & Oke, 2009). Relational transparency effectively enhances interpersonal co-operation and teamwork, as unconditional trust is built during the process of information sharing between leader and follower (Gardner et al., 2005; Jones & George, 1998). By honestly presenting themselves to others, authentic leaders model openness and acceptance, encouraging their staff to feel safe in disclosing information, such as their learning needs, professional goals, and areas for development, amongst others (Laschinger & Smith, 2013).

Authentic leader behaviours produce follower performance outcomes that are sustainable in the current turbulent work environments (Walumbwa et al., 2008). Walumbwa et al. (2008)

in their definition of authentic leadership indicate that authentic leaders are capable through the enactment of their own behaviours, to foster positive self-development within their followers (Leroy et al., 2012; Wong & Laschinger, 2013). It is therefore expected that by enacting their true selves in the workplace, followers of authentic leaders would be capable of their own autonomous work motivation. Motivation that is rooted within contributes to job satisfaction (Griffen, Neal, & Parker, 2007), as it gives employees a sense of competence and accomplishment that goes beyond meeting their basic physiological needs (Compton & Hoffman, 2013).

Authentic leadership may satisfy the employees' need to belong, to be cared for and valued, which vitalises their resilience to cope with hardship (Walumbwa et al., 2008). This results in higher levels of work engagement (Brough et al., 2013; Gardner et al., 2005; Jones & George, 1998), which further leads to better job performance and job satisfaction (Bakker, 2011; Penger & Černe, 2014). Authentic leadership has been linked to higher ratings of patient care quality in healthcare settings (Giallonardo et al., 2010; Rego, Vitória, Magalhães, Ribeiro, & Cunha, 2013; Walumbwa, Wang, Wang, Schaubroeck, & Avolio, 2010; Wong, Laschinger, & Cummings, 2010) through greater trust in management, empowerment and work satisfaction. Importantly, in the management literature, authentic leadership is shown to be a significant predictor of job satisfaction, and ultimately organisational commitment, thereby impacting intention to leave (Walumbwa et al., 2008; Laschinger, Wong, & Grau, 2012b).

Authentic leadership is an essential and vital job resource, which is positively related to job satisfaction (Lu, While, & Barriball, 2005). It also mitigates the negative effects of job demands (for example, work overload, emotional workload, mental workload) on organisational outcomes, such as intention to leave (Xanthopoulou et al., 2007). When employees feel that they are supported and treated sincerely, they experience increased motivation levels at work, thus leading to satisfaction with and enthusiasm for work (Harter, Schmidt, & Hayes, 2002). Authentic support from leaders may function as a buffer on work overload (Van der Doef & Maes, 1999).

Job Satisfaction

Locke (1976) defines job satisfaction as a pleasurable or positive state of mind (as cited in Pietersen, 2005). He postulated that job satisfaction is a function of the perceived relationship between what one expects from and obtains from one's job and the importance or value one attributes to it (Locke, 1970). Job satisfaction is a dimension of affective work-related well-being of employees (Cropanzano & Wright, 2001). According to Diener and Ryan (2009) and Watson, Clark, and Tellegen (1988) (as cited in Simon & Durand-Bush, 2014) affective well-being refers to the balance between one's positive (that is, pleasant emotions) and negative (that is, unpleasant emotions) and how it affects one's satisfaction levels. Job satisfaction is a part of the pleasure-displeasure dimension of work-related well-being (Gagnon & Durand-Bush, 2012; Rothmann, 2008) and has been studied in terms of well-being in the work context. Simply, job satisfaction is an indication of the extent to which people like their jobs (Spector, 1997). Job satisfaction is viewed as a multidimensional construct concerning satisfaction with pay, leadership or supervision, the nature of the job, and company policy (Shanafelt, 2008). Job satisfaction is seen as consisting of two components, intrinsic and extrinsic job satisfaction (Rothmann, 2008). Intrinsic job satisfaction stems from employees' feelings about the job itself and extrinsic job satisfaction refers to how employees' feel about aspects of the work situation that are external to the job itself (Cropanzano & Wright, 2001; Quick & Nelson, 2009; Rothmann, 2008).

The JD-R indicates that the presence of adequate job resources lessens the impact of job demands and fosters involvement bringing about a positive attitude towards the organisation (affective commitment) and positive attitude towards the job (dedication), thus leading to job satisfaction (Mowday, Porter, & Steers, 1982; Schaufeli, Salanova, González-Romá, & Bakker, 2002). Job satisfaction is considered one of the integral factors affecting the growth of performance in the healthcare services and the medical profession (Platis, Reklitis, & Zimeras, 2015). Research shows that job satisfaction helped physicians to achieve and maintain a high level of affective well-being, which may have led to improvements in not only personal health, but also the reduction of medical errors (Goldman, Myers, & Dickstein, 2000) and the overall quality of patient care (Shanafelt et al., 2003). Job satisfaction is

connected with a healthier workforce and has been found to be a good indicator of longevity (Luthans & Avolio, 2003; Pietersen, 2005; Shields & Ward, 2001).

Although job satisfaction is relevant in any work environment, its importance is underscored in the practice of medicine, as this domain involves making critical decisions regarding patients' lives (Uncu, Bayram, & Bilgel, 2006). Reduced job satisfaction among medical personnel has been found to have a negative effect on patient outcomes and quality of overall care (Shanafelt, 2008; Taub et al., 2006). Additionally, the role of job satisfaction in staff retention has received considerable attention in medical and management literature (Giallonardo et al., 2010; Kober & Van Damme, 2006; Uncu et al., 2006). Researchers have found job satisfaction levels to be a predictor of absenteeism, intention to leave, and turnover (Lu, et al., 2005; Shields & Ward, 2001), as public healthcare employees often have heavier workloads, lower levels of autonomy (Aasland, Røvik, & Wiers-Jenssen, 2008; Biaggi, Peters, & Ulich, 2003; Thomas, 2004), and a higher risk of burnout (Cohen & Patten, 2005; Litter, Frank, & Matheson, 2009). Hu, Schaufeli, and Taris (2011) as well as Llorens et al. (2006) found that job demands were negatively associated with job satisfaction.

Research shows that individuals with higher levels of job satisfaction tend to embrace more positive self-care qualities, and exhibit fewer dysfunctional lifestyle and health behaviours (Bhatnagar & Srivastava, 2012; Diener & Ryan, 2009; Zimmerman, 2000). Work-related attitude and behavioural outcomes, such as job satisfaction, and intention to leave are fostered by a wide variety of job demands as well as job resources, such as supervisory or leadership support (Bakker & Demerouti, 2007; Hakanen, Bakker, & Schaufeli, 2006; Schaufeli & Salanova, 2007). Schaufeli and Bakker (2004) showed that a job resource, such as effective leadership serves as the catalyst for increased job satisfaction, and decreased turnover. As such, it seems reasonable to proclaim that finding ways to help public healthcare employees achieve and maintain a high level of job satisfaction through appropriate leadership may lead to improvements in not only personal health, but also the reduction of medical errors (Goldman et al., 2000; Piko, 2006) and the overall quality of patient care (Shanafelt et al., 2003).

Despite various research studies into nursing or healthcare services, there is limited data regarding the relationship between the variables of authentic leadership, and its effect on job satisfaction, and turnover intention amongst public healthcare employees, although, Simpson (2009) found significant negative correlations between the variables of turnover intentions and job satisfaction amongst surgical nurses.

Significant relationships have been found in literature between job satisfaction, and employee retention (Harter et al., 2002; Laschinger & Leiter, 2006; Schaufeli & Bakker, 2004; Simpson, 2009). Demerouti and Cropanzano (2001) as well as Schaufeli and Salanova (2007) reported that job satisfaction is associated with employees' positive attitude, proactive job behaviours, and higher levels of well-being which led to a decrease in turnover intention. Research studies in various contexts have shown that it is more improbable for employees to leave work (that is, more likely to persist and endure) when they enjoy what they are doing (Galletta, Portoghese, & Battistelli, 2011; Solum & Hellriegel, 2011; Wilson & Stranahan, 2000; Wright, Cropanzano, & Bonett, 2007). Thus, employees' who work because of the innate satisfaction and pleasure they experience are less likely to leave (Richer, Blanchard, & Vallerand, 2002). Similarly, finding in a study about early retirement by Higgs, Mein, Ferrie, Hyde, and Nazroo (2003) indicated that employees who are satisfied with their jobs are less likely to retire or, have a lower intention to leave. Job satisfaction, as an intrinsic motivator, can be assumed to negatively relate to intention to leave (Kober & Van Damme, 2006; Schreurs et al., 2011).

Demerouti et al. (2001) observed that job resources, such as supervisory or leadership support predicted employees' positive attitude towards the job. Schaufeli and Bakker (2004) provided evidence of a positive relationship between supervisory or leadership support and supervisory or leadership coaching and employees' positive attitude towards the job. Their research indicated that job satisfaction (JS) is exclusively predicted by job resources (JR) and they demonstrated that job satisfaction is a mediator of the relationship between job resources and intention to leave (Schaufeli & Bakker, 2004).

Based on this discussion, it can be said that job demands are negatively associated with job satisfaction, and that job satisfaction will have a positive relationship with authentic leadership and a negative relationship with turnover intention.

Intention to Leave

The intention to leave is based on an attitudinal inclination or a cognitive manifestation of the behavioural decision to leave employment (Elangovan, 2001; Sager, Griffith, & Hom, 1998), and it is viewed as the final step in the decision-making process (McCarthy, Tyrrell, & Lehane, 2007). Intention to leave indicates an employee's plans to leave an organisation. Since human capital typically provides a very important competitive advantage, it becomes imperative for successful organisations to continuously seek ways to retain their skilled and knowledgeable workforce.

Although some turnover can revitalise an organisation, within the South African healthcare sector, that already faces staff and leadership shortages, the impact of turnover is dire (Bauman, 2007; DoH, 2011b; Engelbrecht & Crisp, 2010; Lloyd et al., 2010; HWSETA, 2015). Given the high rate of intention to leave and turnover reported in healthcare studies with the resulting loss of skilled nurses, doctors, and other personnel, and high cost to healthcare organisations, formulating strategies for retaining employees becomes crucial (DoH, 2011c; HWSETA, 2015; ICN, 2015; Giallonardo et al., 2010; Lavoie-Tremblay, O'Brien-Pallas, Gelinat, Desforges, & Marchionni, 2008; Matsotso & Fryatt, 2013; Scot, Engelke, & Swanson, 2008). Intention to leave has serious implications for workforce planning, thus investigating the impact of focused interventions in relation to job satisfaction and leadership responsibilities may be the key retention strategy for public healthcare leaders.

Elangovan (2001) purported that intention to leave cognitions were seen as mental decisions intervening between an individual's attitude regarding the job (presence or absence of job satisfaction) and their decision to leave or stay. Among the determinates of turnover, job satisfaction stands out as an important variable and it operates as the central psychological predictor in most intention to leave or turnover studies (Laschinger, 2012). Wong and

Laschinger (2013) have shown that employees who are satisfied with their jobs choose to stay in them longer and are less likely to seek out new jobs in a new organisation. Research studies further show that job demands, without the presence of appropriate job resources (Schaufeli et al., 2002) made it difficult for employees to meet the job demands, thus leading to dissatisfaction, which in turn led to intention to leave or turnover (Lu et al., 2005; Maslach, Jackson, & Leiter, 1996; Shields & Ward, 2001). The presence of adequate job resources reduces job demands, fosters goal accomplishment and stimulates personal growth and development (Demerouti et al., 2003). This may contribute to a stronger involvement in the organisation in terms of motivation and thus, a lower intention to leave the organisation (Bakker et al., 2003; Demerouti et al., 2003).

The JD-R model assumes that strain may lead healthcare workers to withdraw from work. Withdrawal may manifest as early retirement or intention to leave (De Croon, Sluiter, Blonk, Broerson, & Frings-Dresen, 2004). This reasoning is in line with Hobfoll's conservation of resources theory (as cited by Grandy & Cropanzano, 1999), which indicates that strain occurs when personal resources are imperilled or threatened (that is, by demands) and that workers then strive to protect remaining resources. In the case of nurses, doctors, and other healthcare personnel, protection of resources takes the form of intention to leave (Asegid et al., 2014). The relationship between health problems and intention to leave can be understood in yet another manner, namely health problems may escalate awareness that there is more to life than work, so that time spent outside the workplace becomes even more valuable and meaningful (Schreurs et al., 2011).

The study by Asegid et al. (2014) concluded that a decrease in job demands coupled with an increase in job resources, such as authentic leadership, is required to retain medical personnel within the profession. In particular, this indicates a need for leadership support to restructure nurses' tasks and roles to reduce work overload and increase the meaning of their work. Similar studies regarding medical staff (resident doctors, physicians, medical technicians, and administrative staff) who were exposed to stressful hospital settings leading to burnout and intention to leave, have concluded that leadership support could assist in providing a healthier work environment, better communication and reduction in stress (Bragard, Etienne, Merckaert, Libert, & Razavi, 2010; Bodur, 2001; Chou, Li, & Hu, 2014).

Studies have shown that the relationship between job satisfaction and turnover intention is usually indicated by a negative correlation (Harter et al., 2002; Laschinger & Leiter, 2006; Schaufeli & Bakker, 2004; Simpson, 2009).

Based on the previous discussion, the following hypotheses were formulated:

Hypothesis 1: Job demands will be negatively associated with job satisfaction.

Hypothesis 2: Authentic leadership moderates the relationship between job demands and job satisfaction.

Hypothesis 3: Job satisfaction will mediate the relationship between job demands and intention to leave.

Hypothesis 4: Job demands have a significant positive relationship with intention to leave.

Hypothesis 5: Authentic leadership will moderate the relationship between job demands and intention to leave.

RESEARCH METHODOLOGY

Research Design

A cross-sectional survey design was used to investigate the relationships between constructs in a sample of healthcare employees. The cross-sectional design refers to the data being collected at a single point in time. This design is most useful in describing differences in a population at that particular moment (De Vos, Strydom, Fouché, & Delpont, 2011).

Participants

The participants were employees from public hospitals and clinics in the Sedibeng District in Gauteng. The non-probability convenient sampling technique was used (Strydom, 2011). A total of 2 000 employees were targeted, of which 633 usable surveys were obtained (response rate of 31%). The participants represented all job levels within the hospitals and clinics. The majority of the participants were female (79.6%). The most representative category was

Black participants (87.9%), followed by White participants (8.2%). The majority of the participants were in the 50 to 59 years age group (26.5%), followed by the 30 to 39 years age group (24.2%). The mean age of the participants was 42 years (SD= 12.27). The majority of the participants indicated Sesotho as their home language (44.7%), followed by 19.2% isiZulu speaking participants. The professional characteristics indicate that more than one third of the participants were in possession of a diploma (38.5%) and close to half the participants had less than five years of service (40.3%). The personal characteristics of the sample are presented below in Table 1.

Table 1.

Characteristics of the participants (n = 633)

Item	Category	Frequency	Percentage (%)
Age	20-29 years	114	20.3
	30-39 years	136	24.2
	40-49 years	117	20.8
	50-59 years	149	26.5
	60-69 years	46	8.2
Gender	Male	121	20.4
	Female	473	79.6
Language	English	39	6.6
	Afrikaans	42	7.1
	Setswana	43	7.3
	isiXhosa	40	6.8
	Xitsonga	6	1.0
	isiZulu	113	19.2
	Sesotho	263	44.7
	isiNdebele	3	0.5
	Tshivenda	3	0.5
	siSwati	7	1.2
	Sepedi	21	3.6
	Other	9	1.5
	Race	Asian	10
Black		522	87.9
Coloured		8	1.3
White		49	8.2
Other		5	0.8
Qualification	Higher certificate (Grade 12)	156	29.8
	Diploma/Tertiary certificate	202	38.5
	Degree	122	23.3
	Postgraduate degree	44	8.4
Years in Organisation	<5 years	238	40.3
	5-10 years	117	19.8
	10-15 years	34	5.4
	>15 years	201	34.1
Years in Job	<5 years	275	47.7
	5 - 9 years	137	23.7
	10 - 15 years	54	9.4
	>15 years	111	19.2

Measuring Instruments

Biographical Questionnaire. A biographical questionnaire was used to determine the biographical characteristics of the research sample. The characteristics that were measured included gender, age, home language, race, qualifications, number of years in the current organisation, and number of years in the current job. This provided a detailed description of the study population.

Job Demands. *The questionnaire on experience and assessment of work* (QEEW; Van Veldhoven, Meijman, Broersen, & Fortuin, 1997) also known in Dutch as *Vragenlijst Beleving en Beoordeling van de Arbeid (VBBA)* was used to measure job characteristics (demands). The instrument consists of 27 subscales of which fourteen were used in the study. The job demands questions used in this study consisted of three subscales with 25 items. The subscales used are as follows: mental load, emotional load, and pace and amount of work. Mental load consisted of seven items, for example “Does your work require a lot of concentration?”. Emotional load consisted of seven items, for example “Does your work put you in emotionally upsetting situations?” Pace and amount of work consisted of 11 items, examples are, “Do you have too much of work to do?” and “Do you have to work very fast?” The QEEW was scored from 1 (Never) to 4 (Always) on a four-point frequency rating scale. Internal consistency of 0.77 to 0.95 was found (Van Veldhoven, Meijman, Broersen, & Fortuin, 2002).

Authentic Leadership. *The authentic leadership inventory* (ALI) (Neider & Schriesheim, 2011) was used to measure self-awareness, balanced processing, relational transparency, and moral perspective. The ALI is based on the original work of Walumbwa et al. (2008) and was constructed based on numerous validity assessments (Neider & Schriesheim, 2011). The instrument consisted of fourteen items with balanced processing and moral perspective measured by four items each and self-awareness and relational transparency measured by three items each. The items were measured on a five-point Likert-type scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Examples of an item are, “My leader shows that he/she understands his/her strengths and weaknesses (self-awareness), “My leader objectively analyses relevant data before making a decision (balanced processing), “My leader expresses

his/her ideas and thoughts clearly to others” (relational transparency), and “My leader is guided in his/her actions by internal moral standards”(moral perspective). The internal consistency of the measures ranged from Cronbach’s alphas of 0.74 to 0.80 (Neider & Schriesheim, 2011).

Job satisfaction. The *job satisfaction scale* (PSYCONES; Guest, Issakson, & De Witte, 2003) was derived from the PSYCONES project and was used to measure employees’ levels of job satisfaction. The instrument comprised four items. Examples are, “I find enjoyment in my job” and “Most days I am enthusiastic about my job”. The items were scored on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Cronbach alpha coefficients of 0.78 indicate that the scale is reliable (Van der Vaart, Linde, & Cockeran, 2013).

Intention to Leave. The *intention to leave scale* as derived from the PSYCONES project was used to determine employees’ intention to leave. The scale measured four items with assessment of attitudes on the current job. Examples are, “These days I often feel like quitting” and “If I could, I would quit today”. The questions were scored on a five-point Likert-type scale in which 1 denotes strong disagreement (strongly disagree) and 5 denotes strong agreement (strongly agree). The scale showed a Cronbach’s alpha coefficient of 0.88 (Van der Vaart et al., 2013).

Research Procedure and Ethical Considerations

The research project was part of a bigger project conducted in the public healthcare sector in Gauteng. Permission to conduct the research was obtained from the management of the participating hospitals and clinics. Participants were provided with information pertaining to the voluntary nature of the project, confidentiality, and the aim of the project. Information letters and questionnaires were distributed to the participants, and prior to participation, the employees had to complete consent forms. The primary researchers ensured that ethical considerations were adhered to. The project leader was available throughout the process to ensure that all queries and questions were tended to. The questionnaires were collected and

safely stored in a storeroom at the University. The project was assessed and accepted by the Ethics Committee of the North-West University [NWU-HS-2014-0143].

Statistical Analysis

The statistical analysis was performed with the Mplus 7.4 programme (Muthén & Muthén, 1998-2016). Descriptive statistics (for example, means, standard deviations, skewness and kurtosis) and inferential statistics (for example, correlations) were used as part of the data analysis. The reliability of the measuring instruments were tested using Raykov's rho coefficients (Raykov, 2009). The proposed relationships between the study variables were measured using Spearman's correlation coefficients. Effect sizes were employed to determine the practical significance of the results. A cut-off point of 0.30 (medium effect) and 0.50 (large effect) was applied for the practical significance of the correlation coefficients (Ellis & Steyn, 2003). The confidence interval level for statistical significance was set at a value of 95% ($p < 0.05$).

The measurement and structural models were tested using structural equation modelling (SEM) methods, as implemented by Mplus 7.4 (Muthén & Muthén, 1998-2016). Multiple relationships between latent and observed variables can be analysed simultaneously using SEM. SEM is also appropriate for large samples and estimating indirect effects (Byrne, 2012).

The factor structure, relationships between constructs and the overall fit of the theoretically hypothesised model were tested by a measurement model. Competing models were compared against the proposed theoretical model to confirm the fit of the proposed measurement model. The chi-square of the competing models could not be directly compared to the originally proposed model because the Maximum Likelihood Robust (MLR) estimator was used to make provision for the skewness and kurtosis of the distribution of the data (Muthén & Muthén, 1998-2016). In order to calculate the significance in chi-square changes between the competing models, the Satorra-Bentler chi-square difference test method was applied (Satorra & Bentler, 2010). The proposed model could indicate a superior fit if the chi-square value is

significantly lower than the chi-square value of the competing models. This would be indicated by a significant change in chi-square ($\Delta\chi^2$). First, different factor structures for the relevant variables were compared without removing any problematic items or allowing error variances to correlate. The best fitting model was then used to develop further, into the final proposed measurement model. That measurement model was compared to other competing models in order to confirm best fit, thereafter, it was used as the basis for the structural model (Iacobucci, 2009).

In order to analyse the estimated regression paths between the theoretical constructs harboured in the model, a structural model was specified (Iacobucci, 2009). Three competing structural models were tested to determine the best fit. To confirm whether the hypothesised model was the best fitting model, the Satorra-Bentler chi-square difference test was again performed (Satorra & Bentler, 2010).

The following indices produced by Mplus were used in the measurement and structural models to evaluate goodness of fit (Hu & Bentler, 1999): The chi-square statistic (χ^2) which is the absolute fit of the model, the comparative fit index (CFI), the standardised root mean square residual (SRMR), the root mean square error of approximation (RMSEA), and the Tucker-Lewis index (TLI). Values larger than or equal to 0.90 for CFI and TLI, and RMSEA and SRMR values less than or equal to 0.08 are considered acceptable fit of the model and the data (Byrne, 2012). The Akaike information criterion (AIC) and Bayes information criterion (BIC) were used to compare alternate model fit. The AIC is a comparative measurement fit and is meaningful when different models are estimated. The lowest AIC indicates the best fitting model. The BIC produces an indication of model parsimony and compares alternate models. The lower the AIC and BIC values, the better the model fit.

The bootstrapping method was used in this study in order to test indirect effects (Hayes & Preacher, 2009). The bias corrected confidence intervals were set at 95% for all indirect effects. The lower and upper percentiles served as a limit, indicating that if zero was contained within the limits, the indirect effect was not achieved (Hayes & Preacher, 2009).

Regression analysis was used to evaluate the relationships between the independent, dependent and moderating variables in the study (Pallant, 2007).

Results

The results for the initial and final measurement models, as well as the respective competing models are discussed first, followed by the results of the alternate structural models, and the results of testing for indirect effects and moderation.

Testing Initial Measurement Models

A four factor hypothesised measurement model and eight alternate permutations were analysed to ascertain the best fitting initial measurement model, each consisting of latent variables as suggested in literature (Guest et al., 2003; Neider & Schriesheim, 2011; Van Veldhoven et al., 1997). The initial measurement model consisted of job demands as a second-order latent variable with its three first-order latent variables (pace and amount of work, mental load, and emotional load) consisting of 25 items, authentic leadership as a second-order latent variable with its four first-order latent variables (self-awareness relational transparency, balanced processing, moral perspective) consisting of 14 items, job satisfaction as a first-order latent variable consisting of four observed variables, and intention to leave as a first-order latent variable consisting of four observed variables. At this stage, no items were removed and no error correlations were included. Only three of the eight models gave usable results.

Models' 1, 5, 6, 7, 8, and 9 presented unreliable fit statistics due to non-positive definite latent variable covariance matrices, and were rejected.

1. Model 2 consisted of job demands as a second-order latent variable, with three first-order latent variables, namely pace and amount of work (PAW) (measured by 11 observed variables), emotional load (EL) (measured by seven observed variables) and mental load

- (ML) (measured by seven observed variables). Authentic leadership was seen as a first-order latent variable, measured by 14 observed variables. Job satisfaction was measured by four observed variables. Intention to leave was measured by four observed variables.
2. Model 3 consisted of six first-order variables, namely PAW, ML, EL, authentic leadership, job satisfaction, and intention to leave, defined by the corresponding observed items.
 3. Model 4 consisted of job demands as a one-factor, first-order variable measured by 25 items, authentic leadership was seen as a first-order variable measured by 14 items, job satisfaction was seen as a first-order variable measured by four observed items and intention to leave was seen as a first-order variable measured by four observed items.

Table 2.

Fit statistics of competing pre-measurement models

Model	χ^2	<i>df</i>	AIC	BIC	CFI	TLI	RMSEA	SRMR
Model 1	Non-positive definite latent variable covariance matrix - Unreliable fit statistics							
Model 2	2655.88	1025	72877.30	73544.63	0.85	0.84	0.05	0.07
Model 3	2586.44	1019	72815.41	73509.44	0.86	0.85	0.05	0.06
Model 4	3395.67	1028	73700.12	74354.11	0.79	0.77	0.06	0.08
Model 5	Non-positive definite latent variable covariance matrix - Unreliable fit statistics							
Model 6	Non-positive definite latent variable covariance matrix - Unreliable fit statistics							
Model 7	Non-positive definite latent variable covariance matrix - Unreliable fit statistics							
Model 8	Non-positive definite latent variable covariance matrix - Unreliable fit statistics							
Model 9	Non-positive definite latent variable covariance matrix - Unreliable fit statistics							

χ^2 = chi-square; *df* = degrees of freedom; AIC = Akaike Information Criteria; BIC = Bayesian Information Criteria; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation; SRMR = Standardized Root Mean Square Residual

According to Table 2, the AIC and BIC values of Model 3 presented the best statistical fit compared to the other competing models. The chi-square values (χ^2) could not be directly compared as a direct indicator of a better fit due to the use of the MLR estimator; therefore, the Satorra-Bentler chi-square difference test was done to determine the significance of the change in chi-square from Model 3 to Models' 2 and 4 respectively. These results are presented in Table 3 (Satorra & Bentler, 2010).

Table 3.

Difference testing for changes in chi-square in competing pre-measurement models

Model	$\Delta\chi^2$	Δdf	<i>p</i> - value
Model 2	79.32	6	0.00**
Model 4	619.76	9	0.00**

** $p < 0.01$

Referring to the significant p -values of Model 2 and Model 4, it is evident that Model 3 fitted the data significantly better. Model 3 was therefore used for development of the final proposed measurement model.

Testing of the Measurement Model

The proposed measurement model, Model 3, indicated the following fit statistics: (χ^2) = 2586.44; $p < 0.01$; $df = 1019$; CFI= 0.86; TLI= 0.85; RMSEA= 0.05; SRMR = 0.06; AIC = 72815.41 and BIC = 73509.44. Hooper et al. (2008) indicate that it is not uncommon to find a poor fit of the proposed model given the complexity of SEM. Hence, the model was further developed in order to find the best fit according to the cut-off values suggested for the fit indices. In order to improve the fit, certain items were either removed or allowance was made to correlate error variances because they were problematic in terms of low factor loadings, cross-loadings and/or high modification indices (Iacobucci, 2009).

After development, the re-specified model became measurement Model 1 and was compared with two other possible measurement models: Model 2 consisted of job demands as a second-order variable comprising of the three first-order variables (PAW, ML and EL). Model 3 consisted of four first-order latent variables, with job demands as a first-order variable without the distinction of its dimensions.

Table 4.

Fit statistics of competing measurement models

Model	χ^2	<i>df</i>	AIC	BIC	CFI	TLI	RMSEA	SRMR
Model 1	1525.34	804	63916.02	64543.31	0.93	0.92	0.04	0.08
Model 2	1591.54	807	63981.68	64595.63	0.92	0.92	0.04	0.08
Model 3	2281.23	811	64752.20	65348.35	0.85	0.85	0.05	0.09

χ^2 = chi-square; *df* = degrees of freedom; AIC = Akaike Information Criteria; BIC = Bayesian Information Criteria; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation; SRMR = Standardized Root Mean Square Residual

According to Table 4, the AIC and BIC values of Model 1 presented a better fit than the other two models. The chi-square values could not be directly compared as an indicator of a better fit due to the use of the MLR estimator. The Satorra and Bentler chi-square difference test was performed to determine if Model 1 was a significantly better fit to the data in addition to the fit statistics described in Table 4 (Satorra, & Bentler, 2010). Model 1 had the following fit statistics: chi-square (χ^2) = 1525.34; *df* = 804; CFI = 0.93; TLI = 0.92; RMSEA = 0.04; SRMR = 0.08; AIC= 63916.02; and BIC = 64543.31.

The results of the difference test are presented in Table 5 (Satorra & Bentler, 2010).

Table 5.

Difference testing for changes in chi-square in competing measurement models

Model	$\Delta\chi^2$	Δdf	<i>p</i> -value
Model 2	93.78	3	0.00**
Model 3	555.31	7	0.00**

** *p* < 0.01

It is evident from Table 5 that Model 1 fitted the data significantly better than the competing models because the chi-square values of Model 2 and Model 3 indicated a significantly worse fit. Therefore, Model 1 was used as a basis for constructing the structural model.

Testing the Structural Model

The descriptive statistics, reliability coefficients and correlations between the different variables are reported in Table 6. Raykov's rho coefficients are considered reliable with ρ ranging from 0.76 to 0.93, which according to Raykov (2009), indicates acceptable internal consistency. The cut-off of 0.70 is recommended (Wang & Wang, 2012). All the relationships between the variables were statistically significant, with the exception of the relationship between mental load and job satisfaction ($r = -0.04$), and mental load and intention to leave ($r = 0.04$). Statistically significant and positive relationships existed between PAW with ML ($r = 0.17$), and EL ($r = 0.20$). PAW had a positive relationship with ITL ($r = 0.16$). PAW had a negative relationship with job satisfaction ($r = -0.18$). Emotional load had a negative relationship with JS ($r = -0.27$) and a positive relationship with intention to leave ($r = 0.29$). The relationship between JS and ITL was significantly and practically negatively correlated ($r = -0.86$; large effect).

Table 6.

Descriptive statistics, reliability coefficients, and correlations.

Variable	M	SD	ρ	1	2	3	4
1. Pace and amount of work (0-3)	2.97	0.75	0.85	-			
2. Mental load (0-3)	3.52	0.62	0.81	0.17**	-		
3. Emotional load (0-3)	2.57	0.73	0.74	0.20**	0.21**	-	
4. Job satisfaction (1-5)	3.63	1.03	0.76	-0.18**	-0.04	-0.27**	-
5. Intention to leave (1-5)	2.53	1.26	0.84	0.16**	0.04	0.29**	-0.86 [†] **
6. Authentic leadership (1-5)	3.38	0.92	0.84				

* $p < 0.05$

** $p < 0.01$

[†] $r > 0.30$

[‡] $r > 0.50$

Regression path analysis between the constructs was conducted using a structural model. The measurement model formed the basis of the structural model. The hypothesised relationships shown in the model in Figure 1 (in Chapter 1) were tested. An acceptable fit of the model to the data was found: (χ^2) = 1525.34; $df = 804$; CFI = 0.93; TLI = 0.92; RMSEA = 0.04; SRMR = 0.08. Table 7 shows the fit statistics and path coefficients of the three competing structural models.

The proposed model (Model 1) estimated all the direct and indirect pathways at the same time. Model 2 (only direct pathways) estimated pathways from job demands – PAW, job demands – ML, job demands – EL, and JS directly to intention to leave (ITL). The pathways from job demands – PAW, job demands – ML, job demands – EL to job satisfaction was constrained to zero.

Model 3 (only indirect pathway) estimated pathways from job demands – PAW, job demands – ML, job demands – EL via job satisfaction to intention to leave (ITL) with the pathways job demands – PAW, job demands – ML, job demands – EL, directly to intention to leave constrained to zero.

The results indicate that the estimated path coefficients from PAW, ML and EL, to job satisfaction were significant in Model 1: PAW ($\beta = -0.25^{**}$, $p < 0.01$), ML ($\beta = 0.35^{**}$, $p < 0.01$) and EL ($\beta = -0.46^{**}$, $p < 0.01$). PAW, ML and EL explained a variance proportion of 24% for job satisfaction. Additionally, only path coefficients from EL to intention to leave ($\beta = 0.18^{**}$, $p < 0.01$) and job satisfaction to intention to leave ($\beta = -0.70^{**}$, $p < 0.01$) were significant in Model 1. Therefore, Hypothesis 1, stating that that job demands predicts job satisfaction, was accepted. Hypothesis 4 stating that job demands predicts intention to leave was partially accepted, as only one of the three factors, EL, was shown to be significant ($\beta = 0.18^{**}$, $p < 0.01$). Job satisfaction was shown to have a significant path coefficient to intention to leave ($\beta = -0.70^{**}$, $p < 0.01$). EL and job satisfaction together explained 62% of the variance for intention to leave.

Table 7.

Initial framework fit indices and standardised path coefficients

Measures		Direct and indirect pathways (Model 1)	Direct pathways (Model 2)	Indirect pathways (Model 3)
		Fit indices	χ^2	1525.34
	<i>df</i>	804	807	807
	AIC	63916.02	64006.10	63920.48
	BIC	64543.31	64620.05	64534.42
	CFI	0.93	0.92	0.93
	TLI	0.92	0.91	0.92
	RMSEA	0.04	0.04	0.04
	SRMR	0.08	0.09	0.08
Direct effects on intention to leave	Pace and amount of work	0.03	0.07	-
	Mental load	-0.01	-0.15*	-
	Emotional load	0.18**	0.25**	-
	Job satisfaction	-0.70**	-0.73**	-0.79**
Direct effects on job satisfaction	Pace and amount of work	-0.25**	-	-0.26**
	Mental load	0.35**	-	0.37**
	Emotional load	-0.46**	-	-0.50**

* p < 0.05

** p < 0.01

Table 8 indicates the significance of changes in chi-square found between Model 1 and Model 2, and Model 1 and Model 3, as indicated by chi-square difference testing. Results indicate that Model 2 and Model 3 were significantly inferior to Model 1. Therefore, Model 1 was used to test for indirect effects and moderation. The AIC levels were also lower than those for Model 2 and Model 3. The BIC levels were lower than those for Model 2 and marginally higher than those for Model 3. Even though this was the case, Model 1 was accepted as the final model, as it had a lower AIC level and significant chi-square values.

Table 8.

Difference testing for changes in chi-square in competing structural models

Model	$\Delta\chi^2$	Δdf	<i>p</i> -value
Model 2	93.12	3	0.01**
Model 3	10.39	3	0.02*

** p < 0.01

Figure 2 indicates the standardised path coefficients that were estimated by using Mplus 7.4 (Muthén & Muthén, 1998-2016). It shows the standardised coefficients for the best fitting model, which was subsequently used to test indirect effects. Statistically significant paths are shown in Figure 2, with $\beta = -.25^{**}$ between PAW and JS, $\beta = -.70^{**}$ between JS and ITL and $\beta = .18^{**}$ between EL and ITL. The paths between PAW and ITL $\beta = 0.03$, and ML and ITL $\beta = -.10$ are not statistically significant. The paths between PAW, ML and EL are not statistically significant.

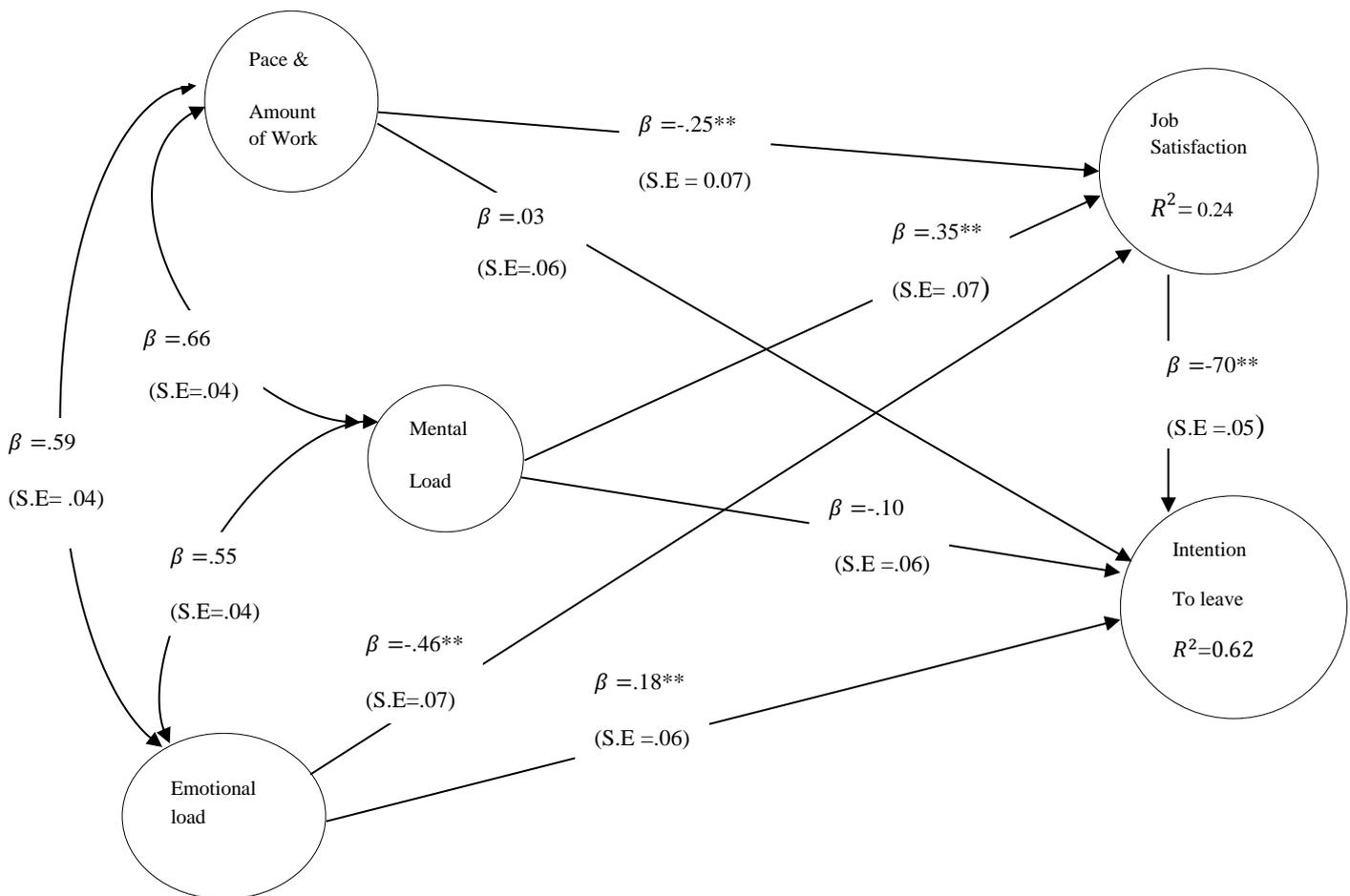


Figure 2. The structural model of job demands, authentic leadership, job satisfaction, and intention to leave

In order to determine any indirect effects of PAW, EL, and ML (job demands), bootstrap samples of 5000 were obtained. As indicated in Table 9, all of the indirect effects were significant. Job demands (PAW, ML, EL) had a significant indirect effect on intention to

leave through job satisfaction. The relationship from PAW to ITL indicated a significant positive indirect effect ($p < 0.01$) through JS. The effect of ML to ITL through JS indicated a significant negative relationship ($p < 0.01$). The effect of JS on the relationship between EL and ITL is positively significant. The confidence levels are a confirmation of the results, as none of them included zero. Therefore, hypothesis 3 suggesting that JS will mediate the relationship between JD and ITL was accepted.

Table 9.

Indirect effects of pace and amount of work, mental load and emotional load on intention to leave

Variable	Job satisfaction		
	Est.	SE	95% CI
Pace and amount of work	0.18**	0.05	[0.08, 0.29]
Mental load	-0.24**	0.06	[-0.37, -0.15]
Emotional load	0.32**	0.05	[0.22, 0.43]

Est., Estimate; SE, Standard Error; CI., Confidence Interval

* $p < 0.05$; ** $p < 0.01$

Moderation formed a part of this study and results in Table 10 show that in the relationship between PAW and JS, AL did not serve a moderating effect ($\rho = 0.665$). Similarly, in the relationship between ML and JS, AL did not serve a moderating effect, with a non-significant ρ -value of 0.752. In the relationship between EL and JS, AL was not a moderator, as indicated by a non-significant value of 0.974. Therefore, Hypothesis 2, suggesting that authentic leadership has a moderating effect on the relationship between job demands and job satisfaction, was not accepted.

Table 10.

Moderation effects of authentic leadership

Variable	Job satisfaction		Intention to leave	
	Est.	<i>p</i>	Est.	<i>p</i>
Pace and amount of work	-0.05	0.67	-	-
Mental load	-0.06	0.75	-	-
Emotional load	-0.00	0.97	0.01	0.88
Job satisfaction	-	-	-0.05	0.20

p* < 0.05; *p* < 0.01

Moderating effects were further tested using AL on the relationship between EL and intention to leave. The relationship proved to be non-significant with a *p* value of 0.88. Moderation from PAW and ML were not estimated, as they were not found to influence ITL in the structural model. Based on this, Hypothesis 5 indicating a possible moderating effect of authentic leadership on the relationship between job demands and intention to leave was rejected.

DISCUSSION

The aim of this study was first, to examine the relationships among job demands, authentic leadership, job satisfaction, and intention to leave; and second, to examine any direct and indirect relationships between authentic leadership, job demands, job satisfaction, and intention to leave.

South Africa faces a public healthcare crisis that is characterised by shortages, declining interest in the nursing profession, poor management, and a disparity between the needs of nurses, their institutions and the communities they serve (White et al., 2015). Previous studies have shown that job demands predict job satisfaction levels (Schaufeli, & Salanova, 2007; Thirapatsakun, Kuntonbutr, & Mechinda, 2014), which in turn are ultimately expected to lead to negative outcomes, such as intention to leave and turnover (Schreurs et al., 2011). The research results of this study show that Hypothesis 1 is in line with expectations and previous empirical research. The results show that a negative relationship exists between job demands and job satisfaction. PAW had a significant negative relationship with JS ($r = -0.18$), EL showed a significant negative relationship with JS ($r = -0.27$) and ML showed a weak negative relationship with JS ($r = -0.04$), which was statistically insignificant. This indicated the low effect of ML on JS in this study.

Empirical research gives credence to the theory that authentic leadership behaviour promotes positive relationships between leaders and employees, which results in higher levels of job satisfaction (Avolio & Gardner, 2005; Giallonardo et al., 2010; Wong & Cummings, 2009). Hypothesis 2 was not accepted in this study. The result of the outcome was unexpected, as authentic leadership, seen as a job resource in this study, did not moderate the relationship between job demands and job satisfaction. The study showed non-significant results, indicating that authentic leadership did not effectively buffer the relationship between job demands (pace and amount of work, emotional load and mental load) and job satisfaction. In the relationship between ML and JS, AL did not have a direct effect, with a non-significant p -value of 0.752. The relationship between EL, JS and AL also indicated a non-significant p -value of 0.974. The relationship between PAW, JS and AL further showed a non-significant result ($p = 0.665$). This implies that a public healthcare manager or leader displaying

authentic qualities is possibly not sufficient in motivating higher job satisfaction levels with the staff within this public healthcare sector. Conversely, theory suggests that authentic leadership positively influences job satisfaction through the cultivation of supportive and motivating work environments (Laschinger & Fida, 2015). An explanation for the above result is that such a culture still needs to be embedded within the organisation. Further, the dimensions of self-awareness and balanced processing are highly correlated with nurse satisfaction (Wong & Laschinger, 2013). In their study of AL, Hassan and Ahmed (2011) indicated that in order for a subordinate to recognise a leader as being authentic, a level of trust must be present between the leader and the subordinate. When subordinates develop a high level of trust in the leader they are likely to become more engaged in their work and this leads to higher levels of job satisfaction (Bamford et al., 2012).

Based on the above discussion, another possible explanation of the results for Hypothesis 2, is that the results could be reflective of a lack of trust in the relationships between managers and employees. Bloch (2012), states that when a poor relationship exists between managers and subordinates, involvement from a manager tends to create a sense of intimidation and intrusion among subordinates. It therefore becomes understandable that under such circumstances, the nurses and other employees may find it difficult to speak openly and honestly with their managers and consequently may find it difficult to stay focused and committed, or to express a positive attitude or feelings towards their work.

Further, public healthcare research in the South African context has shown that most managers have a clinical or administrative background (Munyewende & Rispel, 2015) and are focused on crises management or affecting factors, such as budget or resource-related issues, therefore, the relational aspects of their leadership style is often neglected. Another explanation is that the majority of participants in this study are employees in the 50 to 59 year age category. Research by Aiken et al. (2001) and Erickson and Grove (2008) shows that older doctors and nurses are more in control of their agitated emotions (anger, frustration, and irritation) and have learned behaviours that helped them to cope. These behaviours further insulated them from job burnout or turnover ideation (Fredrickson, 2000). Finally, it is possible that employees' (nurses') job satisfaction levels are intrinsically motivated and not necessarily externally determined by the supervisor or manager, or alternately, other hygiene

factors (pay, workplace conditions, work environment, benefits, policy and administration, relations with co-workers, status, and job security) were perceived as more important (Giallonardo et al., 2010). This could have extrinsically influenced job satisfaction levels in this study.

Hypothesis 3 was supported by the results. The study showed that job demands had a significant, indirect effect on intention to leave through job satisfaction. Shields and Ward (2001) have shown that job satisfaction is a predictor of intention to leave. Empirical research supports this outcome. Demerouti and Cropanzano (2001) as well as Schaufeli and Salanova (2007) supported the theory that higher levels of concentration and contentment at work lead to job satisfaction, which is associated with employees' positive attitude, proactive work behaviour, higher levels of psychological well-being, and increased individual and organisation performance, which in turn lead to lower levels of intention to leave and thus, decreased turnover. The relationship between job satisfaction, and intention to leave was significantly and practically correlated ($r = -.86$) with a large effect. Conversely, if employees perceive that job demands are affecting them negatively, they might become dissatisfied and may entertain thoughts of leaving their current job and seeking alternative employment (Elangovan, 2001). The study showed that the indirect effect of job satisfaction on the relationship between EL and intention to leave is positively significant. EL precedes ITL; therefore, if job satisfaction is increased ITL will decrease. As such, the findings are in line with literature (Egan, Yang, & Bartlett, 2004; Lambert, Hogan, & Barton, 2001; MacIntosh & Doherty, 2010; Schwepker, 2001; Silverthorne, 2004; Van den Broeck, Vansteenkiste, De Witte, Soenens, & Lens, 2010).

Hypothesis 4 stating that job demands predicts intention to leave, was partially accepted as only EL was shown to be significant ($\beta = 0.18^{**}$, $p < 0.01$). The results propose that EL had a negative effect on employees to the extent that it led to thoughts of leaving. Empirical studies in various contexts have indicated that job demands have an effect on nurses' well-being and intention to leave (Armstrong et al., 2015; Laschinger, Finegan, & Wilk, 2011; Laschinger, Leiter, Day, & Gilin, 2009; Maslach, 2004). Intention to leave and turnover have been the focus of research studies in healthcare due to their significant effect on performance and productivity; affecting effective levels of patient care and the profitability of healthcare

organisations (Beecroft, Dorey, & Wenten, 2008; Lavoie-Tremblay et al., 2008). The above result is acceptable and is in line with previous studies.

Literature shows that nurses who were dissatisfied with their jobs reported significantly higher emotional demands than nurses who were satisfied (Asegid et al., 2014; Baker et al., 2004; Bamford et al., 2012; Han, Trinkoff, & Gurses, 2015; Isaksson et al., 2003; Laschinger et al., 2012a). Shields and Ward (2001) found job satisfaction levels to be a predictor of absenteeism, intention to leave, and turnover. Although nursing requires skill and activity like most jobs, unlike many jobs it also demands complex emotional labour (Kowalski et al., 2010). Nurses manage not only their own emotions (which can be complex and draining in the face of death, pain, loss, aggression, and sadness) but also those of others (Asegid et al., 2014; Fredrickson, 2000). They see people at their most vulnerable, full of despair, fear, and uncertainty. They are expected to deal with these feelings and emotions together with other dilemmas and demands, such as disrespectful patient behaviours and bad attitudes, health system inefficiencies, and unsupportive management. For these reasons, the above results regarding emotional demands, are highly acceptable and reveal their effect on employees within this sample.

Hypothesis 5 was not supported by the study. The results indicated that authentic leadership did not moderate the relationship between job demands and intention to leave. The relationship between EL and ITL, with AL as a moderator, indicated a non-significant relationship ($p = 0.88$). PAW and ML were not estimated as they were seen not to influence ITL in the structural model. Previous empirical studies have shown positive relationships between authentic leadership and job satisfaction (Clapp-Smith, Vogelsang, & Avey, 2009; Walumbwa et al., 2010), the resulting effect of which is lowered rates of intention to leave and turnover (Carsten, et al., 2008). Contrary to the results of the study, literature also indicates that the JD-R model proposes that job resources operate as a buffer to diminish the negative consequences of job demands (Bakker & Demerouti, 2007; Bakker et al., 2005) and further, Bakker and Demerouti (2007) famously asserted that supervisory support (authentic leadership in this study) is a potential buffer for work demands. Nevertheless, this study has shown that authentic leadership did not buffer the relationship between job demands and

intention to leave towards a better organisational outcome, such as possible lower levels of turnover. This result is interesting for various reasons.

A plausible explanation for this result is that many job demands in the public healthcare nursing sector, which is globally faced with staff and resource shortages, burnout and high levels of turnover, are fixed and part of daily routine. For example, nurses are trained to respond instantly to medical emergencies, adhere to protocols, norms, rules, regulations, and healthcare practices (Aiken et al., 2001). It is part of their duty to diagnose problems, analyse symptoms, and work closely with physicians and other healthcare providers for the benefit of the patient. Hence, high levels of PAW and ML are part of everyday duty for nurses. The research results show that PAW and ML were not estimated, as they were not found to influence intention to leave in the structural model. It becomes understandable in this context, that pace and amount of work, emotional load and mental load can hardly be reduced or eliminated just because the individual has a supportive supervisor.

Another likely explanation is that leaders being who they are and saying what they think can be highly problematic if the “real” person or leader is overly critical, crass, judgemental, or rigid at their most “real”- but not their best (Gruenfeld & Zander, 2011). By definition, authentic leadership indicates that leaders openly share information, show consistency between their beliefs and actions and clearly state what they mean in their feedback. By mere interpretation of the definition of authentic leadership, authentic leaders are not obliged to protect a fragile ego or their rank and status; they do not feel threatened by followers. They do not hide inconvenient truths to spare followers’ feelings (Gardner et al., 2005; Ilies et al., 2005). Some nurses and employees may experience this type of leader negatively. Kernis (2003) indicated that some individuals have feelings of self-worth that are dependent on the endorsement and approval of others. This means that such individuals have fragile self-worth that crumbles when their ego is under threat from feedback (Kernis & Goldman, 2006). Further, by expressing their own true selves in the workplace, authentic leaders require authentic conduct from their followers, such as acknowledging and admitting mistakes, speaking up, or living by fundamental values. It might be that nurse subordinates and other employees in this study are not ready to be authentic followers at this stage.

Goffee and Jones (2005) indicate that authenticity is a quality that others must attribute to a leader, it is not purely innate. Authenticity in practice is largely defined by what others see in a leader (Goffee & Jones, 2005). This result then can be attributed to leadership style or interpretations of the authentic leadership style. It could also be expressive of the employees' experience or assessment of their leader. Moreover, it could simply reflect the demanding effect of the job. The results have shown that EL affects ITL in this study. The path coefficient from EL to ITL ($\beta = 0.18, p < 0.01$) was significant. Hence, it can be assumed that the impact of emotional demands is negatively experienced, and that AL is not the correct or effective job resource to act as a buffer at this point. Bakker and Demerouti (2007) stated that the right type of job resource provided under high demand situations will stimulate and activate the attention of the employee at work, leading to positive outcomes. In this study, authentic leadership as a job resource did not buffer the effect of job demands on the nurses and other public healthcare employees.

Implications for Management

Public healthcare organisations need stable, highly trained, and fully engaged nursing staff to provide effective levels of patient care (Aiken, Clarke, Sloane, Lake, & Cheney, 2008). Intention to leave and turnover are major issues affecting the performance and profitability of these organisations (Gardner, Cogliser, Davis, & Dickens, 2011). The positive effects of authentic leadership in healthcare has been established through several studies in various contexts (Avolio, Griffith, Wernsing, & Walumbwa, 2010; Dhiman, 2011; Gardner et al., 2005; Giallonardo et al., 2010; Ilies et al., 2005; Macik-Frey, Campbell Quick, & Cooper, 2009; Wong & Cummings, 2009). Since authentic leadership presented as one factor, authentic leadership development as a whole should become an area of focus. Authentic leadership development should be considered for all supervisors, managers and leaders, as authentic leadership theory proposes mechanisms that allow managers to create positive and supportive environments that facilitate work performance, job satisfaction, and addresses intention to leave (Laschinger & Smith, 2013). Managers create the conditions for nurses' work by shaping the quality of support, information, and resources available to them to perform their jobs (Laschinger et al., 2009; Shirey, 2009).

Too often within healthcare institutions, nurses are placed in leadership positions without adequate preparation or support (Armstrong et al., 2015). There is an expectation that nurses who perform well at the bedside will also do well in leadership positions (Robbins & Davidhizar, 2007). Should this be the case, management should consider allowing bedside nurses the opportunity to mentor new nurses, chair committees, advance policy, and attend leadership seminars. These activities may enhance their future ability to lead effectively.

Emotional load (JD) showed a significant relationship with intention to leave within this study. Studies have shown that emotional demands can lead to emotional exhaustion, which will not only affect the well-being of healthcare staff through illness and burnout, but also, indirectly influence the quality of patient care via outcomes, such as compassion fatigue, absenteeism or intention to leave (Clegg, 2001; Kowalski et al., 2010; Maslach et al., 2001; Wood, 2014). Previous research has also shown strong correlations between emotional exhaustion and illness in nurses, resulting in a range of negative outcomes affecting patient satisfaction, safety climate, mortality rates, as well as recruitment and retention (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004).

In light of the above, it is suggested that social support mechanisms be implemented to address the impact of emotional load on employees. Social support is hailed as an effective stress management resource and takes the form of mentoring and coaching (Clegg, 2001; Laschinger et al., 2009; Selamawit & Ammanel, 2014). There is evidence that mentoring programmes can offer social support in healthcare environments and develop emotional competencies, such as empathy (Selamawit & Ammanel, 2014). Formal mentoring has also been found to improve leadership skills and well-being (Chun, Sosik, & Yun, 2012). Additionally, peer coaching has strong potential to help nurses explore different perspectives on emotional interactions with patients and their families (Kelton, 2014) and explore strategies for providing compassionate care while protecting their personal well-being. Peer coaching is a distinct form of coaching and it could foster authentic leadership skills in managers, in the sense that managers could help each other further develop their authentic leadership skills (George & Haag-Heitman, 2010; Kelton, 2014). Authentic leadership studies suggest that opportunities for venting emotions within trusting and non-judgemental relationships would help nursing subordinates manage emotional loads more effectively.

Seeing that EL affects JS and ITL in this study, it is recommended that a climate of AL behaviours be fostered within the organisation for managers and followers alike (Leroy et al., 2012) as a healthy work environment is an essential component of quality patient care and job satisfaction (Laschinger & Fida, 2015).

A practical element to consider is the adoption of recruitment processes designed to assess personal characteristics associated with authentic leaders. Furthermore, an authentic leadership coaching approach, for current and new leaders (Lee & Robert, 2010) could be a starting point for this endeavour. Finally, with respect to fostering work climate improvements, higher management could co-ordinate the review of policies and procedures and job design (Clegg, 2001) based on best practices to reflect and encourage the development of a positive and ethical work climate, that is, giving social support and feedback, opportunities for development or shared rewards (Clegg, 2001), autonomy or control latitude with regard to decisions (Gershon et al., 2007) as well as aligning them with positive leadership and management practices. Furthermore, periodic monitoring of climate and employee well-being through surveys, interviews, or team workshops should be performed. This strategy would help assess, in a timely manner, less than optimal climate and well-being of employees, Hence, corrective measures could be implemented more rapidly.

Limitations and Recommendations for Future Research

Several limitations must be noted. First, the cross-sectional research design limited the ability to establish causality. Ter Doest and De Jonge (2006) postulated that using a cross-sectional survey design limits the observation of change over time. To address the limitation for the purpose of this study, competing measurement models and structural models were tested to reduce inaccurate measurements. However, it is recommended that longitudinal study design is used to address the issue of causality and further examine the effect of JD, AL, JS and turnover intention of nurses, doctors and other public healthcare employees at various points in time. Ideally, participants would be linked at different time points. Such a methodology would also enable actual attrition to be monitored against turnover intention.

Another limitation in this study is the relatively small number of employees participating. This could potentially have an effect on the statistical vivacity required for certain estimation procedures, and the dynamism required to identify significant effects (Nayak, 2010). To increase this number, the survey could be carried out in other public healthcare institutions within the province, to understand the association of the constructs better so that the outcomes can be compared, and an integrated strategy formulated. In the relationship between JD and JS and JD and ITL, authentic leadership showed a non-significant result with no moderating effect. In particular, the examination of these hypotheses using data from a nationally representative sample of nurses and doctors in public healthcare would be particularly valuable. Authentic leadership research in the healthcare sector in the South African context is at an early stage of development, as a consequence the psychometric properties of the ALI still need to be explored further using alternative approaches and looking at different sectors (Dawkins, Martin, Scott, & Sanderson, 2013; Gardner et al., 2011).

As all the measures were self-report measures, another limitation could be the risk of common method variance. Podsakoff, MacKenzie, Lee, & Podsakoff (2003) postulated that a contextual understanding of the variables and the self-report surveys could potentially be the reason for common method bias, which can lead to measurement errors. On the other hand, Doty and Glick (1998) documented that common method variance is rarely strong enough to invalidate findings. Nonetheless, in future studies inclusion of multi-source data, such as objective ratings of employees' assessments of their leader, and other data collection methods, such as interviews, could contribute significantly to the study. Given the challenges within the public healthcare sector, having a leader that is perceived to be authentic in the healthcare environment is not only essential for the employees' well-being but also for organisational outcomes (Wong & Cummings, 2009). Hence, it is recommended that more research is done regarding the role of authentic leadership and its links to quality of care, such as patient satisfaction, adverse events, and nurse-sensitive outcomes in the South African context.

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CHAPTER 3

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

This chapter consists of conclusions pertaining to this study, in accordance with the general and specific objectives. The limitations of the research will be discussed, and recommendations made for the organisation and future research.

3.1 Conclusions

The general objective of this study was to investigate the relationships between job demands, authentic leadership, job satisfaction, and intention to leave amongst public healthcare employees, and to investigate the possible effect of authentic leadership on these relationships. Authentic leadership is hailed as a form of leadership that can positively affect, not only the nursing workforce through job satisfaction, and retention, but the healthcare delivery system and society as a whole (Laschinger, Wong, & Grau, 2012a). It is a positive form of leadership that has come to the fore in the academic arena in recent years (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008) and research shows that authentic leaders play a pivotal role in the retention of nurses and medical doctors by shaping the healthcare practice environment through behaviours, such as transparency, integrity, and positive orientation, to produce quality outcomes for nurses, doctors and patients (Asegid, Belachew, & Yimam, 2014). Theory suggests that authentic leaders are capable of fulfilling the employees' needs to be affiliated, and to be cared for and appreciated, which inspires their resilience to cope with hardship and demands (Walumbwa, et al., 2008). This state has been shown to ultimately lead to better job performance and job satisfaction (Bakker, 2011; Brough et al., 2013; Gardner, Avolio, Luthans, May, & Walumbwa, 2005; Jones & George, 1998; Penger & Černe, 2014). Based on the empirical results in Chapter 2, the following conclusions were drawn:

The first objective of this study was to investigate the relationship between job demands, authentic leadership, job satisfaction, and intention to leave according to literature. Authentic leadership is differentiated from other leadership styles by its “authenticity” component,

which resonates with high moral and principled character, knowing oneself, and demonstrating openness and honesty in relationships (Gardner & Schermerhorn, 2004). Authentic leaders conform to fact, they speak the truth and therefore are worthy of the trust, reliance, and belief of employees (George, Simms, Mclean, & Mayer, 2007). Literature indicates that authentic leadership is a salient predictor of nurses' levels of job satisfaction (Giallonardo, Wong, & Iwasiw, 2010; Walumbwa et al., 2008; Weberg, 2010). Through the enactment of their own behaviours, authentic leaders are capable of encouraging positive self-development within their followers (Leroy, Ansel, Gardner, Sels, 2012; Wong & Laschinger, 2013), hence, it is expected that by being their true selves in the workplace, followers of authentic leaders would be capable of their own autonomous work motivation. Theory postulates that motivation that is rooted within contributes to job satisfaction (Griffen, Neal, & Parker, 2007), as it gives employees a sense of proficiency and accomplishment that goes beyond meeting their basic physiological needs (Compton & Hoffman, 2013). This in turn inspires better job performance and job satisfaction (Bakker, 2011; Penger & Černe, 2014). Authentic leadership has been linked to higher ratings of patient care quality in healthcare settings (Giallonardo et al., 2010; Rego, Sousa, Marques, & Cunha, 2012; Walumbwa, Wang, Wang, Schaubroeck, & Avolio, 2010; Wong, Laschinger, & Cummings, 2010) by inspiring greater trust in management, empowerment, and work satisfaction. Finally and importantly, authentic leadership is shown to be a significant predictor of job satisfaction, which ultimately affects intention to leave (Walumbwa et al., 2008).

Intention to leave is the individual's own decision and thoughts or the expressed inclination and deliberate willingness to leave his or her job (Huber, 2006). Job demands are known to sharply decrease levels of job satisfaction (Bakker, Van Veldhoven, & Xanthopoulou, 2010; Cummings et al., 2010; Iverson & Maguire, 2000; Llorens, Bakker, Schaufeli, & Salanova, 2006; Xanthopoulou, Bakker, & Fischbach, 2013) and have a significant positive association with intention to leave and voluntary turnover (Mueller et al., 1994). Authentic leadership is a crucial job resource, which is positively related to job satisfaction (Lu, While, & Barriball, 2005). Authentic leadership also alleviates the negative effects of job demands (for example, work overload, and emotional demands) on organisational outcomes, such as intention to leave (Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007). Authentic leadership is known to promote a positive work climate even under trying and challenging circumstances (Kouzes

& Posner, 2002; Wong et al., 2010), thereby affecting employees' thoughts or decisions of permanently leaving the organisation at some point in the near future (Cowden, Cummings, & Profetto-McGrath, 2011; Huber 2006; McCarthy, Tyrell, & Lehane, 2007).

The second objective was to investigate the relationship between job demands and job satisfaction. Job demands are the work-related job requirements that are psychological or physical in nature, requiring cognitive effectiveness, mental awareness, and maybe physical exertion (Karasek, 1998; Schaufeli & Bakker, 2004). JD-R research reveals that job demands lead to a higher probability of burnout, disengagement, and dissatisfaction when job resources are inadequate or simply non-existent (Bakker & Demerouti, 2007; Van den Broeck, De Cuyper, De Witte, & Vansteenkiste, 2010; Xanthopoulou et al., 2007). Job satisfaction is viewed as a multidimensional construct concerning satisfaction with pay, leadership or supervision, the nature of the job, and company policy (Shanafelt, 2008). Job satisfaction is seen as consisting of two components, intrinsic and extrinsic job satisfaction (Rothmann, 2008). Intrinsic job satisfaction refers to employees' feelings about the job itself and extrinsic job satisfaction refers to how employees feel about aspects of the work that are external to the job itself (Cropanzano & Wright, 2001; Quick & Nelson, 2009; Rothmann, 2008). Job satisfaction is associated with employees' positive attitude, proactive job behaviours, higher levels of psychological well-being, and increased individual job and organisational performance (Demerouti & Cropanzano, 2001).

Studies show that public healthcare employees, especially nurses and doctors, consistently report higher levels of job demands compared to other professionals (Williams & Smith, 2013). High job demands invoke feelings of inadequacy, which can lead to burnout and compromised well-being of nurses and doctors, ultimately revealing implications for productivity and performance (Najimi, Goudarzi, & Sharifirad, 2012). The JD-R indicates that the presence of adequate job resources lessens the impact of job demands and fosters involvement, bringing about a positive attitude towards the organisation (affective commitment) and positive attitude towards the job (dedication), which in turn lead to job satisfaction (Mowday, Steers, & Porter, 1982; Schaufeli, Salanova, González-Romá, & Bakker, 2002). Job satisfaction is considered one of the integral factors affecting the growth of performance in the healthcare services and the medical profession (Platis, Reklitis, &

Zimeras, 2015). Job satisfaction is connected to a healthier workforce and is a good indicator of service length (Luthans & Avolio, 2003; Pietersen, 2005; Shields & Ward, 2001). Previous studies support the findings of this research.

The third objective was to determine the effect of authentic leadership on the relationship between job demands and job satisfaction. The results of the study indicated that authentic leadership did not have a direct effect on the relationship between job demands and job satisfaction. Authentic leaders create the conditions for public healthcare employees work by shaping the quality of support, information, and resources available in work areas (Laschinger, Finegan, & Wilk, 2009; Shirey, 2009). Authentic leadership is a critical job resource, which is positively related to job satisfaction (Lu, While, & Barriball, 2005) and the JD-R postulates that it also buffers the negative effects of job demands (for example, work overload, emotional workload, and mental workload) on job satisfaction (Xanthopoulou et al., 2007). When employees feel that they are supported and treated sincerely, they experience increased motivation levels at work, thus leading to satisfaction with and passion for work (Harter, Schmidt, & Hayes, 2002), hence, authentic support from leaders may function as a buffer on work overload and job satisfaction levels (Van der Doef & Maes, 1999).

On the other hand, when employees' perceive an incongruence in the leaders' behaviour, pertaining to honesty, integrity, fairness, and feedback, employees will be discouraged from sharing information and ideas. They will view their leaders with distrust, fear and anger. Under such circumstances, public healthcare employees may find it difficult to stay focused, committed or enthusiastic with regard to their work, as they may experience their work situation as frustrating, thereby associating their work with dissatisfaction (Shirey, 2009). Hence, if employees experience their managers as objective, open, truthful, and ethical they will be inspired to respond positively to their work, reporting higher levels of satisfaction (Wang, Sui, Luthans, Wang, & Wu, 2014).

Perceived authentic leadership style did not have an effect on job satisfaction levels of subordinates. It may be because most leaders in public healthcare institutions are clinically or administratively focused, which affects the relational aspect of their leadership style, hence,

authentic leadership qualities may be lacking. It is possible that factors other than leadership motivate employee satisfaction levels. These may be pay, workplace conditions, work environment, relations with co-workers, status, job security, policy, or benefits. Given that the majority of participants had tenure within their profession or in the organisation (50 to 59 years old), they may have been motivated due to their knowledge and experience levels (Fredrickson, 2000).

The fourth objective was to determine the effect of job satisfaction on the relationship between job demands and intention to leave. Job dissatisfaction and intention to leave are strong predictors of turnover (Griffith, Hom, & Gaertner, 2000), which has significant organisational impact. McShane and Von Glinow (2010) stated that job satisfaction is an individual's appraisal of his or her job and work situation, and the evaluation of the perceived job requirements, work environment, and the emotional experiences of the job. Results of the study show that EL precedes ITL, the relationship between EL and ITL was correlated significantly and practically ($r = -.86$). If employees feel that job demands, specifically EL has a negative effect on them, they will become dissatisfied and entertain thoughts of leaving their jobs. Theory indicates a negative relationship between job satisfaction, and intention to leave (Hallberg & Schaufeli, 2006; Saks, 2006; Schaufeli & Bakker, 2004). Employees who work because of the innate satisfaction and pleasure they experience, are less likely to think of leaving their jobs (ITL) (Higgs, Mein, Ferrie, Hyde, & Nazroo, 2003; Richer, Blanchard, & Vallerand, 2002). The results of the study indicated that job satisfaction had an indirect effect on the relationship between job demands and intention to leave. This is in line with prior empirical research findings, which show that job satisfaction is strongly and conversely associated with employees' intention to leave an organisation (Egan, Yang, & Bartlett, 2004; Lambert, Hogan, & Barton, 2001; MacIntosh & Doherty, 2010; Schwegker, 2001; Silverthorne, 2004). In other words, it is highly improbable that satisfied employees will seek out a new job, with a new employer.

The fifth objective was to investigate the relationship between job demands and intention to leave. Research has shown that public healthcare employees, especially nurses, are faced with demanding workloads, that is, high levels of mental, physical, and emotional demands, which constantly threaten the depletion of personal resources. Hence, they often become victims of

burnout or intention to leave (Armstrong, Rispel, & Penn-Kekana, 2015). Results of the study indicating that job demands predicts intention to leave, was partially accepted as only EL was shown to be significant ($\beta = 0.18^{**}$, $p < 0.01$). The results propose that EL negatively affected public healthcare employees to the extent that it led to thoughts of leaving. Because of the nature of their work, nurses and other public healthcare employees are at high risk of experiencing the emotional exhaustion component of burnout (Maslach, Schaufeli, & Leiter, 2001) and Lafer (2005) observed that emotions related to stress, anger, exhaustion and frustration, which makes up the normal daily routine experiences of nurses, doctors and other public healthcare employees, constitute the single biggest factor that causes intention to leave and turnover. Studies have shown the nurses' and doctors' feelings about their jobs tend to be influenced more by organisational practices governing the workplace than by the challenges inherent to caring for others (Aiken et al., 2001).

The sixth objective of the study was to determine the effect of authentic leadership on the relationship between job demands and intention to leave. The results of this study indicated no moderating effect.

3.2 Limitations

The use of the cross-sectional design was an important limitation, as no causal inferences could be made among the variables. A longitudinal research design may have allowed for more robust causal relations and conclusions.

Another limitation was the use of self-reported questionnaires, which presented a risk associated with common method variance. Oosthuizen (2005) indicated that when one method of data collection is used, it may increase the probability of relations being false or insignificant. The fact that the research was based on employee perceptions, could further have caused the results to be artificially inflated.

3.3 Recommendations

3.3.1 Recommendations for the Organisation

Empirical research has shown the positive effect of authentic leadership on job satisfaction (Griffen et al., 2007; Walumbwa et al., 2008). This creates the impression that authentic leadership is a suitable leadership style for enhancing employee outcomes and leads to the conclusion that if leaders want to improve results from the employee and organisational perspective, they should develop personality traits and behaviour in the direction of authenticity. In particular, when employees are involved in decision-making processes and perceive their leaders as authentic, supportive, open and truthful, they respond positively to their work, reporting higher work satisfaction and performance (Wong, Laschinger, & Cummings, 2010). Job dissatisfaction and the intention to leave one's job are the strongest predictors of actual turnover (Griffith et al., 2000). Given the positive outcome of AL research in the healthcare sector, it is recommended that organisations actively develop skills and behaviour of authentic leadership within. According to Eigel and Kuhnert (2005), it is possible to develop authentic leadership behaviours. Leadership training can be implemented during recruitment, selection, and promotion processes, to develop authentic leadership skills that are relationally orientated.

The current results indicate that in terms of ITL, job satisfaction has proven to be an important factor. On examination of the antecedents of ITL, the emphasis is on the direct positive effects of job satisfaction, and not the buffering impact of job resources on the relationship between job demands and negative ITL. This has important implications for the healthcare sector striving to retain nurses. Recognising both that the emotional experiences that are an integral but an often invisible part of the nursing environment, and the impact that such experiences and their management have on job burnout, are central to efforts aimed at increasing the retention of nurses. Management should implement motivational processes that are important to lower ITL, for example, by re-examining requirements of the job with the emphasis on expanding job resources instead of the conventional approach of decreasing job demands. It is particularly crucial in a time of increased patient acuity, nursing and doctor shortages, declining enrolments, and an aging nurse population, to recognise the impact of

emotional demands on nurses (Buerhaus, Staiger, & Auerbach, 2003). Older nurses are less likely to experience agitation or burnout (Fredrickson, 2001). Therefore, creating roles for older, more experienced nurses to provide emotional mentorship to younger nurses may be one way to help them cope with the emotional demands of the profession and to retain the services and experience of the older nurses. With the majority of the nurses in this study approaching retirement, it is imperative that employers look beyond recruiting initiatives and become unrelenting in their attempts to improve the work environment so that nurses entering the profession remain and those who are expected to retire, postpone that decision.

In light of the above, it is also suggested that social support mechanisms be implemented to address the impact of emotional load on nurses. Peer coaching and formal coaching are considered effective for building skills and stress management (Clegg, 2001; Laschinger et al., 2009; Selamawit & Ammanel, 2014). A healthy work environment is an essential component of quality patient care and job satisfaction (Laschinger & Fida, 2015).

Job dissatisfaction and the intention to leave one's job are the strongest prognosticators of actual turnover (Griffith et al., 2000). To motivate employees in the face of increased demands – particularly when public healthcare institutions are being asked to meet these demands with fewer resources – is a major challenge. Motivation plays an indispensable role in many of the critical challenges facing the healthcare workforce today. Thus, investigations into factors that motivate the healthcare employees may produce valuable insight into many of the challenges facing public healthcare. Meeting the needs and achieving the goals of both the employee and the organisation is the keystone of job satisfaction, and is of crucial importance for management, as it is associated with the upgrading of the quality of the services provided.

Furthermore, periodic monitoring of organisational climate (values and authenticity) and employee well-being through surveys, interviews, or team workshops is recommended. This action would help assess, in a timely manner, less than optimal climate and well-being of employees, thereby allowing corrective measures to be implemented rapidly.

3.3.2 Recommendations for Future Research

First, longitudinal research design should be utilised for future research as this research design analyses change over a period on the same units (Ployhart & Vandenberg, 2010). Self-reported questionnaires were used in the current study, which allowed for the risk of common method variances. A recommendation to improve on this study in future, is to also use multi-rater methods, such as in-depth interviews.

It is recommended that exploratory research be considered to properly understand the concept of authentic leadership. The authentic leadership questionnaire (ALQ) (Walumbwa et al., 2008) has not been developed for the South African context. The poor model fit can be explained by this fact. The findings of this study indicate that authentic leadership does not precede job satisfaction, and ITL. Further research to explore this concept across a wider sample of registered nurses, doctors and other healthcare employees is recommended. The perception of leadership is not viewed as universal; hence, authentic leadership can be seen as a general construct and not a higher order factor (Neider & Schriesheim, 2011). The study should also be expanded to public healthcare institutions in other provinces; to provide a wider sample population from which inferences can be drawn.

3.4. Chapter Summary

In this chapter, conclusions on each of the objectives of this study were provided from an empirical and theoretical perspective. The chapter concluded with the limitations of the current study, as well as recommendations for future research and practice.

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