



ORGANISATIONAL SUPPORT RESOURCES - A PRECONDITION FOR PRACTICING HEALTH PROMOTING LEADERSHIP?

A questionnaire study

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Abstract

The purpose of this study was to investigate if health promoting leadership orientations (*Participative leadership, Developmental leadership, Health oriented leadership*) were associated with organisational support resources among first-line managers in Gothenburg City. This study was conducted with theoretical basis in Kanter's (1993) organisational theory of structural empowerment and Bakker and Demerouti's (2007) job demands-resources model. Additionally, health promoting leadership, transformational leadership and servant leadership was used as foundation to the leadership variables. To investigate the purpose, a cross sectional quantitative research design was chosen, using a web survey with first-line managers in Gothenburg City as participants (n=763, 56% response rate). Most variables were measured with indexes from Gothenburg Manager Stress Index (GMSI). The data was analysed by doing descriptive analysis, bivariate correlation analysis, multiple regression analysis and a hierarchical multiple regression analysis. Through this analysis, organisational support was associated with *Participative leadership* and *Health oriented leadership*. Other forms of organisational support, such as *Health promoting self-leadership* and *Health promoting organisational projects* were also important factors affecting *Health oriented leadership*. In conclusion, well-functioning organisational support resources can give first-line managers more time to practice health promoting leadership orientations and hence increase well-being and health for their employees. The organisational support resources chosen for this study cannot alone explain the variance in the health promoting leadership orientations. Our results reveal that other support resources and structures and to date unknown variables may also play an important role in how to increase the occurrence of health promoting leadership orientations.

Keywords: Organisational support, health promotion, health promoting leadership, first-line managers, employee well-being,

Foreword

The time has come to say goodbye to our academic career, as of now. The process of writing a master thesis was bewildering, filled with frustration and confusion, but also insight and laughter. Several people have helped us in different ways during the semester, and we would like to direct a big THANK YOU to some of the special ones.

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Despite the reputation of Swedes' having a healthy lifestyle, the overall sick leave has increased since 2010 (Försäkringskassan, 2018). The work environment, where individuals spend the majority of their time, has great influence on employees mental, social and physical well-being (Chu, Breucker, Harris, Stitzel Gan, Gu, & Dwyer, 2000). However, some workforces seem to be more affected by the working environment than others. For example, Swedish municipal employees have more extensive sick leave than private sector employees and other public employees (AFA, 2020). This discrepancy is observed in spite of the fact that both private and public sector organisations are obligated to follow the same guidelines and regulations regarding working environment. Organisations are obliged to work systematically with work environment management (SAM) (AFS 2001:1), which addresses how to actively work with accident prevention and health. Since March 2016, the organisational- and social work environment is regulated by Swedish law through specific regulations focusing on managers' demands and responsibilities (AFS 2015:4). To work systematically with work environment management is an established part of the HR role. In recent years the responsibility has grown to include working actively with the organisational- and social work environment regulation. However, there is a call for more preventive work and expanded knowledge both in upper management and for HR professionals in order to actively improve the work environment for all stakeholders (Schmidt, Sjöström & Strehlenert, 2019). In addition, because of these regulations and the higher than average sick leave rates in some parts of the public sector, it is of great importance to investigate public sector employees' well-being and how the work environment can be improved to decrease the sick leave trend.

To find possible explanations for the high level of sick leave, several factors in the work environment has been under scrutiny by researchers. It has been argued that leadership could explain a significant amount of the variation of sick leave in municipalities across Sweden (Dellve, Karlberg, Allebeck, Herloff & Hagberg, 2006) and there is a correlation between leadership behaviours and degree of employee well-being and health (Åkerlind, Larsson & Ljungblad, 2018). Furthermore, leadership level can predict the risk of sick-leave, employees' well-being and job satisfaction (Kuoppala, Lamminpää, Liira & Vainio, 2008). With this background, one could argue that leadership is an explanatory factor of employee well-being and the right leadership could contribute to reduce the sick leave rates for municipal employees. Organisations can approach this by striving to provide health promoting workplaces and developing managers into health promoting leaders. Health promoting leadership consist of components of different leadership styles that enables the leaders to construct health and a health promoting environment in an organisation (Jimenez, Winkler & Dunkl, 2017). Some of

these leadership components are participation, development, relation oriented and serving leadership behaviours, according to Dellve and Eriksson (2016). These leadership orientations are all related to employee health.

However, if leadership is so important for the employees to remain healthy in the workplace, one could ask what the leader requires from their organisations to be able to practice the best, most health promoting leadership. According to a study done by Ledarna (2015), many managers in Sweden lack the organisational support they need to lead in the best way possible. Organisational support is defined as different kinds of support accessible to the manager (from e.g. HR and IT) which enables them to carry out their work tasks and support their employees more successfully. Since health promoting leadership thus influences both the leader's and employees' well-being (Dellve & Eriksson, 2016), it is therefore interesting to investigate if organisational support resources can affect this leadership approach because of its potential in turning the organisation into an overall healthier one.

The aim of the study was therefore to investigate if there is a relationship between perceived organisational support resources and health promoting leadership orientations. The health promoting leadership orientations that were under scrutiny were *Participative leadership*, *Developmental leadership* and *Health oriented leadership*. The study was conducted in collaboration with Gothenburg University and Gothenburg City. The managing role investigated was the first-line manager, because of the close and daily interactions they have with their employees.

Purpose

The purpose of this study was to investigate if health promoting leadership orientations are related to organisational support resources as perceived by first-line managers. The results could provide implications on how to increase the health promoting leadership, which in turn could have the potential to decrease number of sick leave days for public sector workers. Also, there is an interest in studying this area because of organisations' general willingness to have healthy employees.

Research Questions

The following research questions were developed to investigate the purpose of this study;

RQ1: Organisational support

What kind of organisational support resources are perceived by municipal first-line managers?

RQ2. Leadership approaches

What kind of health promoting leadership orientations are approached by municipal first-line managers?

RQ3. Organisational support resources relationship with leadership approaches

Is there a relationship between municipal first-line managers perceived organisational support resources and health promoting leadership orientations (*Participative leadership, Developmental leadership and Health oriented leadership*)?

RQ4. Alternative HR support resources and organisational structures

Is there a relationship between health promoting leadership orientations (*Participative leadership, Developmental leadership and Health oriented leadership*) and other HR support resources and organisational structures?

Research Context

This study has been conducted in collaboration with Gothenburg City and Gothenburg University, in connection to an assessment of first-line managers' organisational preconditions (Dellve, Hasselgren, Allard & Bäck Andersson, 2020). The leadership role under scrutiny is the first-line managers. First-line managers are defined by Hales (2005) as operational managers that are responsible for non-managerial employees on a day-to-day basis. One could claim that line managers serve as a bridge-position between strategic management and the operational business and thus represents a crucial part of the organisation. Investigating if organisational support resources could be a source for improving their skills of leading in a health-oriented way, thus affecting both employees and themselves, should be a priority for organisations wanting to create and maintain a sustainable leadership and optimal leadership conditions.

Contribution to Research

Investigating how first-line managers perceived organisational support resources affects their health promoting leadership strategies, have to the authors knowledge not

previously been studied. There is evidence that points to the fact that public sector line managers could be under more strain than private sector managers (AFA, 2020) which is evidenced by a high turnover rate for managers working in public care- and service organisations (Skagert, Dellve & Ahlborg, 2012). This suggests, that improvements of health promoting efforts, such as working actively with improving health promoting leadership orientations, is needed. The focus of the study is on first-line managers health promoting leadership because of their close daily interaction with the employees. It is therefore believed that first-line managers have the most impact on employees' health.

Furthermore, even if organisational support has previously been investigated in relation to employee commitment, health and job satisfaction, there is to date no research on how organisational support resources can influence various health promoting leadership orientations. Thus, one could assume that organisational support resources will affect first-line managers in the same way as other employees.

This study contributes to research with deeper knowledge of which organisational support resources that can improve health promoting leadership orientations. This study will be valuable to HR professionals because of its aim to investigate what type of organisational support resources that have potential to improve health promoting leadership amongst public sector first-line managers. Further, the chosen topic is unique of its kind and is believed to possibly be of great importance for HR professionals.

Background

This chapter will provide an overview of the study's field of research as well as an insight into its relevance for HR management.

Leadership

Leadership has been thoroughly explored by researchers, especially with regard to determinants for effective leadership (Yukl, 2013). Early studies of leadership focused on different leadership traits, behaviours and power sources in order to determine to what extent the leader was able to influence its followers and fulfil organisational goals (Yukl, 2013). Modern research focused more on behavioural and situational leadership theories and investigated leadership as a shared process in a group or an organisation, and what makes this process effective or ineffective (Yukl, 2013; Alimo-Metcalfe, Alban-Metcalfe, Bradley, Mariathasan & Samele, 2008). Because of its research popularity, there are numerous amounts of leadership definitions. According to Yukl (2013) the most recurring definition of leadership involves a process where the leader influences and guides the followers, structuring work, facilitating activities and building relationships in a team or an organisation (Yukl, 2013). Common for many researchers is that they agree that leadership is of great importance for organisational effectiveness.

Leadership researchers often separate leaders and managers, regarding both values and personalities (Yukl, 2013). Managers focus on stability, efficiency, structuring and order and are more concerned about short-term results and outcomes. Leaders are argued to be flexible, strategic and innovative, caring for both the followers and economic results from a long-term perspective. Leaders are guiding employees towards common goals whilst managers organise work and follow up on the department (Yukl, 2013). In this particular study, the focus is on both leaders and managers. To practice health promoting leadership, one needs to be a manager in order to structurally promote employees' well-being. However, a sustainable health promoting leader needs to actively develop employees and build relationships with them in order to practice a health promoting leadership orientations.

Workplace Health Promotion

Health promotion is *“the process of enabling people to increase control over, and to improve their health”* (WHO, n.d.). WHO is actively working with health promotion through three main strategies; advocate (spread knowledge and emphasises factors that encourage

health), enable (providing access to all people to achieve health equity) and mediate (promote collaborations between sectors to enable above strategies) (WHO, n.d.). According to the Luxembourg Declaration (2007), Workplace health promotion (WHP) is the society's, employers' and employees' combined efforts to improve the employees' health and well-being. To achieve WHP, the employer should promote active participation, improve work environment and encourage employees' personal development. This in turn will lead to reduced costs related to sickness, an increased productivity within the organisation and the workforce will become healthier and more motivated (Luxembourg Declaration, 2007). Furthermore, empowerment is important when working with health promotion. Leaders facilitating employees' skill and knowledge development strengthens the employees' self-esteem and self-efficacy (Torp, Eklund & Thorpenberg, 2011). Improving employees' knowledge of health and their skills to manage health in combination with having a health promoting work environment will benefit both employees and the organisation itself (Breucker et al., 2000).

Regulations and Guidelines of Workplace Health Promotion

As mentioned, the Swedish Work Environment Authority has provided organisations with guidelines for working with systematic work environment management (SAM) (AFS 2001:1). The aim of these guidelines is to prevent accidents, illness and to achieve a satisfactory and safe work environment for every employee in an organisation. In March 2016, provisions regarding organisational and social work environment were implemented, which are regulated by Swedish law (AFS 2015:4). The provisions regulate managers knowledge requirements regarding health promoting aspects and preventive work. The regulations include organisational work environment aspects, such as managers' direction and governance, communication, participation, workload, distribution of work tasks, demands and resources. Additionally, social work environment regulations, such as collaborations, social interactions, victimisation and support from managers and colleagues (AFS 2015:4).

The employer is responsible for ensuring that the provisions are followed, by systematically planning and organising the work to facilitate good working conditions for the employees. Moreover, the employer has to ensure that managers have knowledge about how to work preventively and health promoting, and also how to apply this knowledge in practice in their daily work (AFS 2015:4). Managers' responsibility for the work environment implies that proper organisational support is crucial to be able to successfully manage it. Since HR often is the organising component of working with organisational and social work environment, it is of

importance for HR practitioners to gain knowledge of how managers health promoting leadership orientations can be developed through various organisational support resources.

Organisational Support

It has been established that leadership has a great impact on employees' health (Skakon, Nielsen, Borg & Guzman, 2010), meaning that the manner in which managers act, support and lead their employees effects the employees' well-being, and in turn their work outcomes. Managers' main task is to make sure their subordinates have the best resources, support and guidance to best succeed in their daily tasks and careers. However, these requirements can be challenged by the high demands and hectic schedule that is generally associated with a managing position. According to a study by Nyberg, Leineweber & Hanson (2015), using data from the Swedish Longitudinal Occupational Survey of Health (SLOSH), many leaders experience high job demands and disruptions between their work and family life. Furthermore, participants reported a higher number of psychosocial stressors in the public sector than the private (Nyberg, Leineweber & Hanson, 2015). Some of the work challenges first-line managers possibly face on a regular basis are; to act as a bridge between higher and lower levels, to deal with various employee issues e.g. lack of engagement and collaborative difficulties, dealing with lack of resources and time management (Dellve & Eriksson, 2016).

To cope with these strains, it is important to define the support managers need. To this day, there are very few studies about the importance of support for leaders (Dellve, Andreassen & Jutengren, 2013). Studies have shown that when the preconditions for leading are not sufficient, the significance of leadership styles decreases (Cummings, MacGregor, Davey, Wong, Paul & Stafford, 2008). In other words, proper conditions need to be developed for the leader in order to lead successfully. Managers need support through proper introduction to work tasks and continuous support through education and interactions with more experienced colleagues from other areas. To make this possible, organisational support resources must be well functioning (Dellve & Wolmesjö, 2016). Some organisational support resources within organisations are;

- Access to administrative support functions
- Access to HR support when needed
- Rules, policies and regulations that provides support in the managing role
- Role clarity, such as clear responsibility, assignment and capacity of the managing role
- Access to support by professional experts when needed.

There is scarce research on what effect different kinds of support has on managers and what the important sources for support are. However, general social support to managers has been studied and correlated with e.g. lower levels of stress (Lindholm, 2006) and informal learning at work (Ouweneel, Taxis, Van Zolingen & Schreurs, 2009).

Studies of municipalities in Sweden states that leaders are missing structural multifold support from the organisation regarding e.g. HR, IT and administrative services (Dellve & Wikström, 2009; Wikström & Dellve, 2009). The latter may demand much time and hinder the manager from leading employees to solve IT problems or administration. In fact, leaders with higher levels of organisational support are less stressed (Hagerman, Engström, Häggström, Wadensten & Skytt, 2015, 2019; Hagerman, Skytt, Wadensten, Högberg & Engström, 2016), experience less value-conflicts and rates more increased improvement-work of the service (Dellve & Wolmensjö, 2016).

The HR Role in Enabling Organisational Support

As stated above, a variety of organisational support resources are crucial for managers to cope and handle the challenges of a managing position. The Human Resource (HR) function is normally the department that holds the threads for all kinds of organisational support. HR is responsible for recruiting and being in contact with inhouse and external personnel that could assist the managers in various fields, e.g. IT, Admin and Payroll. Furthermore, HR supports managers regarding recruitment, labour law, rehabilitation, employee management and other personnel related questions (Corin & Björk, 2017). Furthermore, HR is also responsible for ensuring that these resources are accessible for the managers through e.g. providing the resource staff with proper training. Competence development is also a main part of HR's work including teaching and supporting leaders in how they can lead in the best possible way (Boxall & Purcell, 2016). This support should be given to all managing levels, and can affect how lower level managers perceive the support and clarity in their own role and responsibilities. Additionally, HR also plays an important role in developing policies and regulations in the organisation, especially concerning how to best support the managers in their role.

Theoretical Framework & Previous Research

In this chapter theories and previous research will be provided and applied to the variables. First, organisational support theories will be presented with accompanying previous research, followed by the organisational support variables. Second, leadership theories will be presented together with relevant previous research. Lastly, variables related to leadership orientations will be presented.

Organisational Support

In this section, theories related to organisational support and previous studies on the topic are presented. A clarification of the bridge between theory and the chosen variables is provided, followed by the organisational support variables.

Structural Empowerment

Kanter (1993) was one of the first researchers to give empowerment scientific attention. She views empowerment as being determined by organisational characteristics and represent the social-structural perspective to view empowerment. There are both formal and informal factors in an organisation that affects empowerment, such as personal relationships in the workplace, access to information and job characteristics (Orgamibídez-Ramos & Borrego-Alés, 2014). Access to or status of these formal and informal factors, determines if the employee is encouraged and feels empowered or constrained (Kanter, 1993).

The theory revolves around the concept of power. Power is defined as “*the ability to mobilize resources to get things done*” (Kanter, 1993, p. 210). This power can reach the individual through a set of “lines”, e.g. support, information and opportunities to evolve in their role. If the power is on, the employee has access to these lines which enables the individual to work effectively. If the power is off, empowerment cannot be reached. There are different forms of this power in organisations, informal and formal power. Informal power is strong when employees have good relationships with co-workers and superiors. A high degree of formal power indicates that the employee has a position regarded as central to the organisation, is highly visible and generally known by other employees and has capacity to manage their own work. Having high levels of both power forms facilitates the power “lines” and enables the creation of a higher degree of meaningful work for the employee. Informal power stems from continuous social relations in the workplace, their development and the communication routines. The job design of the employees’ position, like certain job characteristics and

centrality to the organisational purpose and goals determines what degree of formal power is present (Kanter, 1993).

As mentioned, the degree of structural empowerment is dependent on the access to power structures, these being:

Access to opportunity; having the possibility to grow, i.e. to be able to develop skills, attain new knowledge and have access to movement within the organisation

Access to resources; refers to the ability to acquire financial means, materials, time and supplies required to conduct a good job

Access to information; means having the right and necessary information required to conduct the job effectively (e.g. knowledge of policies, programs etc.)

Access to support; from superiors, peers, and subordinates, both for feedback and guidance (Kanter, 1993).

At the core of the structural empowerment theory, there is an idea of power in an organisation being shared and that all employees, non-dependent of level, are structurally empowered and can make decisions in accordance of their position. To achieve this, employers have to give the employees the opportunity to access to the power "lines" through e.g. education and flat organisational structures (Spreitzer, 2008).

Previous Research on Structural Empowerment. Structural empowerment is a well-researched area, especially in the nursing community. According to several studies, there are positive outcomes to gain from being structurally empowered. A longitudinal study by Laschinger et al. (2004) investigated nurses' job satisfaction with a structural empowerment perspective. The job satisfaction decreased when perceived access to structural empowerment "lines" changed, supporting that this form of power effects job satisfaction overall. The statement is also supported by another nurse study by Laschinger et al. (2001).

Furthermore, structurally empowered nurses are more likely to be committed to their organisation. This was concluded from a study that has found a positive relationship between job-related empowerment and their self-assessed commitment to the organisation (McDermott, Laschinger, & Shamian, 1996). Additionally, a study has investigated structural empowerment as a mediator between authentic leadership and e.g. job performance and job satisfaction (Wong & Laschinger, 2013). This opens up for studying structural empowerment in connection to other types of leadership, as in this study.

Job Demands-Resources Model

Job characteristics has been established to have an impact on employees' well-being. The majority of research in this area has been grounded in two theoretical models; the demand-control model (DCM) (Karasek, 1979) and the effort-reward imbalance model (ERI) (Siegrist, 1996). The demand-control model for stress management shows that the interaction of job decisions and job demands predicts mental strains for employees. This model was later further developed by Karasek and Theorell (1990) through including support. The effort-reward imbalance model focuses more on the employees' rewards, not the control and structure of the work (Siegrist, 1996). Bakker and Demerouti (2007) argued that the two models are limited because of the predicting variables used in the models are argued to not be relevant for all industries and job positions. Because of these limitations, Bakker and Demerouti (2007) developed their own model, the job demands-resources model (JDR-model). In contrast to previous models which mostly focus on the negative outcome variables, the JD-R model incorporated more working conditions, both positive and negative indicators of well-being. The JD-R model focuses on improving employee performance and well-being and can be applied on many occupational positions, according to Bakker and Demerouti (2007).

Furthermore, the model is based on the assumption that every profession has specific risk factors connected to job stress. According to the model, those factors can be clustered into either job demands or job resources (Bakker & Demerouti, 2007). Job demands are different aspects of the job such as physical, psychological, organisational and social. All of which require sustained cognitive or emotional skills and efforts which results in physiological and psychological costs for the employee. If job demands require high levels of efforts, the demands can develop into job stressors. High work pressure, demanding interactions with external clients and a bad physical environment are some examples of job demands (Bakker & Demerouti, 2007). Job resources are the physical, psychological, organisational or social aspects of the job that are functional in reaching work goals, stimulating learning, personal development and the individual's growth. Therefore, job resources reduce job demands and both physiological and psychological costs. Job resources are located at three different levels. Firstly, in the organisation, such as pay and career opportunities. Secondly, at the interpersonal and social such as support from manager and co-workers. Thirdly, the organising of work regarding role clarity and participation. Finally, job resources include job autonomy, task significance and feedback on performance at task level (Bakker & Demerouti, 2007).

Job Demands-Resources and Health Promoting Leadership. Health promoting leadership is a critical aspect in order to promote well-being and reduce risk factors in an organisation (Dellve & Eriksson, 2016; 2017). To carry out a health promoting leadership, it is important that the leader has the right preconditions and resources. Demands and resources can, according to Dellve and Eriksson (2016; 2017), have an impact on the leaders' sustainability and their motivation to be good leaders and in turn impact the organisational outcomes. Dellve and Eriksson (2016; 2017) have applied Demerouti and Bakkers (2007) job demands-resources model into a system-theoretical framework focusing on the leaders' preconditions and practice to carry out a sustained health promoting leadership. The model is based on a review of research of leaders in the public sector, their preconditions and challenges with the preconditions.

Furthermore, challenges can be a lack of employee engagement, goal unclarity, and collaboration problems within the team (Dellve & Eriksson, 2016). According to their framework managers need well-functioning and close organisational support resources in order to handle the challenges in a sustainable way.

Organisational Support Resources Variables

Leadership has been argued to have a determining impact on the health and well-being of the employees (Skakon et al., 2010). However, in order to handle challenges in a sustainable way and to carry out a sustainable leadership, the leader needs access to various types of well-functioning organisational support (Dellve & Wolmesjö, 2016). Managers that are new in their roles and have poor organisational preconditions, e.g. such as a high number of subordinates, need such support to maintain their own health (Dellve, Andreasson and Jutengren, 2013). As stated earlier, access to administrative support functions, professional experts and HR department when needed are important organisational support resources. Furthermore, role clarity such as clear responsibilities in the managerial role and rules, policies and regulations that provide support to the leader, are also important resources (Dellve & Eriksson, 2017).

With this background, the variables in this study have been developed to investigate if the chosen organisational support resources can improve different leadership orientations, that in the long-term could improve employees' well-being. Therefore, the organisational support resources mentioned in Dellve and Erikssons (2016; 2017) framework have set the foundation for the organisational support variables used in this study. They were as following;

Administrative support. Administrative support is often referred to as support from administrative staff available for the managers, handling daily work tasks, e.g. scheduling,

coordination of staff and meetings. Administrative support functions can be both full time or part time employees supporting the managers. The quality of support is a determining factor to what extent the support is helping and unburden the managers (Corin & Björk, 2017). Other administrative functions within the organisation are the IT and financial department, supporting managers daily work with challenges regarding technology, purchases and financial planning (Corin & Björk, 2017).

Human Resource support. Human Resources (HR) is regarded as an important support function for managers, supporting the managers' daily work in regard to recruitment, labour law, rehabilitation and other personnel related questions (Corin & Björk, 2017). Because of the HR departments' work tasks development into more strategic ones, the managers' need for operational support is increasing. Managers need more HR support to be updated, and to follow the labour law and organisational processes (Thilander, 2013). The need for HR support stems foremost from the managers lacking both time and competencies to work with employee related questions (Nehles, van Reijmsdijk, Kok & Looise, 2006).

Trusting collaboration with resource functions. Organisational support and support from top management are found to have a positive influence on leaders own health and their engagement in organisational development (Dellve & Wolmesjö, 2016). Support in regard to organisational development includes a trustful collaboration with organisational support functions within the organisation and mostly with operation developers and improvement leaders, leading change and development (Dellve & Wolmesjö, 2016).

Organisational rules, policies and regulations. Dellve and Wolmesjö's (2016) study showed that rules, policies and regulations within the organisation can provide support to managers and give clarity on what regulations the manager have to relate to. In order to carry out a sustained leadership, especially among managers experiencing work-overload, such organisational support through rules, policies and regulations are invaluable (Dellve & Wolmesjö, 2016).

Role clarity. Researchers have defined role clarity as to which extent the leader has access to sufficient information in regard to how to perform their job (Kahn, Wolfe, Quinn, Snoek & Rosenthal, 1964). The more information the manager receives about their role, job and responsibilities the more it will decrease the managers' perception of uncertainty. Managers lacking clarity in their role and work tasks can be hindered to fulfil their job, mostly because of them not knowing the boundaries of the requirements which can compromise the quality of their work (Corin & Björk, 2017).

In this study, the perceived access to organisational support is similar to having access to the power structures mentioned in Kanter's organisational theory of structural empowerment (1993). Having access to opportunity can be interpreted as having access to implicit *HR support* with self-development. Furthermore, access to resources is reached through having a clear managing role and good knowledge on what capacity can be reached with the available resources (Kanter, 1993). The resources can be *Role clarity, Administrative support* and *Trusting collaboration with resource functions*. Access to information can be interpreted as having access to *Organisational rules, policies, and regulations* that facilitates' your leadership. Access to support can be interpreted as both *HR support* and *Administrative support*.

The JD-R model is focusing on improving employee performance and well-being, therefore it is also important for managers to improve their leadership approaches to support their employees, but also their own sustainability (Bakker & Demerouti, 2006).

Health Promoting Leadership Orientations

In this section, theories related to health promoting leadership are presented, previous studies are reviewed and a clear bridge between theories and the chosen variables are presented.

Leaders have a crucial role in creating an environment where employees can develop and experience high levels of well-being (Nielsen, Yarker, Brenner, Randall & Borg, 2008). These positive outcomes can be achieved by adopting a health promoting leadership, a process where leaders positively influence health by designing the work environment accordingly (Jiménez, Winkler and Dunkl, 2017). Leaders adopting a health promoting leadership could impact their employees' health and well-being positively (Dellve & Eriksson, 2016). The leaders' awareness of the employees' health is important to carry out a health promoting leadership, meaning the leaders approach and general attitude towards health is a key factor (Jiménez et al., 2017). Developing and maintaining a relationship with the employees is important when practicing health promoting leadership. This can be done through e.g. being present, participative, relation oriented and honest. Some of these leadership orientations have proven to have strong relationships with employees' well-being and work engagement. Furthermore, the concept of health promoting leadership is a combination of different leadership behaviours rather than a single leadership style (Jiménez et al., 2017). Transformational-, servant-, participative- and developmental leadership are according to Dellve and Eriksson (2016) health promoting leadership orientations that facilitates and

supports well-being in an organisation. In this study, transformational- and servant leadership was chosen as theoretical framework for the health promoting leadership orientations. These leadership styles are the foundation to two of our leadership variables and are found to have a positive impact on employees' health (Nielsen et al., 2008; Rivkin, Diestel & Schmidt, 2014).

Transformational Leadership as Health Promoting

In 1978, leadership was divided into two leadership styles by Burns (1978), transactional and transformational leadership. Transactional leaders are, according to Bass and Riggio (2006), characterised by leading by social exchange, trading one thing for another in return. One example of a transactional leadership behaviour is rewarding followers financially in return of productivity. Transformational leaders on the other hand, stimulate and inspire their followers to achieve better outcomes and at the same time develop their own capacity for being a leader (Bass & Riggio, 2006). Facilitating the followers' own growth and development through setting individual goals for the followers, the team and the organisation are transformational leadership traits. Transformational leaders inspire and motivates the followers and make the followers self-interested in both the team and the organisation (Yukl, 2013). Furthermore, transformational leaders inspire followers by being challenging and persuasive and at the same time giving the followers understanding and meaning in their work, functioning as a mentor or coach. Followers to a transformational leader feel trust, respect and are loyal towards the leader and are motivated to perform above their own expected ability (Bass & Riggio, 2006).

Yukl (2013) describes four stereotypical behaviours of transformational leaders. The first one is intellectual stimulation, the leader influence the followers to view problems in a different way in order to find creative solutions. The second one, idealised influence, making the followers identify themselves with the leader by setting an example which shows courage and dedication for self-sacrifice in order to benefit the followers and the organisation. The third behaviour is individualised consideration, giving the followers support, encouragement and being a coach and mentor for them. The last one, inspirational motivation, includes communicating an appealing vision to help the followers focus their efforts in the right direction (Yukl, 2013).

Previous Research on Transformational Leadership as Health Promoting. Transformational leaders create a perception of a meaningful and good work environment for

the followers and according to Nielsen et al. (2008), transformational leadership has a positive correlation with employees' well-being. According to Franke and Felfe (2011), followers to transformational leaders can short-term increase their health by having a higher level of self-efficacy and long-term by leaders being considerate for every individual in the team. In contrast, it is argued that there is a backside to transformational leadership. Leaders can use their skills in a way that result in selfish and destructive outcomes, inspiring the followers to carry out the leaders' personal evil ends (Yukl, 2013).

Moreover, leaders are most often a combination of leadership approaches, different leader dimensions complement one other and therefore, leaders who combine different leadership dimensions are the most effective. Judge and Piccolo (2004) argue that transformational leaders complement their leadership approach with transactional in order to be more effective.

Servant Leadership as Health Promoting

Servant leadership was established in the 1970's by Robert Greenleaf, and has the past 20 years become an increasingly popular leadership field of study (Day, Liden, Panaccio, Meuser, Hu & Wayne, 2014). It is considered to be more of a philosophy than a leadership style, a philosophy one can implement in both private- and working life (Greenleaf, 1970). The philosophy revolves around the leader being first and foremost a servant for the followers, sharing power instead of exercising it, a feature different from more traditional leadership styles. The servant leader puts all their efforts into strengthening their followers' well-being and development. Their ultimate goal is to help individuals reach their full potential and perform as good as possible (Greenleaf, 1970).

Some characteristics connected to servant leader has been appointed by Larry Spears, a researcher who spent most of his working life reviewing Greenleaf's original texts (Spears, 2004). These characteristics are;

Listening: the servant leader has excellent communication skills, and is decisive on what direction the following group should move towards. These skills stem from first and foremost being able to carefully listen to the followers will, both individually and as a group. This paired with time for reflection is essential for a servant leader.

Empathy: a servant leader always strives to understand and empathise with the followers. Acceptance and assuming good intentions are key.

Healing: with acceptance comes healing. Servant leaders have the ability to heal others and themselves on the united journey forward, together searching for their emotional wholeness.

Awareness: this characteristic is both in regard to self-awareness and general awareness, which aids the servant leader to gain a more holistic view on situations.

Persuasion: “the servant leader is effective at building consensus within groups” (Spears, 2004, p. 9) and is what sets them aside from traditional leadership styles that seek to obtain compliance.

Conceptualisation: being able to conceptualise dilemmas and stay close to the everyday operations is a constant struggle for the servant leader, capable of both.

Foresight: the ability to connect past, present and future consequences to make the best decision is essential to the servant leaders.

Stewardship: this characteristic emphasises the leaders’ role to take responsibility for the team regardless of what role they possess in the organisation.

Commitment to the growth of people: the servant leader believes all individuals has potential to grow and constantly tries to nurture all followers’ personal development.

Building community: Lastly, building community within the institution where the servant leader is active is important for the servant leader, for all followers to be a part of something greater (Spears, 2004).

Previous Research on Servant Leadership as Health Promoting. Greenleaf himself theorised that servant leadership would be associated with multiple positive outcomes, a successful servant leader would ultimately lead to personal growth in the follower. This growth would lead to healthier, wiser and freer followers with an increased sense of autonomy (Greenleaf, 1970). Servant leadership has been a popular leadership approach since Greenleaf’s publications, but still very little empirical evidence is to be found about positive consequences of servant leadership. Some studies reported to have come to the conclusion that servant leadership is positively related to overall well-being and negatively related to psychological strain, therefore being a determinant for psychological health (e.g. Rivkin, Diestel & Schmidt, 2014). Another study concluded that servant leadership was positively related to high levels of work engagement and life satisfaction (Upadyaya, Vartiainen & Salmela-Aro, 2016). Servant leadership has also been researched to be connected to job satisfaction, through satisfying followers needs (David, Bardes and Piccolo, 2008).

When Greenleaf wrote the original texts about servant leadership, he warned the research community that it would be hard to operationalise and apply it. Instead, he encourages the reader to reflect and then make your own assumptions, and through that grow (Greenleaf, 1977). So, one could claim that the theory is still not elaborated and the definitions remain vague (Anderson, 2000).

Health Promoting Leadership Variables

Because of the general difficulty to study leadership styles as a whole, the choice to study certain dimensions at play in servant and transformational leadership was made. There are several similarities between transformational and servant leadership, e.g. adopting a participative approach, i.e. to be highly involved in each follower. Also, the will and effort to encourage and develop the follower is present within each leadership theory. Being participative and developmental leaders are main ingredients in both servant- and transformational leadership. This study contributes to knowledge by investigating how applying these orientations in leadership practice, are affected by support to the first-line manager from its organisation.

Furthermore, a new leadership orientation has been constructed, grounded in health promoting leadership research; *Health oriented leadership*. This variable has a close connection to health promoting leadership and concerns finding a balance between demands and resources.

Participative Leadership. In both servant- and transformational leadership, participation is an important element. In these theories, participation includes inviting the followers to participate in the managers' work, ask for followers' opinions and showing trust and confidence in their opinion. Koopman and Wierdsma (1998) described participative leadership as joint, or closely shared influence, decision-making process between a superior and an inferior. The manager is thus involving the employees in the decision-making process, information flow and other important matters. Participation is a natural part of managing positions, but the extent of how much a manager can work participative can depend on what the organisational preconditions.

Research has found multiple good outcomes of leaders applying a participative leadership style. It is considered to be one of the leadership orientations that has a close connection to employee sustainability and work engagement (Aronsson et al, 2012). In a recent study done by Chan (2019) on retail workers in Hong Kong, participative leadership was

positively related to employees' job satisfaction and work engagement. Participative leadership has also been positively related to affective and normative commitment in a study on civil servants in China (Miao, Newman, Schwarz and Xu, 2013). Additionally, quantitative reviews have demonstrated moderate positive relationships between participative leadership and employee turnover and performance (e.g. Miller & Monge, 1986).

Leaders approaching a participation strategy is strongly connected to employees' overall well-being and work engagement (Dellve & Eriksson, 2016; 2017). Participation can also be interpreted as being a part of Antonovsky's "Sense of Coherence" (SOC). In order to feel the parts of SOC, meaningfulness, comprehensibility and manageability, the leader must encourage the employees to participate in their work. High levels of SOC is related to overall good health, according to several studies (e.g. Eriksson & Lindström, 2007; Nilsson, Leppert, Simonsson & Starrin, 2010).

In contrast, other studies failed to find a statistically significant relationship between participative leadership and positive outcomes such as employee commitment (e.g. Cotton, Vollrath, Froggatt, Lengnick-Hall & Jennings, 1988). This can be interpreted as an argument that several aspects need to be in place for an employee to experience the previously mentioned positive outcomes, not just participative leadership.

To the authors' knowledge, *Participative leadership* has not previously been studied in connection to organisational support resources.

Developmental Leadership. Developmental leadership is defined as the process in which the leader supports employees to develop knowledge and skills through goal setting and encouragement (Zhang and Chen, 2013; Gilley, Shelton & Gilley, 2011). Behaviours connected to developmental leadership are individualised consideration, coaching, counselling, providing feedback and offering employees opportunities to grow and develop (Zhang & Chen, 2013; Gilley, Shelton & Gilley, 2011). Developmental leadership is an important ingredient in how leaders can influence and improve employees' health and well-being (Dellve & Eriksson, 2016). In previous studies, the leadership orientation has been investigated without labelling it as developmental. Transformational leadership is one example of a leadership theory that is considerate of the individuals needs in order to develop employees and help them achieve better outcomes (Zhang & Chen, 2013). A developmental leadership approach can strengthen the employees' well-being and engagement by enlightening employees' awareness of goals and values (Bass & Riggio, 2006).

Researchers have proposed that developmental leadership has its roots in transformational leadership, since both leadership approaches develops employees' skills and self-efficacy (Rafferty & Griffin, 2006). Individualised consideration, one dimension of transformational leadership, has been compared to developmental leadership, since it is a development orientation of the employees (Rafferty & Griffin, 2006). The dimension includes individualised employee consideration, counselling, encouraging and supporting the employees in order to develop and improve the employees' performance (Yukl, 2013). In a study by Rafferty and Griffin (2006), developmental leadership had a strong impact on employee commitment and job satisfaction. Research has proposed developmental leadership skills, such as consideration and response to individuals needs and the ability to motivate employees, to be leadership behaviours effective in a change process (Gilley, McMillan & Gilley, 2009).

Developmental leadership behaviours can also be found in servant leadership. An important characteristic in servant leadership is the urge to develop followers and support them in this development by having consideration for every individual. Both developmental and servant leaders provide clear visions and work with goal setting in order to achieve higher performance (Greenleaf, 1970; Zhang & Chen, 2013).

Because of there being a limited amount of research on developmental leadership as a concept, it is interesting to investigate further, since research suggests that it is related to employee health and well-being. In this study, *Developmental leadership* will be investigated further in relation to organisational support resources.

Health Oriented Leadership. Health oriented leaders are focusing on supporting employees to balance demands and resources in order to individually adjust the work tasks and workload according to the employees' capacity, which can lead to improved working conditions (Dellve et al., 2020; Strömberg, Dellve & Eriksson, 2017). They are responsive towards employees' signals of work overload and create working conditions that facilitate the employees' opportunities to adjust their own work (Dellve et al., 2020).

The concept of health oriented leadership is the foundation to health promoting leadership according to Franke, Felfe and Pundt (2014). A health oriented leadership approach includes health specific behaviours, designing good working conditions and highlights the leaders own values and awareness of the employees and organisations health (Franke, Felfe & Pundt, 2014). The leadership orientation focuses on follower-directed health promotion and self-directed health promotion, in other words encompasses both employee care and self-care of the leader and the follower. Employee care is defined as an external resource, having health

promoting working conditions in combination with supporting the employees to promote their own well-being. Self-care, on the other hand, is an internal resource, the individuals' ability to promote their own health by handling job demands and support health promoting working conditions (Franke, Felfe & Pundt, 2014).

Health oriented leadership is strongly related to servant leadership in regard to servant leaders' priority to serve their followers and to adjust in accordance to their needs. The concept of health oriented leadership is a rather new research area, therefore it is of interest to investigate if different organisational support resources can promote *Health oriented leadership*.

Method

In this chapter, the methodology will be presented in detail. First, the study design and study setting will be presented followed by a presentation of the sample. The data collection method and the study's variables will be provided and lastly the analysis process and ethical considerations will be addressed.

Study Design

The purpose of this study was to investigate if health promoting leadership orientations are affected by organisational support resources as perceived by first-line managers. In order to investigate this purpose, a quantitative research design was chosen. A quantitative approach was suitable because of the relationship-based nature of the research question (Blaikie, 2003). The overall research question was descriptive, in order to provide descriptive answers and measurement of the characteristics of our population and our research problem (Blaikie, 2003). To investigate our research problem in depth, the choice to include four research questions was made. The first two research questions are of descriptive nature (Blaikie, 2003) and were included to understand the populations' current situation. Research question three focus on the relationship between organisational support and the health promoting leadership orientations. Lastly, the fourth research question was developed to include other HR-related support resources and structures, potentially affecting the health promoting leadership orientations. This was done with the purpose of exploring other variables that potentially had an impact on the health promoting leadership orientations, to better understand how these can be improved.

A web survey was chosen as method for data collection. It was of cross sectional nature, meaning the information was gathered one time by a sample that was drawn from the population at one time (Shaughnessy, Zechmeister & Zechmeister, 2014). The choice of doing a web survey was based on its convenience, both for the researcher and the participants. The advantages of using internet based surveys are many; costs are kept low, it is environmentally friendly and respondents can choose an appropriate setting that suits them to best answer the questions in the survey (Bryman, 2011; Shaughnessy, Zechmeister & Zechmeister, 2014).

Study Setting

The study was conducted in a collaboration with the City of Gothenburg and Gothenburg University, with the objective to assess first-line managers perception of organisational preconditions, support, resources and leadership orientations before an

organisational restructuring (Dellve et al., 2020). This study was conducted in order to provide deeper knowledge, focusing on organisational preconditions for health promoting leadership. All participants were permanent full-time first-line managers within the sectors undergoing restructuring. Furthermore, the focused sectors, in Gothenburg City and other cities/municipalities, are facing challenges concerning tending to a growing need of service in the human service areas and challenges with recruitment and improvement of service. The collaboration was formed with hopes of result in valuable learnings to increase their employer attraction and to address these challenges. This setting was chosen since the research questions was directed to investigate public sector first-line managers.

Sample

Sample Strategy

In this study, the sample consisted of all first-line managers within selected sectors in Gothenburg City. The sectors were as following; Elder care, Disability, Administrative and supportive departments, Social work, Culture and Children and leisure. These sectors were selected as they were all undergoing an organisational restructuring. All first-line managers were asked to participate in order to provide them a possibility to describe their situation. This resulted in a total sample of the selected population, meaning that every unit in the population had the possibility to participate in the study (David & Sutton, 2016). This strategy was chosen to achieve maximum number of participants and a high response rate (Bryman, 2011).

Population

The selected population was all permanent full-time first-line managers in the selected sectors in Gothenburg City by February 2020. The survey was sent out to 736 number of employees and 412 employees participated. The response rate was 56%, which is considered to be acceptable (Blaikie, 2003). There were 319 managers who chose to not answer the survey, whilst five notified the researchers they were not a part of the selected population. Out of the first-line managers, 333 were women (80.8%) and 79 were men (19.2%). The age ($M = 49.75$, $SD = 9.2$) of the participants varied between 28 and 69, with a majority of them being over 46 years old (68.45%). The participants worked across six different sectors. The sector with most participants was Elder care ($N = 143$) and Children and leisure activities was the one with the least participants ($N = 2$). Table 1 displays a distribution of participating managers with respect to sector.

Table 1*Distribution of Population, Participants and Response Rates Across Sectors*

	Total	Participated	Response rate
	<i>N (%) Mean value (SD)</i>	<i>N (%) Mean value (SD)</i>	<i>(%)</i>
Total	736	412	56.0
Women	597	333 (80.8)	55.8
Men	139	79 (19.2)	56.8
Age	49.8	49.8 (9.2)	
Sector			
Elder care	259	143 (34.7)	55.2
Disability	184	107 (26.0)	58.2
Administrative & Supportive departments	110	64 (15.5)	58.2
Social work	155	83 (20.1)	53.5
Culture	19	13 (3.2)	68.4
Children and leisure	9	2 (0.5)	22.2

Data Collection

As previously stated, a web questionnaire was chosen as data collection method. Data for the study was collected from a larger survey in collaboration with researchers from Gothenburg University. The full questionnaire therefore contained more variables and measurements than related to the present study. In the full questionnaire, primary data was collected through 214 questions of both closed, open and Likert scale sort. The questionnaire was structured in an understandable way, using clear sentencing and an appropriate level of language (Bryman, 2011). The questionnaire was created and distributed to the participants through the software Qualtrix. The part of the questionnaire relevant for this study's' purpose and research questions consisted of 29 questions, the majority of them being Likert scale questions collected from instruments presented below, but also included demographic questions and closed questions.

Procedure

The questionnaire was sent out by the researchers to the chosen population in February 2020. All first-line managers in the population were asked to participate in the web questionnaire. The estimated response time was informed to be approximately 15-30 minutes and the distributing software Qualtrix accepted answers via both computers and mobile phones. The web survey was open during the first three weeks of March 2020 and three reminders was sent out to the participants during this time in order to increase the possibility of a high response rate. Information regarding the survey was distributed by the employer on the internal intranet and in the emails sent out to the participants. The information included the research purpose, the procedure and how the results would be reported back to the respondents and used in research. All of the participants were informed that participation was optional and could be ended at any time without reason. Additionally, contact information to responsible researcher at Gothenburg University was given.

Instrument and Variables

The part of the questionnaire relevant for this study consisted of questions mainly collected from Gothenburg Managers Stress Inventory (GMSI) (Eklöf, Pousette, Dellve, Skagert & Ahlborg, 2010). GMSI is an instrument with an extensive number of questions that was originally intended to measure results from interventions focusing on reducing managers' stress levels and develop their ability to perform a health promoting leadership in an effective way (Eklöf, Pousette, Dellve, Skagert & Ahlborg, 2010). The instrument has been developed through several pilot studies through which the number of questions and scales were reduced in order to reach highest possible content-, face validity and reliability. The instrument has been used in many earlier studies as a whole or selected index since its publication, which also has assured the instruments' high reliability (Eklöf, Pousette, Dellve, Skagert & Ahlborg, 2010).

Organisational Support Resource Variables. The predictor variables that together form the index of organisational support was measured with GMSI (Eklöf, Pousette, Dellve, Skagert & Ahlborg, 2010). The instrument questions were in Swedish and was measured only on Swedish employees in Swedish. The following English translations were formulated for the sake of clarity for the reader of this study. The questions were answered on a five point Likert scale. The organisational support index (Cronbach's alpha 0.7) was made up of five questions regarding different types of support. They were as following;

Administrative support: “I have a trusting cooperation with *Administrative support* functions in my managing position/my leadership” (“Jag har ett förtroendefullt samarbete administrativa stödfunktioner i mitt chefs-/ledarskap”).

Human Resource support: “I have a trusting cooperation with the human resources department” (“Jag har ett förtroendefullt samarbete med personalavdelningen”).

Trusting collaboration with resource functions; “I have trusting cooperation with organisational resource functions (i.e. operations developer, improvement leader or similar) in my operational development work” (“Jag har ett förtroendefullt samarbete med resurspersoner (s.k. verksamhetsutvecklare, förbättringsledare (eller motsvarande) i arbetet med verksamhetsutvecklingen”).

Organisational rules, policies and regulations: “Rules, policies and routines offer my support in my managing position” (“Regler, policys och standardisering ger gott stöd för mig i min chefs-/ledarroll”).

Role clarity (Clear responsibility, assignment and capacity): “My responsibilities and assignment as a manager is clear and defined” (“Mitt ansvarsområde och uppdrag som chef/ledare är tillräckligt tydligt och avgränsat”).

Leadership orientation variables. The questions regarding leadership orientations were collected from GMSI, except the index of *Health oriented leadership* which was developed based on previous studies, to better grasp important aspects of health focusing approaches.

Participative leadership: The index *Participative leadership* (Cronbach’s alpha 0.86) consisted of four questions that was answered on a five point Likert scale. The questions were as following; “I let the staff participate/take part of in decision-making” (“Jag låter personalen få vara med och bestämma”), “I ask my co-workers for advice and opinions” (“Jag ber medarbetare om deras synpunkter och idéer”), “I give my co-workers the opportunity to affect the design and future of the business” (“Jag ger medarbetare möjlighet att påverka verksamhetens utformning och framtid”) and “I express that I trust my employees ability to take responsibility” (“Jag visar medarbetare att jag litar på deras förmåga att ta ansvar”).

Developmental leadership: The index *Developmental leadership* (Cronbach’s alpha 0.66) consisted of two questions that were answered on a five point Likert-scale. The questions were as following; “I offer benefits or opportunities for development to motivate my co-workers” (“Jag erbjuder förmåner eller utvecklingsmöjligheter för att motivera medarbetare”) and “I arrange courses, seminars, supervision and lectures to develop the competence of the co-

workers” (“Jag ordnar kurser, seminarier, handledning eller föreläsningar för att utveckla medarbetares kompetens”).

Health oriented leadership: The index *Health oriented leadership* (Cronbach’s alpha 0.67) questions have been created based on previous studies (Dellve & Eriksson, 2017). The index consisted of three questions that were all measured on a five point Likert-scale. The questions were as following: “I have the possibility to let my co-workers/employees adjust their work according to their own preference and capacity” (“Jag har möjlighet att låta enskilda medarbetare anpassa arbetet efter egna önskemål och kapacitet”), “I have the ability to create working conditions that facilitates the adjustment of work to all co-workers/employees” (“Jag har möjlighet att skapa arbetsvillkor som gör det lätt för alla medarbetare att anpassa arbetet”) and “I am responsive towards my co-workers’ signs of overload” (“Jag kan vara lyhörd för medarbetarnas signaler på överbelastning”).

Alternative HR Support Resource and Organisational Structure variables. A number of items that also could have importance for health promoting leadership was also selected. The variables are alternative support resources and organisational structures provided and managed by HR. Thus, these variables are explanatory variables but not in focus of the present study. In the analysis, they were used as control variables, e.g. of their relative impact when the association between organisational support and health promotive leadership was assessed in the multivariate regressions.

Number of employees/Control span: Many studies have investigated what control span is just enough to keep the effectiveness at a high level. A study from 2008 gave the golden rule max 30 employees (Anderson Felé, 2008). The interest in this study is to see if the level of leadership orientations is affected by this and see if there is a relationship between perceived organisational support resources and number of employees. It would be reasonable to assume that the managers’ strain increases with the number of employees, which could affect the levels on both dependent and independent variables. The variable was measured with the following question: “How many individuals have you as their main manager/leader? - Number of employees” (“Hur många personer har Dig som närmaste chef/ledare? - Antal anställda”).

Number of locations: Even though no research has been done on this particular area, one can assume the same reasoning as concerning the number of employees. If the employees are spread out on several locations, the first-line managers’ strain to be e.g. present and supportive will increase and potentially affect the level of leadership orientations and level of perceived organisational support resources. The variable was measured with the following

question: “The work place location: At how many addresses does the work take place that you are responsible for - the number of addresses/locations” (“Verksamhetens lokalisering: Vid hur många adresser bedrivs den verksamhet du leder: - antal adresser/platser”)

Administrative support at location: As mentioned above, employees spread out on several locations is hypothesised to potentially affect level of leadership orientations and level of perceived organisational support resources. The same goes for functions that are spread on several locations, which can impact the perceived administrative support. This variable was measured with the following question: “Is there administrative support at same locations where you mainly work?” (“Finns administrativt stöd på samma adress som du har din huvudsakliga arbetsplats?”)

Number of manager levels: There are studies suggesting that first-line managers estimate manager dilemmas higher and organisational support resources lower in comparison to managers on higher levels (e.g. Björklund et al., 2011). Based on this, one can assume that first-line managers with more manager levels up to a political board or top management will estimate lower levels of perceived organisational support resources. The variable was measured with the following question: “How many manager levels are there from your department up to governing political committee? - Number of manager levels” (“Hur många chefsnivåer finns det från din verksamhet upp till politisk nämnd eller styrelse? - Antal chefsnivåer”).

Leadership education: Logically, one could presume that the more educated the leader is, through attending different sorts of leader educations, the more aware would the leader be and practice different leadership orientations. It is therefore hypothesised that the more educations a leader has attended, the higher occurrence of all health promoting leadership orientations. The variable was measured with four closed questions (yes/no), all addressing different sorts of leader educations: ”Have you attended any leadership education? If yes, state the type of education” (“Har du gått någon chefs- och ledarutbildning? Om ja, ange typ av utbildning”).

Health promoting self-leadership: Health promoting self-leadership is a variable looking at the managers’ own ability to be responsive to strain, work situation and such. One can assume that being aware of one's own situation and behaving in a health promoting way increases the chances of higher levels of *Health oriented leadership*. The variable was measured on a seven point Likert scale with the following question: “I am responsive towards my work load becoming overwhelming or too difficult” (“Jag är lyhörd för om min belastningen skulle bli för stor eller svår”).

Health promoting organisational projects: Health promoting organisational projects was chosen to assess the prevalence of supportive organisational measures regarding the focused outcome and as a control variable to the importance of regular organisational support. The question measuring this variable is from an ongoing research-project (VICE, Forte Dnr) and the variable was measured on a five point Likert scale with the following question: “At your department, have you actively taken part of or initiated any developmental work regarding health promoting initiatives the past year?” (“Har du i den verksamhet du leder, under de senaste året drivit eller deltagit aktivt i utvecklingsarbeten som handlar om - stärka hälsofrämjande arbetsförhållanden”).

Analysis

Firstly, a screening process was made to check whether each participant met the research criteria. Second, some data editing was conducted to avoid errors. An initial analysis was conducted in order to check that the data was normally distributed, which was ensured through ocular inspection of histogram, scatter plot and trimmed mean. This inspection also ensured that the requirements for linearity and homoscedasticity was met (Tabachnick & Fidell, 2007). Through a correlation study it was ensured that there were no correlations between the predictor variables that were close to or over 0.7 (Pallant, 2010), checking the multicollinearity and singularity assumptions. Outliers were also checked for, and all values had standardised residual values within +/- 3.3 (Tabachnick & Fidell, 2007).

For research question one and two, descriptive analysis was conducted to study means, standard deviations and ranges. Diagrams were also used to see the distribution of variables.

Research question three was divided into three sub-questions, to analyse the independent variable perceived organisational support resources and all leadership orientations independently. In all sub-questions, a correlation study was first conducted in order to see if there was a correlation between the different types of perceived organisational support and all leadership orientations. Next, where significant correlations were found, two multiple regression analyses were conducted with selected perceived organisational support variables and *Participative leadership* and *Health oriented leadership*. Standard multiple regression analysis was chosen in order to include several independent, predictor variables for each dependent variable.

Regarding research question four, descriptive analysis was conducted firstly on all alternative support resource and organisational structure variables. Next, these variables were added in separate diagrams to study potential correlation with all leadership orientations, all

organisational support resources and background variables. Then, an exploration of alternative explanations regarding the perceived organisational support resources effect on *Health oriented leadership* through a hierarchical multiple regression was made. This method was chosen because of its characteristic to add predictor variables block-wise. The choice was made to only conduct a hierarchical multiple regression analysis with *Health oriented leadership* because of the leadership orientation being the most related to the organisational support resources. Similar initial analysis to check for assumptions were done when necessary. In the first block, the organisational support index was included. In the second block, *Health promoting organisational projects* was included. In the third block, *Health promoting self-leadership* was added. Then, in block four, *Control span, Number of manager levels, Number of locations, Leadership education and Administrative support at location* was included. Lastly, gender was added in the fifth and final block of the hierarchical regression.

Ethical Considerations

This study and survey was conducted with consideration to the four research ethical principles; sufficient information, consent, confidentiality and use of collected data (Vetenskapsrådet, 2002). The ethical principle of providing information to the participants were fulfilled by giving the participants information about the study's purpose, use of method and the intended use of collected data before participating in the survey. Participants were informed that participation was voluntary and they could end their participation in the study at any time. At the beginning of the questionnaire, the participants gave their consent to be a part of the study by choosing to click on a link to either to start the questionnaire or decline participation. All of the participants were informed that participation was anonymous and that data would only be analysed on group level. The requirement for confidentiality was fulfilled by ensuring collected data would not consist of any details about the participants names, as data was limited to descriptions from the background questions in the survey. The respondents were notified that collected data would only be processed by the researchers and only compiled reports were to be given to Gothenburg City in order to ensure anonymity for the respondents. The study, including the information given to the participants, was approved by the Swedish Ethical Advisory Board (Dnr 2019-02934).

Limitations

Covid-19

Due to circumstances with the current COVID-19 pandemic, libraries in Sweden have been closed. Due to this, the authors have had a very limited access to literary books. Therefore, the sources of literature in this study are mainly consisting of internet based literature, available on open-access, through the University or provided by the supervisor. The authors are aware of the possible limitations of this situation. However, it is of the authors believes that this has not affected the outcome of the thesis.

Results

In this chapter, the results of the study will be presented. Firstly, research questions one and two will be presented. Then, research question three will present the relationship between organisational support and the health promoting leadership orientations separately. Lastly, alternative HR support resources and organisational structures are investigated, both connected to the leadership orientations and the organisational support resources, with a final hierarchical regression.

RQ1: Organisational Support

What kind of organisational support resources are perceived by municipal first-line managers?

The top organisational support perceived by first-line managers was *Administrative support* ($M = 3.83, SD = 1.04$), closely followed by *Human Resource support* ($M = 3.78, SD = 0.99$). There were 30.66% and respectively 23.9% of the first-line managers that reported the highest possible occurrence of these support functions. *Trusting collaboration with resource functions* was the third highest rated ($M = 3.59, SD = 1.11$). There were 22.44% of the first-line managers who strongly agreed to have a trusting collaboration with change leaders and other resource staff. To have *Role clarity* ($M = 3.33, SD = 1.07$) and support in the managing role from *Organisational rules, policies and regulations* ($M = 3.24, SD = 0.92$) were the lowest rated organisational support functions. The respondents age, gender and sectorial belonging did not covariate with the perceived organisational support resources.

Computing all organisational support resources variables together formed our organisational support measurement index ($M = 3.56, SD = 0.69$).

Table 2*Descriptive Data of Organisational Support Resources*

Organisational support	Mean-value	S.D	% highest	% lowest
Human Resource support	3.78	0.99	23.9%	2.7%
Administrative support	3.83	1.04	30.7%	1.9%
Trusting collaboration with resource functions	3.59	1.11	22.44%	5.1%
Organisational rules, policies and regulations	3.24	0.92	7.3%	3.6%
Role clarity	3.33	1.07	10.2%	7.1%

RQ2. Leadership Approaches

What kind of health promoting leadership orientations are approached by municipal first-line managers?

The three leadership orientations were rated as follows; *Participative leadership* ($M = 4.3$, $SD = 0.52$), *Developmental leadership* ($M = 3.16$, $SD = 0.93$) and *Health oriented leadership* ($M = 3.35$, $SD = 0.67$). The scores were consistent between men and women, sectors and respondents of different age.

Table 3*Descriptive Data of Leadership Orientations*

Leadership orientation	Mean-value	S.D	% highest	% lowest
Participative	4.3	0.52	20.5%	0%
Developmental	3.2	0.93	5.2%	2.7%
Health oriented	3.4	0.67	1.3%	0%

RQ3. Organisational Support Resources Relationship with Leadership Approaches

Is there a relationship between municipal first-line managers perceived organisational support and health promoting leadership orientations (Participative leadership, Developmental leadership and Health oriented leadership)?

RQ3-1. Participative Leadership

A correlation study was conducted to investigate if there was a relationship between the independent organisational support variables and the dependent variable *Participative leadership*. A significant correlation was found between the variables *Administrative support* ($M = 3.83, SD = 1.04$) and *Participative leadership* ($M = 4.3, SD = 0.52$) ($r(403) = .181, p = .000$) and between *Role clarity* ($M = 3.33, SD = 1.07$) and *Participative leadership* ($r(403) = .087, p = .080$). No correlation was found for the other organisational support variables, see Table 4.

Table 4

Pearson's r and P-values of the Correlation Between Participative Leadership and all Independent Organisational Support Variables

Participative leadership	Pearson's r	P-value
Human Resource support	0.044	0.376
Administrative support	0.181***	0.000
Trusting collaboration with resource functions	0.069	0.165
Organisational rules, policies and regulations	0.036	0.467
Role clarity	0.087*	0.080

* $p < 0.1$, *** $p < 0.01$

In the subsequent multiple regression analysis, *Administrative support* and *Role clarity* ($M = 3.33, SD = 1.07$) were included because of their significance and indicated correlation. The multiple regression demonstrated that the two variables explain 3.4% of the variance in *Participative leadership*, in a statistically significant regression model ($F(2, 7.117) = p = .001, R^2 = .034$). Looking at the variables independently, one can see that *Administrative support* was an independent significant predictor of *Participative leadership* ($B = .170, t = 3.328, p = .001$), explaining the total R^2 value (3.4%) with 2.7%.

RQ3-2. Developmental Leadership

In the bivariate correlation analysis, no correlation was found between the dependent variable *Development leadership* and the independent organisational support variables, see Table 5. Therefore, no multiple regression study was conducted.

Table 5

Pearson's r and P-values of the Correlation Between Developmental Leadership and all Independent Organisational Support Variables

Developmental leadership	Pearson's r	P-value
Human Resource support	0.058	0.246
Administrative support	0.037	0.459
Trusting collaboration with resource functions	0.037	0.461
Organisational rules, policies and regulations	-0.016	0.757
Role clarity	-0.025	0.621

RQ3-3. Health Oriented Leadership

In a bivariate correlation analysis, between independent organisational support variables and the dependent variable *Health oriented leadership* ($M = 3.35$, $SD = 0.67$), a significant correlation was found between *Administrative support* ($M = 3.83$, $SD = 1.04$) ($r(396) = .206$, $p = .000$), *Trusting collaboration with resource functions* ($M = 3.59$, $SD = 1.11$) ($r(395) = .150$, $p = .003$), *Organisational rules, policies and regulations* ($M = 3.24$, $SD = 0.92$) ($r(397) = .153$, $p = .002$), *Role clarity* ($M = 3.33$, $SD = 1.07$) ($r(396) = .228$, $p = .000$) and *Health oriented leadership*.

Table 6

Pearson's r and P-values of the Correlation Between Health Oriented Leadership and all Independent Organisational Support Variables

Health oriented leadership	Pearson's r	P-value
Human Resource support	0.028	0.584
Administrative support	0.206***	0.000
Trusting collaboration with resource functions	0.150***	0.003
Organisational rules, policies and regulations	0.153***	0.002
Role clarity	0.228***	0.000

*** $p < 0.01$

In the following multiple regression, *Administrative support*, *Trusting collaboration with resource functions*, *Organisational rules, policies and regulations*, and *Role clarity* were included because of their statistically significant correlations. The multiple regression had statistically significant results ($F(4, 8.083) = p = .000$, $R^2 = .077$), stating that the predictor variables could explain the variance in *Health oriented leadership* with 7.7%. Reviewing the variables independently, the results stated that *Role clarity* ($B = .162$, $t = 2.872$, $p = .004$) and *Administrative support* ($B = .136$, $t = 2.485$, $p = .013$) had an independent significant effect on the R^2 (7.7%), explaining it with 2% respectively 1.5%. The leadership orientation levels were not affected by the respondents' gender, age or what sector they belonged to.

RQ4. Alternative HR support Resources and Organisational Structures

RQ4 -1. Alternative HR Support Resources and Organisational Structures

Is there a relationship between health promoting leadership orientations (Participative leadership, Developmental leadership and Health oriented leadership) and alternative HR support resources and organisational structures?

Health promoting organisational projects ($M = 3.31$, $SD = 1.13$). Across the sectors, about half of the participants had not taken part of or initiated any health promoting developmental work (51.43%). A majority (65%) of the first-line managers at the

Administrative and supportive departments had often to very often participated in these organisational initiatives.

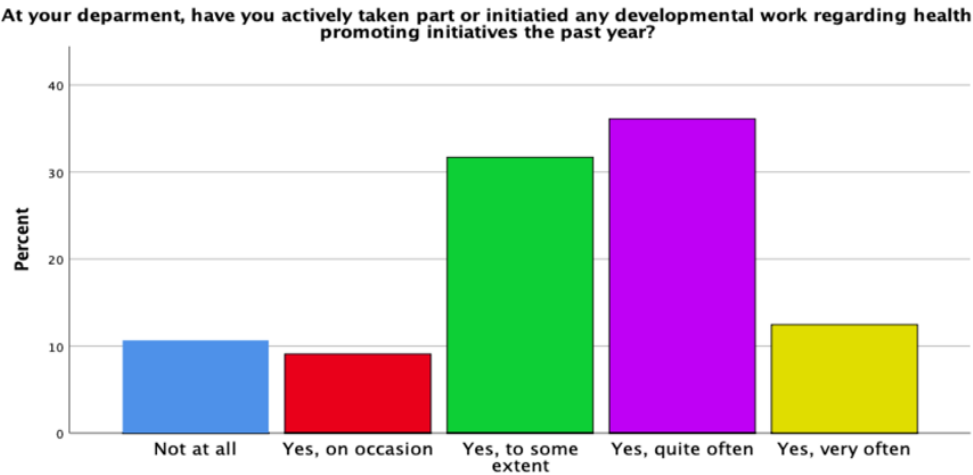


Figure 1. *Percent distribution of the possible answers to “At your department, have you actively taken part of or initiated any developmental work regarding health promoting initiatives the past year?”*

Health promotive self-leadership ($M = 4.66, SD = 1.12$). As demonstrated in Figure 2, none of the first-line managers strongly agree that they are responsive to take action against overwhelming work. But, 21.48% and respectively 45.52% state they agree and somewhat agree that they are responsive. A very small amount, 0.77% state that they strongly disagree to the statement question. Furthermore, 6.14% of the first-line managers disagree that they are responsive towards overwhelming work and 7.42% somewhat agrees. Neither agree nor disagree is the opinion of 18.67%.

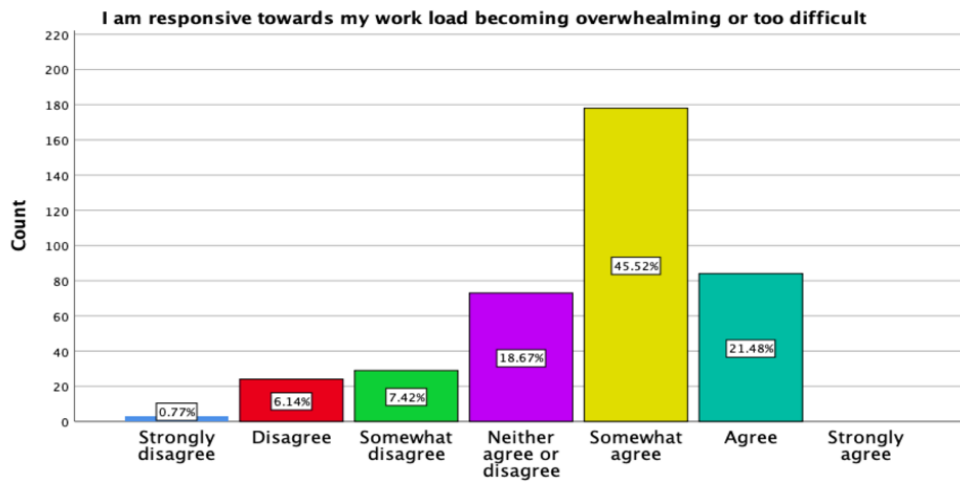


Figure 2. Percental distribution and count of the possible answers to the question “I am responsive towards my workload becoming overwhelming or too difficult”

Control span ($M = 27.60$, $SD = 13.16$). The first-line managers’ number of employees ($M = 27.60$, $SD = 13.16$) varied between five and 100 employees. The majority (62.99%) had 20-39 employees.

Leadership education ($M = 1.42$, $SD = 0.67$). A majority of the participants had experience of some leadership education (95.1%). The most common education type was internal leadership education with 60.2%. Second, 43.9% had attended a leadership course at a university. Moreover, 32.8% of the participants had participated in an external leadership education (32.8%) and only a few had not participated in any leadership education (4.9%).

Number of locations ($M = 3.39$, $SD = 3.19$). The majority of the first-line managers (71.32%) had employees spread out on 1-3 locations. At the other extreme, almost 20% of the first-line managers have employees on 7-10 locations.

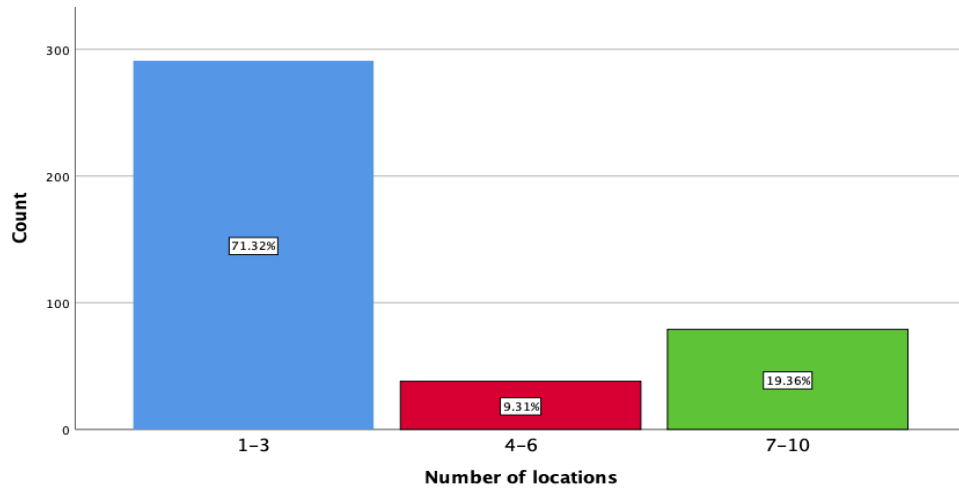


Figure 3. *Count and percentage of first-line manager's Number of locations*

Number of manager levels ($M = 3.27$, $SD = 0.8$). The majority (82%) of the first-line managers had 3-4 management levels up to top management. Only 3.19% had five levels to top management and 2.21% had one level to top management.

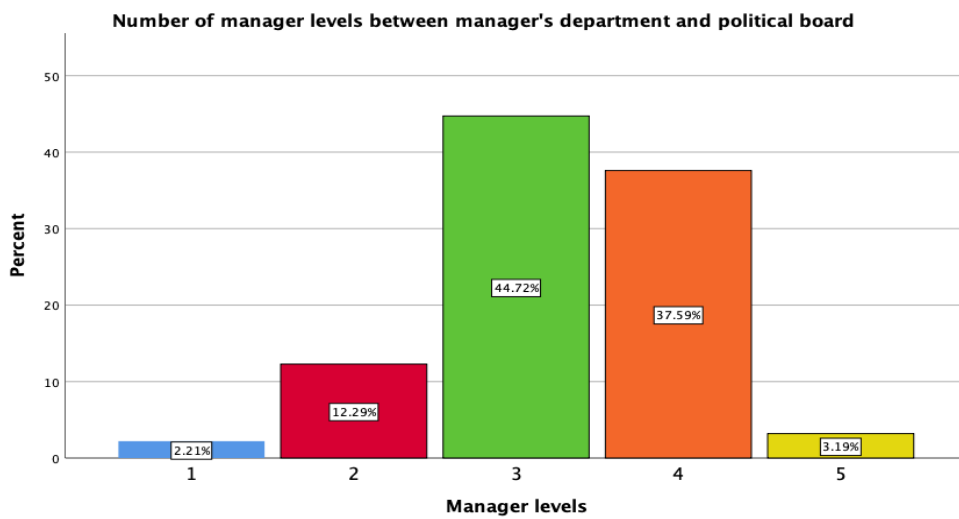


Figure 4. *Percental distribution of how many manager levels are between the first-line manager's sector and the political board*

Administrative support at location. The majority (68.2 %) of the first-line managers responded that they had administrative support at the same address as their office and 38.2% responded they did not have administrative support at the same address.

RQ4-2. Alternative HR Support Resources and Organisational Structures and Perceived Organisational Support Resources

Is there a relationship between first-line managers perceived organisational support resources and alternative HR support resources and organisational structures?

Control span. Figure 5 indicates that first-line-managers having more than 60 employees responded the highest degree of perceived organisational support. The line-managers with 40-59 employees also responded a high mean value for perceived organisational support, and the line-managers having 0-19 employees responded a slightly lower degree. The first-line managers having 20-39 employees reported the lowest perceived organisational support.

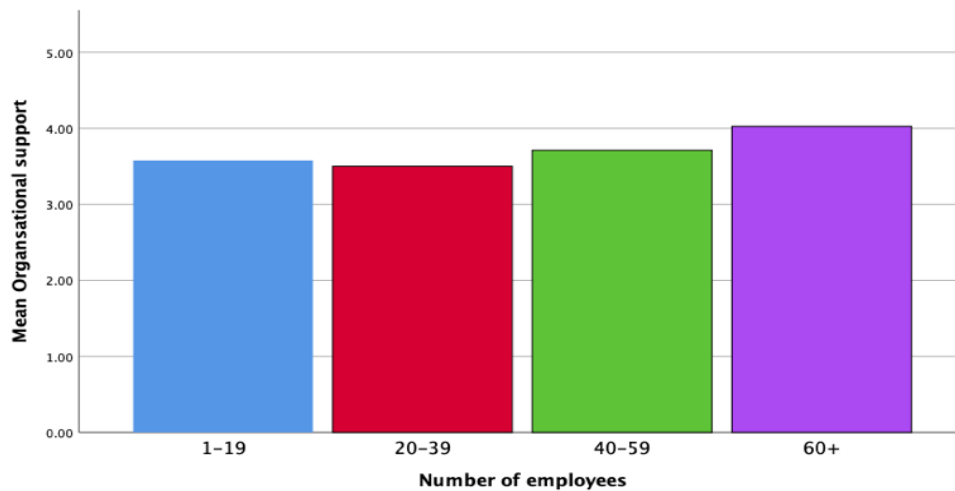


Figure 5. Mean values of organisational support distributed over number of employees

Number of locations. Having employees spread out on several addresses seems to slightly increase perceived organisational support resources for the first-line managers (mean score of 3.69 versus 3.52).

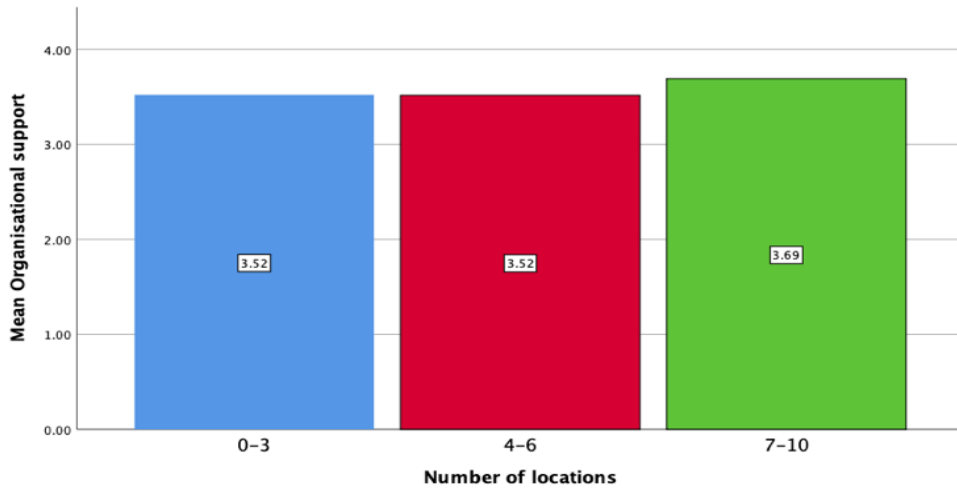


Figure 6. Mean values of organisational support distributed over Number of locations

Health promoting self-leadership. First-line managers that are responsive towards their own workload becoming too overwhelming have a higher perceived organisational support mean value (3.66) than those that are less responsive (3.34).

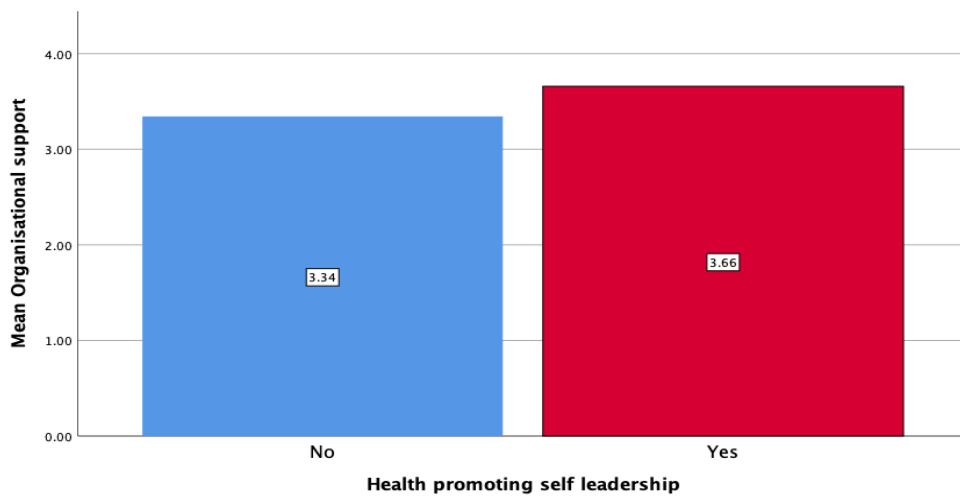


Figure 7. Mean values of organisational support distributed over responsiveness towards own workload

Health promoting organisational projects. The first-line managers that are often and actively taken part in Health promoting organisational projects exhibits a slightly higher perceived organisational support mean value (3.70 and 3.46).

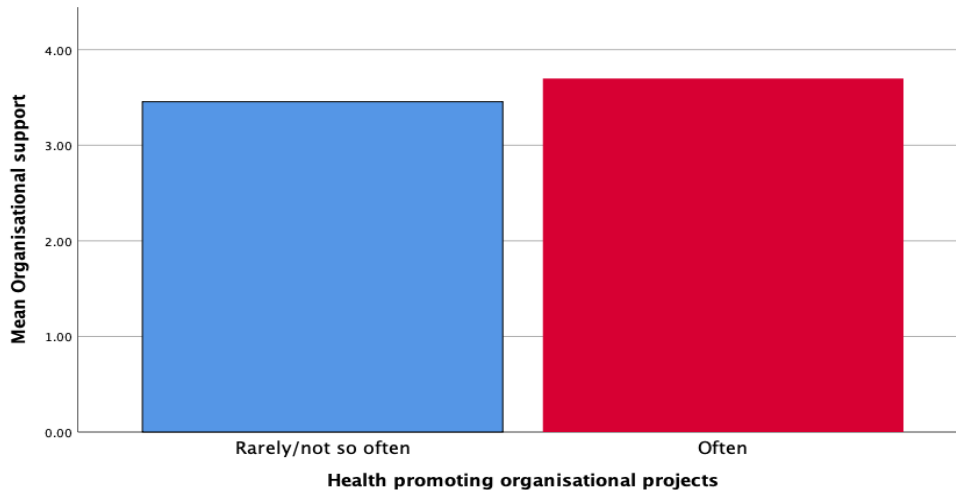


Figure 8. Mean values of organisational support distributed over participation in health promoting organisational projects

Perceived organisational support was interpreted not to be affected by *Number of manager levels* and *Administrative support at location*.

RQ4-3. Alternative HR Support Resources and Organisational Structures and Leadership Orientations

Is there a relationship between health promoting leadership orientations (Participative leadership, Developmental leadership and Health oriented leadership) and alternative HR support resources and organisational structures?

Control span. Figure 9 indicates a possible relationship between having few employees and having higher levels of all leadership orientations. The managers with more than 60 employees responded to have a *Participative-* and *Health oriented leadership* approach rather than a *Developmental*. The first-line managers with 20-39 and 40-59 employees responded similar regarding *Health oriented-* and *Participative leadership*. But, the manager group with 40-59 had higher mean score on *Developmental leadership* than the smaller management group.

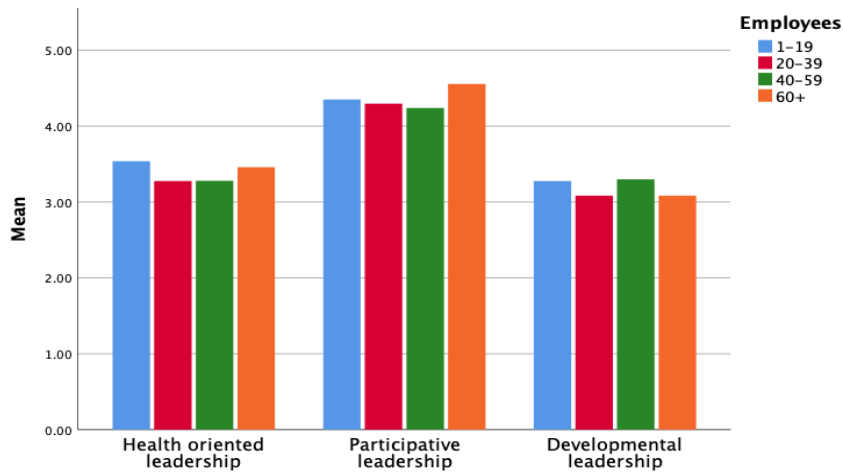


Figure 9. Mean values of health promoting leadership orientations distributed over number of employees

Administrative support at location. Having administrative support in the same building increased the respondents' degree only slightly on all leadership orientations. The differences were most visible in *Health oriented-* and *Developmental leadership*.

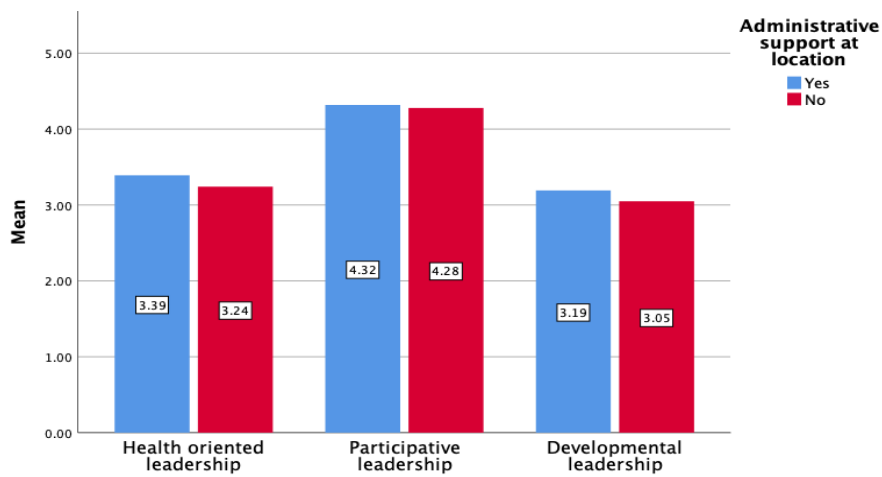


Figure 10. Mean values of health promoting leadership orientations distributed over if administrative support was present at location or not

Number of manager levels. First-line managers having fewer managerial levels (1-2) between their own manager position and top management reported higher level of *Health*

oriented- and *Developmental leadership* approaches. First-line managers with additional manager levels (3-5) to top management reported lower mean scores on *Health oriented-* and *Developmental leadership* approaches. Figure 11 indicates that first-line managers having higher or lower levels to top management does not have a relationship with *Participative leadership*.

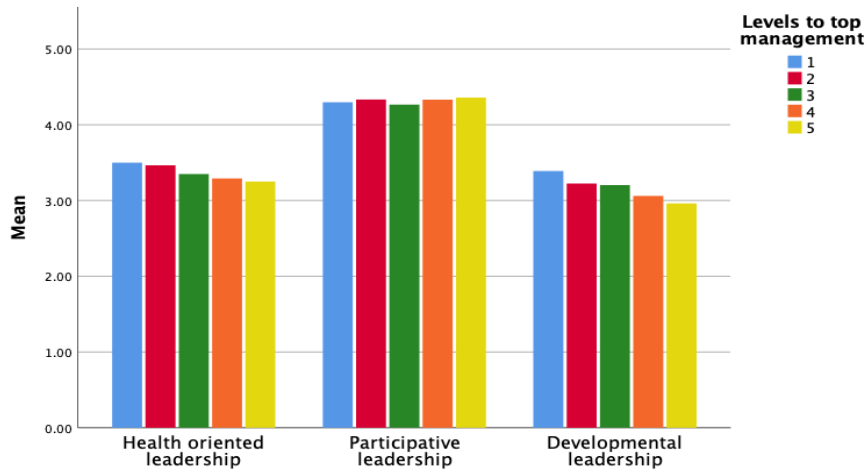


Figure 11. Mean values of health promoting leadership orientations distributed over number of management levels

Leadership education. The extent of leadership education in and prior their position was linked to the higher levels of *Participative* and *Developmental leadership* was found. *Health oriented leadership* received the highest levels when the first-line managers only had undergone two different leadership educations.

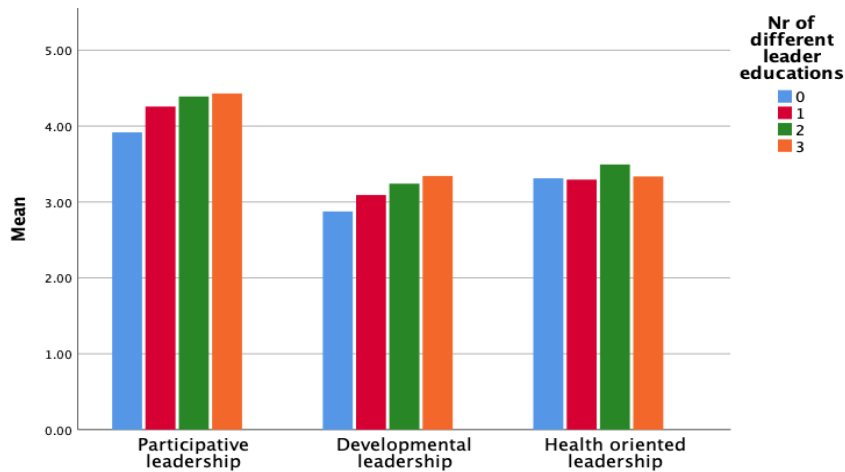


Figure 12. Mean values of health promoting leadership orientations distributed number of leadership educations

Health promoting self-leadership. The managers who were responsive towards overwhelming work also demonstrated slightly higher degrees of all leadership orientations, especially *Health oriented leadership*.

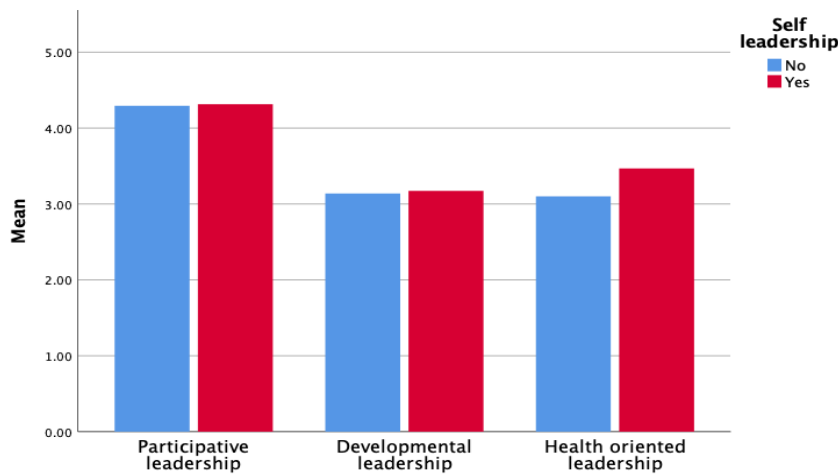


Figure 13. Mean values of health promoting leadership orientations distributed over if leaders were responsive towards overwhelming work or not

Health promoting organisational projects. The managers who are actively involved in health promoting organisational projects have higher degrees of all leadership orientations, see Figure 14.

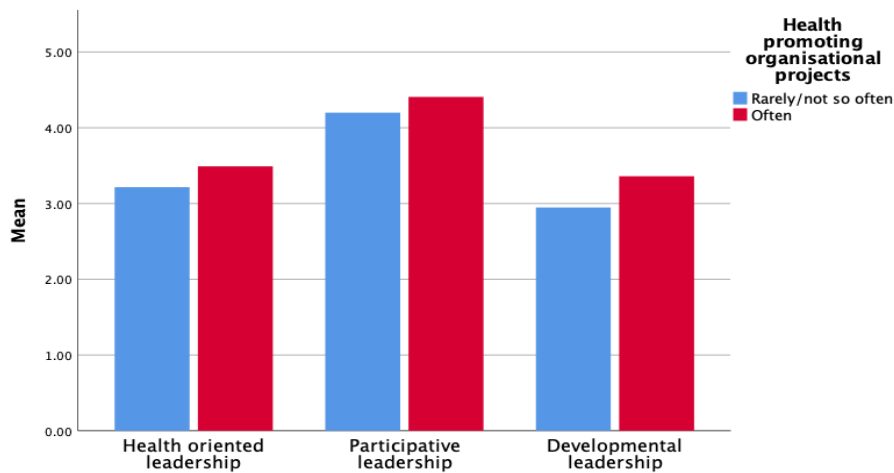


Figure 14. Mean values of health promoting leadership orientations distributed by the managers' participation in health promoting organisational projects or not

The leadership orientations did not seem to be affected by *Number of locations*.

RQ4-4. Exploration of Alternative Explanations

Is there a relationship between leadership orientations (Participative leadership, Developmental leadership and Health oriented leadership) and alternative HR support resources and organisational structures?

A hierarchical regression was conducted in order to study the relationship between the organisational support index, the alternative HR support resources and organisational structures and the most significantly influenced by organisational support, the dependent variable *Health oriented leadership*. Prior to this, the same check for assumptions was made as in previous multiple regression. The analysis resulted in the whole model with all predictor variables explaining the variance in *Health oriented leadership* by 21.7%. Besides organisational support, gender, *Health promoting self-leadership* and *Health promoting organisational projects* were also significantly contributing to Health promoting leadership. While, *Number of manager levels*, *Administrative support at location*, *Number of locations* and *Leadership education* were not unique predictors to the R²-value. The standardised beta-values that were statistically significant were unique predictors of *Health oriented leadership* and contributed to the R²-value.

Table 7

Result from Hierarchical Regression Analysis with Health Oriented Leadership as Dependent Variable

Variables	Model 1	Model 2	Model 3	Model 4	Model 5
Organisational support	0.227***	0.191***	0.126**	0.129***	0.145***
Health promoting organisational projects		0.218***	0.208***	0.214***	0.212***
Health promoting self leadership			0.263***	0.249***	0.242***
Control span				-0.145***	-0.132***
Manager levels				-0.062	-0.054
Number of locations				-0.002	-0.014
Leadership education				0.058	0.074
Administrative support at location				-0.066	-0.070
Gender					0.156***
R2	0.051	0.098	0.162	0.194	0.217
R2 change		0.046***	0.065***	0.031	0.023***
F-value	20.174***	20.120***	23.992***	10.979***	11.234***
df	1	2	3	8	9
* p<0.1, ** p<0.05, *** p<0.01					

Discussion

In this chapter, the results will be discussed to answer the study's purpose and research questions. The chapter begins with perceived organisational support, followed by health promotive leadership orientations and lastly alternative explanations. Thereafter, the methodology of the study is discussed and possible limitations are addressed.

The purpose of this study was to investigate if health promoting leadership orientations could be associated with organisational support resources perceived by first-line managers. Through our analysis, it has been discovered that *Participative leadership* and *Health oriented leadership*, important parts of health promoting leadership, can be partly explained by perceived organisational support resources. In the case of *Health oriented leadership* even more so, if other organisational support resources and structures were included in the calculation. In the following discussion, the authors will discuss these results in relation to the theoretical framework, with emphasis on Kanter's (1993) structural empowerment theory, that urge the importance of organisational support.

Organisational Support Resources

The first-line managers highest perceived organisational support resources were *Administrative support*, followed by *Human Resource support*. This does not go in line with the fact that previous studies state that managers are missing structural support from HR and administrative services (Dellve & Wikström, 2009; Wikström & Dellve, 2009). According to Kanter (1993), structural empowerment can be reached through accessing power structures through different "lines" e.g. of support and information. Reviewing these results in the eyes of Kanter (1993), the interpretations are mixed. The fact that *Administrative-* and *HR support* occur in a high degree could be a sign of there being good access to some of the power "lines", namely access to support and access to opportunity. However, one could assume that *Administrative-* and *HR support* was the organisational support that was perceived in the highest degree since those could be seen as visible and concrete support resources provided to the managers. When managers reflect upon what organisational support they are perceiving, *Administrative support* such as help with daily work tasks and *HR support* regarding recruitment and labour law could be more noticeable than the more abstract support resources.

The two least occurring organisational support resources was having *Role clarity* and support from *Organisational rules, policies and regulations*. According to Kanter (1993),

access to resources and information is connected to having a clear managerial role and having proper access to rules, policies and regulations. These are the power structures the first-line managers in Gothenburg City do not have full access to according to these results. For the first-line managers to be structurally empowered, the access to these power lines need to be improved.

Additionally, these results could be an indicator that the first-line managers are missing some components to carry out a health promotive leadership, since having access to these support resources is a precondition for its achievement (Dellve & Eriksson, 2016; 2017). Improving the organisational support resources for the first-line managers in the areas with lower ratings, can increase their access to organisational job resources, that in turn could improve managers well-being (Bakker & Demerouti, 2007). All of the organisational support variables investigated in this study are needed for first-line managers to handle challenges and demands that comes with the managing role (Dellve & Eriksson, 2016). Therefore, it could be of importance to provide the first-line managers with even more well-functioning organisational support resources, since this is a precondition for approaching health promotive leadership orientations (Dellve & Wolmesjö, 2016).

Participative Leadership

Participative leadership was reported in the highest degree by the first-line managers in Gothenburg City. The results could be interpreted as a sign of first-line managers being very engaged in their employees and involving them in the daily decision making. This could be explained by the day-to-day interactions first-line managers have with their employees, being operational rather than strategic (Hales, 2005). The first-line manager position itself can facilitate the conditions needed to be participative. In contrast, if the study had focused on managers in superior levels the results may have been very different, since upper management often work more strategically. A high degree of *Participative leadership* could be interpreted from Kanter's (1993) perspective that the first-line managers' informal power is high. The participative leader engages in an exchange relationship with their employees and is involved in their work, and involve the employees in their managing decisions. The results suggest that the first-line managers have access to the power structures that enables them to have this informal power.

Approaching a *Participative leadership* style is connected to several positive organisational aspects, that we therefore could assume to be consequences of this leadership approach in Gothenburg City. These positive outcomes are; lower employee turnover and

performance (Miller & Monge, 1986), work engagement (Aronsson et al, 2012, Chan 2019), job satisfaction (Chan, 2019) and affective and normative commitment (Miao, Newman, Schwarz and Xu, 2013). Being participative as a leader is a component found in both transformational and servant leadership. Approaching both leadership styles are theorised to have a positive impact on employee well-being (Nielsen et al., 2008; Rivkin, Diestel & Schmidt, 2014). Moreover, previous research states that adopting a *Participative leadership* style is strongly connected to employee well-being (Dellve & Eriksson, 2016; 2017) and employee sustainability (Aronsson et al, 2012). The fact that the first-line managers in Gothenburg City approach this leader orientation to the highest degree could suggest that when it comes to *Participative leadership*, the leaders have good conditions for fostering health in the workplace.

Participative leadership correlated with *Administrative support* and *Role clarity*, which means that the power structures the first-line managers possibly have access to is resources and support (Kanter, 1993). *Role clarity* could be interpreted as an implicit support for the leader, in comparison to *Administrative support* which is easier to grasp. *Role clarity* was one of the least perceived organisational support resources in Gothenburg City and identifies an area of improvement. To maintain a high level of *Participative leadership*, it is important to continuously improve the clarity in the managers' responsibilities, assignments and capacity, components included in *Role clarity*.

In a subsequent multiple regression, *Administrative support* proved to be a significant unique predictor of variance in the *Participative leadership* scores. Administrative tasks could devour a lot of time that could be spent on supporting the employees and used for valuable interaction. Managing and distributing time is according to Dellve and Eriksson (2016) a work challenge for managers. The results indicate that first-line managers in Gothenburg City have access to *Administrative support*, that *Participative leadership* is facilitated and the time needed to practice such leadership is available.

Health Oriented Leadership

Health oriented leadership was the second most approached leadership orientation amongst the first-line managers. This could be a sign of the first-line managers having balance between demands and resources, which is important for being a sustained health promoting leader (Dellve & Eriksson, 2016; 2017). This balance in combination with having the right preconditions and resources are determinants for carrying out a *Health oriented leadership*

(Dellve & Eriksson, 2016; 2017). Therefore, one could assume that the first-line managers have been given the right preconditions and resources.

Health oriented leadership correlated with four of the organisational support resources. This is in agreement with previous studies stating that the right preconditions and resources are important for being a health promotive leader (Dellve & Eriksson, 2016; 2017). According to Kanter (1993), this could be interpreted as first-line managers approaching a *Health oriented leadership* having access to the most power "lines" of all leadership approaches measured in this study. In theory, this would mean high levels of both informal and formal power. One could assume that first-line managers in Gothenburg City have rather well-functioning organisational support resources that enable them to carry out a *Health oriented leadership*. However, our results show that other components also play a significant role in the first-line managers *Health oriented leadership*, since the explained variance in the subsequent multiple regression was only 7.7%. Based on the later hierarchical regression, *Health promoting organisational projects* could be one component that have facilitated the presence of *Health oriented leadership*. The participation in these initiatives might have had an effect on spreading knowledge about working in a health promoting way, making the first-line managers aware of the *Health oriented leadership* orientation, as it is the foundation of health promoting leadership (Franke, Felfe and Pundt, 2014), in such way that they have incorporated this in their leadership.

Furthermore, *Administrative support* and *Role clarity* were both independent predictors of *Health oriented leadership*. These two variables are therefore most important when predicting the level of *Health oriented leadership* in first-line managers in Gothenburg City. Two challenges for managers are difficulties with distributing their time and lack of resources (Dellve & Eriksson, 2016). *Administrative support* and *Role clarity* aids the first-line manager in these challenges, by liberating time that otherwise would have been put on administrative tasks and understanding the capacity of the managing role. This liberated time enables the first-line manager to be sensitive towards their employees demands, which is the basis of *Health oriented leadership*.

The results indicate that an improvement of *Health oriented leadership* could add to employees' health in Gothenburg City. *Health oriented leadership* is a rather new research area. Since *Health oriented leadership* is a part of health promoting leadership, connected to employee health and well-being (Dellve & Eriksson, 2016), one could assume that adopting this leadership style will also affect the employees' health in a positive manner. This type of leadership correlated with the most organisational support resources, and could be a good place

to start if Gothenburg City would like to increase *Health oriented leadership* ability in their first-line managers.

Developmental Leadership

Developmental leadership was the least approached orientation by the first-line managers in Gothenburg City. This could be an indicator of there not being enough or the right organisational support resources present to be able to practice a *Developmental leadership*, or that this leadership approach is not affected by organisational support resources. A possible explanation to the lower degree of *Developmental leadership* could be that the first-line managers access to resources in terms of money, support or time is compromised (Kanter, 1993). Therefore, organising development opportunities for the employees might not be possible. Additionally, the development of employees might not be an area where the first-line managers are foremost responsible, the responsibility might be at a higher level in the organisation. In regard to the first-line managers' employees, the lower occurrence of *Developmental leadership* could affect the power sharing that is at the very core of structural empowerment theory (Spreitzer, 2008). In other words, when employees are offered less development opportunities, e.g. lectures and seminars, their structural empowerment may be threatened. This loss could compromise the positive outcomes of structural empowerment for employees. Since developmental leaders develop employees' knowledge and skills through goal setting and encouragement (Gilley, Shelton & Gilley, 2011), there is supposedly both a lack of time for first-line managers to do this and a lack of knowledge for practicing this leadership.

Developmental leadership did not correlate with any organisational support. Therefore, one could propose that in order to practice a *Developmental leadership*, there could be a need for other resources and preconditions. For instance, expanded knowledge, education or peer coaching might be more relevant in order to encourage this leadership approach. With this background, one could assume that the managers do not have access to opportunity, a power structure needed in order to develop skills and attain new knowledge (Kanter, 1993).

Furthermore, since the first-line managers did not perceive high support in regard to *Organisational rules, policies and regulations* and *Role clarity*, this could also be a contributing component to the low degree of *Developmental leadership*. *Organisational rules, policies and regulations* provide managers with support, information and knowledge (Dellve and Wolmesjö, 2016), and if they were to perceive this support higher, perhaps the first-line managers would have more information and knowledge on how to facilitate the development of their employees.

Role clarity gives managers information on how to perform their job (Corin & Björk, 2017), and not having access to this support could hinder the first-line managers to know how to practice a *Developmental leadership*.

To sum up, there is a limited amount of research on *Developmental leadership*. This in combination with the results, indicates a need for more research in regard to what resources and preconditions managers need in order to practice *Developmental leadership*, since it could increase well-being in the organisation.

Alternative HR Support Resources and Organisational Structures

To investigate other possible explanations and contributors to *Health oriented leadership*, a number of alternative explanation variables were included. All predictor variables together explained the variance in *Health oriented leadership* with 21.7%. Gender, *Health promoting self-leadership* and *Health promoting organisational projects* were also, besides organisational support, significantly contributing to *Health oriented leadership*. These results demonstrate the importance of these variables and their importance when working with *Health oriented leadership* in workplaces. But, there are also signs that other aspects, not investigated in this study, have an effect and deserve attention.

Surprisingly, organisational structural aspects such as *Number of employees*, *Number of locations* and accessible *Administrative support at location* had none or a small negative impact on *Health oriented leadership*. These results contradict previous studies in somewhat similar areas (Björklund et al, 2011; Anderson-Felé, 2008) and theorised views of the authors, stating that these factors would have a positive impact on the relationship. A reason for this could be that the first-line managers that have ordinary or mediocre structural conditions, have other types of support and conditions that outweigh the challenging structural conditions. Examples of this could be a very manageable department or a well-functioning and autonomous team.

From the results, one can see that *Health promoting self-leadership* was the factor most contributing to the total explained variance (R²). This implies that educating the first-line managers in and increasing the knowledge of *Health promoting self-leadership* could lead to increased *Health oriented leadership*, which in turn could improve employees' health (Dellve & Eriksson, 2016). The reason for *Health promoting self-leadership* being such a large unique contributing factor could be because the first-line managers experience the health benefits themselves of behaving health promoting. Then, it is easier to embody the approach towards their employees. A closely related variable, also provided by the HR department, is *Health*

promoting organisational projects, which was the third biggest contributor to the total R2. The projects increase the first-line managers knowledge in behaving health promoting, which the authors believe is the reason for its big impact on *Health oriented leadership*. As discussed above, educational efforts enable the first-line managers access to the power “line” access to opportunity, which increases the overall empowerment for the managers (Kanter, 1993). Reviewing these results sprouts thoughts about the role of HR in facilitating health promoting behaviours for first-line managers. One could assume that HR support consisting of education and competence development is more needed for the managers, rather than only administrative HR support. The administrative *HR support* variable had no correlation in this study with two of the health promoting leadership orientations, which indicates a need for more strategic support from HR. One could further assume that if the first-line managers perceived higher support from HR in terms of knowledge and competence development, this could lead to managers approaching the *Developmental leadership* orientation to a higher extent.

Organisational support resources were the second biggest contributor, which states the importance organisational support has for *Health oriented leadership*. A leader need support to offer support to their employees as reported in the study by Ledarna (2015), stating that managers lack the necessary support they need to lead in the best possible way. This also contributes to the research gap on the importance of organisational support for leaders, a research area that has barely been studied before. Surprisingly, gender was also a significant contributor in predicting the variance in *Health oriented leadership*. This was not a part of the study’s scope, but the results imply that male first-line managers approach a *Health oriented leadership* more than women. This makes one wonder if men, perhaps, have better preconditions and resources to be health oriented leaders? One could also interpret that men might be more structural empowered than women, and therefore have more informal and formal power in general that enables them to behave in a health oriented manner. An important message for Gothenburg City could be to reflect on this discrepancy.

To sum up, the variables that previously have not been given much attention by research, *Health promoting self-leadership* and *Health promoting organisational projects*, display a strong relationship with *Health oriented leadership*, together with the organisational support index. These results imply that educating and engaging the managers' practically in health promoting activities could increase the *Health oriented leadership*.

Based on the results and discussion, one can presume that the first-line managers in Gothenburg City have varying degrees of access to some power “lines” presented by Kanter

(1993) and are somewhat structurally empowered. The first-line managers have the most well-functioning access to the power structures created by resources and support out of all power “lines”. However, there are implications that some power structures, access to opportunity and information, need to be improved and the first-line managers’ access to these “lines” need to be ensured by the HR department of Gothenburg City in order for them to be fully empowered.

Methodology discussion

Response rate bias

There are several factors that could possibly have affected the response rate of this study. Firstly, the response rate could have been affected by the Covid-19 pandemic, even if the distribution of questionnaires was before the pandemic situation with increased number of employees working from home. During the data collection period, the employees might have been under more strain due to this and were adjusting to the beginning of the pandemic situation. This might have led to employees eliminating unnecessary work-related assignments, such as answering the survey, and only focusing on the core of their position. Secondly, the response rate could have been affected by the amount of questions in the complete survey, resulting in a decreased response rate in comparison to what it could have been with the questions only used in this study (Bryman, 2011). This factor was out of the authors hands, but could be something to bear in mind in the future when conducting a similar study.

Despite these issues, a response rate of 56% was reached, which is according to several researchers (e.g. Bryman, 2011) an acceptable response rate. Additionally, the research team at Gothenburg University and the collaborative HR department in Gothenburg city worked actively to achieve a high response rate by e.g. sending out several reminders to partake in the study and give information on the organisations’ internal website.

Sample Bias

There is always a risk in survey studies where participation is voluntary, that researchers miss opinions from individuals who are less prone to partake in studies. However, it is impossible to measure the impact of this risk and therefore the authors find no reason to believe that this would be the case in the study.

One of the study’s strengths is the power of transferability on similar public sector organisations, such as municipalities and cities, because of the total sample strategy. To achieve

generalisability, all municipal and city first-line managers would have had to participated in the study, which was not achievable and a reasonable goal for a master thesis.

A response analysis was conducted in order to assure that the sample had no systematic biases. The analysis of the respondents indicates that men, women and all of the sectors have a good response rate and there is no sign of systematic errors or biases. The only prominent statistic was the sector Children and leisure's response rate, with 22.2% response rate versus the other sectors around 50-60%. The authors believe that because of the size of this sector (9 employees), the fact that the response rate was lower have not impacted the overall results.

Procedure

A consequence that is undeniable when conducting internet surveys is the lack of control over the research environment (Shaughnessy, Zechmeister & Zechmeister, 2014). One could argue that this could lead to complications regarding the informed consent, but the authors are of the belief that informed consent was not compromised in the study. On the contrary, a strength of the study is that through internet surveys, another ethical principle is strengthened, namely anonymity. Because of the face-to-face interaction with the researcher being eliminated, the participant can experience a higher sense of anonymity than during an interview session.

Furthermore, another positive aspect with this study is the strength of Gothenburg University being an impartial party. The first-line managers possibly answered the survey questions more honestly than if the study would have been conducted by their employer, Gothenburg City. For this reason, the authors believe it to be no risk for response bias.

Instrument and Variables

Some might argue that leadership is a concept that is hard to capture in a survey and with such few questions, which could compromise the construct validity. However, in this study well validated instruments have been used, mostly GMSI. Also, the construction of variables was rigorously supported by the theoretical framework.

Overall, the internal reliability was on a good level, measured by Cronbach's alpha. In the cases of the indexes for *Developmental leadership* and *Health oriented leadership*, the Cronbach's alpha was lowest out of all the variables, with a value of 0.66 and 0.67. The acceptable level of Cronbach's alpha is debated amongst researchers, and some state that acceptable values should not be lower than 0.7 (Bryman, 2011). Other researchers state that

values as low as 0.5 can be acceptable, if the concepts and field of study are rather under researched (Field, 2013), which is the case for *Developmental leadership* and *Health oriented leadership*. Bearing that in mind, all of the Cronbach's alpha levels in the study is more than acceptable.

Theory

In retrospect, an aspect that could have been included to make the study of structural empowerment more complete is to also measure psychological empowerment. In this study, the social-structural perspective of empowerment was in focus. Even though this perspective has gained a lot of attention in research, it is still limited to its "organisation-centric perspective" (Spritzer, 2008, 56). To address this, an improvement and suggestion for further research could be to also include measuring psychological empowerment.

Conclusion

The purpose of this study was to investigate if health promoting leadership orientations are related to organisational support resources as perceived by first-line managers. To address this question, four research questions were constructed and data was analysed through descriptive-, bivariate-, multiple regression- and hierarchical multiple regression analysis. Our results indicate that the overall access to different organisational support resources is on an acceptable level, enabling the first-line managers to be structurally empowered. More specifically, *Administrative support* and *Human Resource support* received the highest ratings of the first-line managers in Gothenburg City, which we interpret to be explained by these being the most visible support resources. In contrast, *Role clarity* and *Organisational rules, policies and regulations* were the least perceived, indicating a need for higher levels of support in these areas. Improvements in these parameters could improve the first-line manager's formal power. In summary, one could assume the first-line managers need more organisational support resources in combination with other components in order to heighten their structural power and improve their practice of health promoting leadership orientations.

Regarding the health promoting leadership orientations, *Participative leadership* was rated highest. The authors believe that this leadership orientation was approached to the highest extent because of the nature of the first-line manager position, having close interactions with their employees on a daily basis. The results indicate that the first-line managers' informal power is thus high, since *Participative leadership* requires maintenance of the social interactions that is the foundation of informal power.

Health oriented leadership was the second most approached leadership orientation. It was also the leadership orientation with the strongest relationship to the organisational support resources. In line with previous research, the authors conclude that well-functioning organisational support resources could facilitate a *Health oriented leadership* approach.

Furthermore, *Developmental leadership* was least approached by the first-line managers and had no significant correlations with organisational support resources. With this background, Gothenburg City might have difficulties empowering the employees of the first-line managers, since empowerment is an effect of education (Spreitzer, 2008). The authors interpret this as an indicator that there might not be enough nor the right organisational support resources present to practice this leadership orientation. Alternately, that *Developmental leadership* is not affected by organisational support resources.

The authors conclude that *Administrative support* and *Role clarity* were the organisational support resources with the strongest relationship to *Participative-* and *Health oriented leadership*. The relationship was discussed to possibly be explained by the fact that well-functioning support in these areas liberates time to the first-line managers to practice these leadership orientations. Moreover, if the now low perceived *Role clarity* was improved, a potential positive effect could be achieved regarding practicing health promoting leadership orientations.

Another important result of the study is the effect of the alternative HR support resources, namely *Health promoting organisational projects* and *Health promoting self-leadership*, that both have a significant relationship with *Health oriented leadership*. This sheds light on the importance of a more strategic HR support for the first-line managers, it may also explain why the administrative *HR support* variable in most leadership orientations was rather low.

In conclusion, well-functioning organisational support resources could give the first-line managers more time to practice health promoting leadership orientations and therefore increase the well-being and health of their employees. The organisational support resources chosen for this study cannot alone explain the variance in the health promoting leadership orientations. Our results reveal that other support resources and structures and to date unknown variables may also play an important role in how to increase the occurrence of health promoting leadership orientations.

Future Research

The authors would like to see more research conducted on the importance of organisational support for managers on different levels of organisations, in both public and private sector. Our results indicate that organisational support has potential positive effects on specific leadership orientations, known to improve health in organisations. The authors believe these findings to be of interest to many organisations wanting to increase health in the workplace. We also call for more research in this relatively unexplored field. Furthermore, there is a need for more research on what resources and preconditions managers need to practice these health promoting leadership orientations.

Practical Implications

This study is of interest for the researching community because it provides implications on how to increase parts of health promoting leadership for first-line managers, which in turn could have potential to decrease sick leave rates for public sector workers. Since the investigated relationship has not previously been studied, it opens up a new research interest in how to work with different kinds of organisational support for leaders in order for them to receive the best conditions in practicing a health promoting leadership.

Furthermore, this study is of value for HR professionals since it indicates the need for additional types of organisational support resources and HR support resources with the potential to improve health promoting leadership orientations amongst first-line managers in public sector organisations in Sweden.

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