Full Length Research Paper

Leadership in public health care: Staff satisfaction in selected South African hospitals

A. A. Braam Rust[1]* and J. W. Johan de Jager[2]

[1]Business Faculty, Cape Peninsula University of Technology, South Africa.
[2]Tshwane University of Technology, South Africa.

The main objective of this study is to evaluate expressed levels of staff satisfaction regarding specific leadership characteristics at two public hospitals in two South African provinces. Currently, public hospitals in South Africa are highly stressed institutions because of understaffing, management and leadership failures. For example, a lack of effective leadership and management capacity exists; hospitals managers are disempowered and frustrated by growing centralized control at provincial level; doctors and nurses have departed for more lucrative positions within the private sector; and there has been a significant reduction of posts for support workers. Frustrations culminated in the most severe strike within the South African public sector (June, 2007) . It was assumed that the wage dispute was the highlight of a variety of conflicts that have undertones of several other examples of frustrations and unsatisfactory behaviour. These problems and obstacles reflect inappropriate leadership. In this study (2009 Please provide full reference), it was found that staff at hospitals experience more active leadership abilities (inspire trust; motivate subordinates; care deeply about the well being of employees; assist subordinate workers) from leaders in their workplaces (hospitals) and to a lesser extent, from leaders at provincial and national level. Thus, leadership abilities of managers further from the workplace (managers at provincial and national levels), are not as active as the managers at the hospitals.

Key words: Leadership; public hospital management; leadership in public hospitals; public sector hospitals.

INTRODUCTION

The hospital industry globally varies owing to mainly historical factors. State hospitals are given in all countries and form part of the state as a service provider. Research in the management of hospitals were, in the past, mainly conducted in the USA and Britain and focused on probably all circumstances within the private sector. Also, the management of state hospitals is impacted by unique external and internal factors. State hospitals in South Africa are unique in various aspects, which all impact on the smooth running of their activities. A state hospital should serve communities, especially the poor (this makes state hospitals unique), with the smooth running of patient care in wards, in the trauma areas and in the operation theatres. The nature of workplace relations which is largely founded in effective leadership is thus important, given its service-intensive nature as well as the relatively high ratio of labour costs to the total costs. Prevention and elimination of managerial obstacles, is vital in today's health care environment. Problems and obstacles often reflect inappropriate leadership.

Due to the June 2007 strike in the South African public sector, it is assumed that the wage dispute is the highlight of a variety of conflicts that have undertones of several other examples of frustration and unsatisfactory behaviour. The strike was more prominent within the hospital sector and, at times, even more aggressive than other public sectors, which may be an indication of deep-rooted frustrations. A strike is usually a culmination of several factors. A strike has a developmental phase, which comprises accumulating conflicts, disputes and deadlocks that end in industrial action where employees withhold their labour (Nel, Swanepoel, Kirsten, Erasmus

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*Corresponding author. E-mail: rustb@cput.ac.za.

and Tsabadi, 2005:199; Venter, 2003:470). Non-strike actions, e.g. various forms of slowdowns such as sickouts, work -to-rule and refusals to work overtime, can be as severe as a strike. In order to prevent these actions, an in-depth study of the workplace situation is necessary to focus on the real problems and to adapt and make changes. Leadership in hospitals, in general, and particularly within provincial hospitals in South Africa, experiences difficulties. Actually, the entire public sector industry is searching for an appropriate and sensible model.

DISTINCT SOUTH AFRICAN PROBLEMS IN PUBLIC HOSPITALS

Over 80% of South Africans have no medical aid, and have no choice but to seek treatment at the government hospitals and clinics. This is not the ideal situation when a common perception exists that public sector hospitals are inefficient and ineffective while the privately owned and managed hospitals provide superior care and are more sustainable. A lack of proper leadership and management flaws has lead to this perception. A recent survey rated public hospitals as the worst of all public services in South Africa (Naledi, 2006). The result is that patients are dying unnecessarily because the public hospitals are over- burdened, under-staffed and poorly managed. Reasons for these perceptions are (Benjamin, 2006; Cullinan, 2006; Pillay, 2008; Von Holdt, 2007) as discussed.

Leadership and management failures

There is a lack of leadership and management capacity within the public health sector in South Africa. e.g. head office officials at provincial level have very little understanding of the operational complexities of running bigger hospitals. These offices micromanage the hospitals and handcuff the hospital managers with endless regulations and tedious procedures. Hospital managers have little control over budgets, procurement, discipline, staffing levels and staff structures. They are disempowered and frustrated by the centralized control that departmental officials exert over their everyday activities. The result is that hospital managers cannot be regarded as accountable for health-care failures in the hospitals, as they lack the necessary powers to change things. This fragmented management structure results in a pervasive disempowerment, frustration and lack of res-ponsibility; (no clear lines of authority and accountability).

Management capacity problems

There is a common perception that public sector hospitals are inefficient and ineffective. Hospital's Chief executives and superintendents are unable to decide on staff numbers, draw up their own budgets or play any role in the procurement of goods and services; dysfunctional relationships between hospitals and provincial head offices, which "have centralised control over strategic, operational and detailed processes but are unable to deliver on these. A possible reason for this is the bureaucracies, both in head offices and in hospitals.

Understaffing

Doctors and nurses have departed for the more lucrative private sector where conditions and pay were better, thus staff shortages and management failures compromise patient care. This led to a cycle of young professionals choosing to move to the private sector where conditions and pay were better. Public hospitals are highly stressed institutions because of understaffing; public health service is essentially running on the commitment of nurses and doctors to serve their communities, despite pathetic pay packages, enormous workloads and horrible working conditions. The reason: Budgets have been slashed in real terms. 'Fiscal discipline', meant a gross deterioration in most public hospitals. Another reason, the closure of nursing colleges by government in the mid-1990s is the primary cause of the shortage of skilled nurses. The result: Hospitals have been forced to limit their services. Patients are dying unnecessarily because South Africa's public hospitals are over-burdened, under-staffed and poorly managed.

Increased patient loads

Hospitals are battling to cope with the demand. Two factors are mainly behind the massive increase in patients: the AIDS epidemic and rapid urbanisation, where a large number of people are now living in unhealthy conditions in informal settlements.

Reduction of support workers' posts (cleaners, porters, clerks and messengers)

Approximately one-third of health posts countrywide are vacant, but some institutions are running with less than half the staff they need.

Lack of staff discipline

A widespread lack of discipline exists, which generally has a corrosive effect on work ethic and morale. Hospital managers' ability to take disciplinary action is severely limited by the centralised nature of provincial health

bureaucracies. Absenteeism among health workers is rife, due to stress; nurses also turn up late, leave early and often neglect patient care such as regular monitoring of vital signs.

LITERATURE STUDY

Leadership in public hospitals

Meaning of leadership in public hospitals

It is commonly accepted that all managers have leadership and managerial functions (Robbins, et al., 2003:242). Leadership has been historically and typically defined and understood in terms of traits, qualities, the situation in which the leader exists and the behaviour of the leaders (Dotlich, Noel and Walker, 2004:4). However, there is no academic agreement on what essential leadership competencies are most important, let alone if they can be taught or are effective. As Stogdill (1974:7) points out, *"there are almost as many different definitions of leadership as there are people who have tried to define it. But, successful managers must lead and manage effectively."*

Goodwin (2006:2) sees leadership as: *"…a dynamic process of pursuing a vision for change"* and *"leadership is concerned with change and the future"*. This means leaders must be able to look over the horizon to identify the opportunities and threats over the course of decades, not just months or years. They must be able to construct practical options for action that are flexible and open to change. And they must be able to bring people along with them. Charney (2006:6) says leaders are people of influence. Nelson and Economy (2005:6) add: *"Leaders need to energize and motivate: create visions that inspire employees to bring out their very best performance."* Employees are the most important resource and are much more productive when energized, that is, unleashing their passion and talent. Motivated people are always looking for better results. Rondeau and Wagar (2002:3) argue that motivated employees have improved morale, commitment, and satisfaction. They accept that change means adaptation and not being afraid of reinforcing a new mission, culture, and values of restructuring and that it involves redefining beliefs, structures, and practices (Wooten & Decker, 1996:15). They also understood that the change will not immediately result in increased effectiveness. Godard and Delaney (2000) say they always have a need or desire to change from the status quo.

Horner (1997) argues further that the current theories of leadership view leadership as a process in which leaders do not lead the followers, but are seen more as members of a community of practice. Goodwin (2006) agrees that modern leaders are part of a team: "Leaders today are far more open to consensus building than were

previous generations. And the most important leadership skill is therefore influence." This view is also supported by Denis, Lamothe and Langley (2001), with: "collective leadership"; "contributions of more than a single individual" and "leadership is shared". The effectiveness of leadership, though, depends on the degree of complementarities among their members. Adler, Riley, Kwon, Signer, Lee and Satrasala (2003:18) also agree, and are of the view that team leadership is possible and will result in greater collaboration with more centralized (hospital-wide) decision making and standardization and with regular meetings with representatives from all the hospital departments.

Nevertheless, effective leadership is accepted as an important ingredient for management success. In general management, public hospitals don't differ from other hospitals or even with any other organisations – the emphasis is on service to the community. Therefore, if we can identify exactly what it is, it could then be replicated in the management of public hospitals.

A common goal in public hospital leadership is effectiveness. Wankhade and Brinkman (2007) say effective leadership is a key ingredient in modernising today's health services. The core question today is: how do public hospital leaders successfully lead? 'Management' is vital and it consumes much time but in most organisations successful managers must do more to truly lead.

The basic premise of management is that managers set goals that represent some level of growth for a particular group in a particular environment. Managers then develop strategies for reaching these goals. Results are evaluated and altered or new directions are set. Managers constantly design strategies for moving groups of personnel to more efficient and more qualitative levels of functioning. In conducting these processes, managers plan, organise, motivate, control and evaluate the work of health-care personnel in the delivery of professional care. In practice it means better service delivery, better patient care and improved working practices for staff. The challenge is to select the best leadership style for the moment and circumstances. The authors argue that an effective leadership style will necessitate a successful partnership and teamwork between individuals, organisations, politicians, healthcare professionals and other stakeholders within the complex network of public health.

Leadership traits and characteristics

The following are important leadership traits and characteristics for effective organisations (Byrum, 2005; Eade, 1996; Kennedy, 2000):

Motivation

Autocratic leadership styles were more common in the

1970s (and earlier). Gradually this made room for more democratic styles. The autocratic style feeds high staff turnover and low employee morale. Low morale, in turn, causes a decline in productivity and in the quality of service provided to your clients (patients). The leader has a direct impact on staff performance, productivity, satisfaction, and turnover (Rondeau and Wagar, 2002:3). The most important technique for motivating the people you supervise is to treat them the same way you wish to be treated: as responsible professionals (McCauley and Van Velsor, 2004:5), that is to strike the right balance of respect, dignity, fairness, incentive, and guidance, to create a motivated, productive, caring, satisfying, and secure work environment (Wooten and Decker, 1996:15; Buzan T., Israel and Dottino, 2003:90; Jaques and Clement, 1994: 69). In short, motivational leaders produce better results; those who focus on positive reinforcement rather than fear and intimidation will be the successful managers in the next millennium.

Adaptive Leadership

Good leaders have the ability to be innovative to adapt to ever-changing and ever-challenging environment (Bennis, Spreitzer and Cummings, 2001:116; Charan, Drotter and Noel 2001: 94) . They have a capacity to generate promise, hope, and trust.

Reputation

Outstanding leaders have developed a positive reputation with peers. Integrity and credibility are two of the most important factors (Williams, 2005:3; Schuitema, 1998:92; Pardey, 2007:25; Cranwell-Ward J, Bacon A, and Mackie R, 2002:172; Shaw P, 2006:64). The well respected, excellent practitioner who has a 'track record' of high values can be most influential with peers and colleagues (Denis et al., 2001:820; Avolio and Luthans, 2006:95)

Reliability

They inspire trust (Williams, 2005:148; Dotlich et al., 2004:4; Cranwell-Ward et al., 2002:172). Confidence and reliability in leaders are integral components to accepting and supporting the decisions made (Barrett 1998:27; Shaw P, 2006:187).

Involvement

Leaders have the conviction and passion to get involved and stay involved. The commitment to service and the ethical determination to lead is crucial to being a successful leader. They are energetic, capture people's attention and command their best energies (Nelson and

Economy, 2005:6; Barrett, 1998:231).

Interpersonal skills

Leaders also need to develop interpersonal skills to lead properly. They listen and communicate effectively (Adler et al., 2003:18; McCauley and Van Velsor, 2004:14; Bennis and Townsend, 1995: 52; Phillips and Schmidt, 2004:222). A leader listens to subordinates, solves problems and leads the way (Bennis et al., 2001:84; Buzan et al., 2003:111; Shriberg et al., 2005:86).

Coaching and leadership development

Leaders are willing to develop, empower and coach others. They want peers, and subordinates to grow (Williams, 2005:4; Schuitema, 1998:133; Avolio and Luthans, 2006:83; Bennis and Townsend, 1995:73; Jaques and Clement, 1994:195; Maxwell, 2001: 93).

Create culture

Leaders create a family environment (Cranwell-Ward et al., 2002:371; Maxwell, 2001: 93; Phillips and Schmidt, 2004:9; Shriberg et al., 2005).

Problems with leadership in public hospitals worldwide

The modern hospital is a complex institution that operates with limited resources. Unfortunately, as soon as the complexities of the delivery of health care in public hospitals mix with human relationships, even the best-intentioned supervisors can find the management side of their jobs deteriorating into chaos. Berwick (1997:2) agues this is why a large gap exists between how health care could perform and how it does. Eade (1996:1) says today's health care providers face expanding workloads, fewer resources, greater patient expectations, increasing threats (e.g., malpractice lawsuits), and closer scrutiny, especially from third-party providers. Nurses and doctors often find themselves in managerial roles, with tremendous responsibilities. Job performance is reflected more in the bottom line than in the quality of patient care.

Justice (2005:2) adds by saying that most people (up to recently) got into the healthcare management arena because of their technical skills and not because of their managerial and leadership skills. Nurses and doctors often find themselves in managerial roles, with tremendous responsibilities. Bloom (1990:2) says this leads to competition for economic and psychological dominance, as a result, problem solving by the staff is

ineffective. A somewhat unanswered problem is why, in this environment, do some managers thrive while others burn out? The answer lies in each manager's ability to work with peers, that is, to inspire trust, loyalty, commitment, and collegiality among team members. Eggli and Halfon (2003:29) take it further and highlight the problem when a lack of qualified staff exists and the situation is exploited by those in demand. Preventing and overcoming these obstacles is vital in today's competitive marketplace. Many hospitals are spending thousands in sign-on and retention bonuses to keep talented workers who will provide quality care.

Rising cost is a further problem that has its roots in management, more specifically the waste of resources because of the technical and managerial inefficiency within hospitals (Tabish, 1998:109; Goodwin, 2006:2). In order to control hospital expenditure and improve the efficiency, management, and role of hospitals in the health sector, there is a need to introduce professionalism in hospital management and leadership.

Distinctiveness of public sector hospitals

The scenario of the hospital as an entity, and more specifically the public sector hospital, needs to be highlighted. In general management, public hospitals do not differ from other hospitals or even from any other organisation, the emphasis is on service to the community. But, the interaction between economic/business, medical and management values needs to be understood. For instance information handling should give maximum consideration to the needs of decision-making in the management process. In a hospital, management includes patient management (the point where clinical management takes over from hospital management), thus reaching right to the bedside. Information selection, storage, and dissemination functions in the hospital must be designed to ensure maximum compatibility between the requirements of both business and clinical aspects of management.

The line and staff relations, that is, managers/ administrators and doctors, in hospitals may differ from those in other organisations. Delegation, decentralisation and formalisation may have other characteristics in health care than in other sectors. The relations between different departments and units in a hospital could present a structure different from that of, e.g. a manufacturing company. The environment, technology and lifecycle stage of hospitals may differ greatly from those in the industrial sector. Organisational identity and culture are other issues which show differences between the two categories of organisation.

Challenges for public hospital leaders

The typical public sector hospital employee in South Africa

can end up in a work environment with colleagues from different backgrounds in terms of age. This can confuse any worker if good leadership is not applied. For instance, people who started in the 1970s came from an environment of a rigid and bureaucratised public service with its treatment of talent, restraint on creativity and isolation from the community. In the 1980s and 1990s the characteristics of our modern public service evolved to include: heightened responsiveness to the elected government; improved efficiency and effectiveness, including more results-based management, and increased community participation.

During the 1990's citizens became "clients" or "customers", and the public sector competed with the private sector in contestable markets. People in permanent posts lost their permanency and were employed on performance-based contracts in line with private sector practice. After 2000, the public's expectations of government have never been higher. And at the same time, government accountability has never been greater.

During the last ten years, hospital executives were focused on restructuring and re-engineering their organizations for greater efficiency. Today, the leadership skill set being sought by future-oriented hospital organizations has shifted dramatically. What has changed is that beyond financial acumen (to accomplish more with less), a much wider range of complex skills in leadership, communications and management of rapid technological changes are increasingly essential for managers (Justice, 2005:2). Coye, Foege and Roper (1994:6) also say that public health leaders of today deal with multidimensional public health problems that are intertwined with seemingly intractable social and economic ills. These issues demand that leaders in public health be equipped differently than the leaders of yesterday. Even active professionals, who have been working in the field for some time, are not prepared for the current and future challenges facing public health.

What skills are needed to prepare leaders in public health? The business community and academia have moved increasingly into the study and teaching of leadership, and away from the more technical discipline of management, a trend that is taking hold in the public health sector as well. Leadership includes skills like the ability to see the big picture, to think and plan strategically, to share a vision with others, and to marshal constituencies and coalitions for action.

Broad-based leadership in the public hospital sector is essential to create a new culture based on innovative, joined-up, citizen-centred delivery at the local level. It's about meeting the challenge of rising public expectations of government in a resource-constrained world. This in turn has encouraged hospital workers to strive for continuous improvement in the quality of public policy work. Kennedy (2000:5) adds with: "Because of the many changes that medical care has undergone recently, we

need excellent leadership to guide health care into the 21st Century."

Leadership is not generated spontaneously. The public hospital community needs to formally develop leaders to address the many problems that confront them. To meet these challenges and obstacles they must get involved in the discussions, debates, and decision-making processes that affect them. Those with experience have the greatest knowledge, involvement, and ability to direct changes. If they do not lead the decision-making processes that will dictate the future, decisions will be made by insurers, politicians, and businessmen whose primary goal may not be the betterment of health care provision (Kennedy, 2000:7).

OBJECTIVES OF THE STUDY

The relationship between leadership, in general, and human resource management practices as well as organisational performance (including qualitative care within health-care organisations), is an important topic in the organisational sciences, however, little research has been conducted, which examines this relationship within state hospital settings in South Africa. Nevertheless, it is well known from a variety of studies, that organisations operate more effectively and efficiently when specific leadership functions are applied and management operations are dealt with correctly (Robbins, Odendaal and Roodt, 2003).

The main objective of this study is to evaluate expressed levels of staff satisfaction regarding specific leadership characteristics at two public hospitals in South Africa, situated in Gauteng Province and in the Western Cape Province where levels of employee satisfaction are tested. For a better understanding, leadership in public hospitals in South Africa is applied at different levels (national, provincial and local/hospital) . Centralisation of decision-making authority has moved over the last ten years towards a more central point at national and provincial levels. In this study, the first four variables have been tested with respect to the three management levels, while the remaining nine variables have been tested in general management terms, which are applicable to the hospital.

RESEARCH METHOD

Hypotheses

With regards to the staff satisfaction variables the following hypotheses were formulated:

H_o; there exist no significant differences in the staff satisfaction evaluations between the staff members of the two hospital samples. H_a; there exist significant differences in the staff satisfaction evaluations of the two hospitals' staff members.

Data collection

Sample framework

Staff satisfaction surveys were conducted amongst staff members at two provincial hospitals; one in Gauteng and the other in the Western Cape region, South Africa. The attitudes of the staff were tested regarding certain pre-identified staff satisfaction variables. These variables are identified in order to eventually implement an internal marketing strategy. A list of variables was generated after an extensive literature study was conducted as well as focus groups consisting of staff members employed by the hospital. The final questionnaire was subsequently approved by the hospital's management team and the researchers. A total of 542 hospital staff members were randomly selected and voluntarily completed a self-administered questionnaire. The response rate was 94%.

Out of a total of 542 staff members that were interviewed, 75% were employed at a hospital in Gauteng while 24.5% were from a hospital in the Western Cape. Thirty one percent of the respondents were males while 61% were female. With regards to the level of the posts, 61% of the staff is in an operational capacity, 27% in a supervisory capacity and 13% in a management capacity. Thirteen percent of the staff is in the age group 18-25 years, 29% between 26-35 years of age, 29% between 36- 45 years and 28.2% older than 45 years of age. Thirty percent of the staff has between one and five years of experience while 70% of the staff has more than five years experience.

Measuring instrument and data collection method

A survey using a self administered questionnaire was conducted among hospital staff in a hospital in the Gauteng province and a hospital in the Western Cape. The survey (questionnaire) focuses on the views of staff regarding the levels of experience of general leadership characteristics within the hospital. The information collected is categorized into four sections e.g. Leaders ability to inspire trust, leaders ability to motivate subordinates, leaders ability to care about the well being of the employees and the willingness of the leaders to help subordinate workers. Ratings were based on a five point Likert scale ranging from a very poor level of experience (definitely do not agree) to a very high degree of experience (definitely agree). Data was collected by means of personal interviews. This was conducted by trained fieldworkers.

Techniques of data analysis

Data was captured by a trained assistant and analysed using the SPSS version 12 statistical package. An item analysis was carried out to test the validity and the reliability of the questionnaire and an overall Cronbach coefficient Alpha of a 0,944 was measured. A two sample t test was conducted to test the null hypothesis and the alternative hypothesis that there exists no significant difference between the levels of satisfaction between the two groups and there do exist significant differences between the groups (medical staff and nursing staff).

RESULTS AND DISCUSSION

The following findings were made: Table 1 indicates the ability of the different levels of leaders to inspire trust. It is evident that staff members of both hospitals are in agreement that the management level closest to them

Table 1. Extent to which leaders have the ability to inspire trust.

Leader	Hospital A		Hospital B		Value/Remark
	Mean	SD	Mean	SD	
Departmental management (Ministers at national and . provincial levels)	3.08	1.21	2.19	1.00	Df = 1 p-value 0.000 Conclusion: Ho rejected
Institutional/Hospital managers (CEO, superintendents of hospitals, heads of departments)	3.17	1.81	2.51	1.06	Df = 1 p-value 0.000 Conclusion: Ho rejected
First level managers (supervisors)	3.37	1.18	3.13	1.19	Df = 1 p-value 0.085 Conclusion: Ho accepted

Table 2. Extent to which leaders have the ability to motivate subordinates.

Leader	Hospital A		Hospital B		Value/Remark
	Mean	SD	Mean	SD	
Departmental management (Ministers at national and provincial levels)	2.95	1.17	2.31	1.03	Df = 1 p-value 0.000 Conclusion: Ho rejected
Institutional/Hospital managers (CEO, superintendents of hospitals, heads of departments)	3.13	1.18	2.53	1.05	Df = 1 p-value 0.000 Conclusion: Ho rejected
First level managers (supervisors)	3.36	1.17	3.04	1.21	Df = 1 p-value 0.018 Conclusion: Ho rejected

has a greater ability to inspire trust compare to the managers that are higher up in the hierarchy. Statistical significant differences exist between the respondents of both hospitals regarding all three questions.

Table 2 indicates the ability of the leaders to motivate subordinates. It indicates a similar trend to the findings in Table 2. It appears that the further away the managers are from the hospitals employees (respondents) in terms of the hierarchy, the lower are their ability to motivate subordinates. This applies to staff of both hospitals. Statistical significant differences exist between the respondents of both hospitals regarding all three questions.

Table 3 indicates the leaders' ability to care about the well being of the employees. It indicates a similar trend to the findings in the previous two tables. It appears that the further away the managers are from the hospitals' employees (respondents) in terms of the hierarchy, the lower are their ability to care deeply about the well being of the employees. This applies to staff of both hospitals. Statistical significant differences exist between the res-pondents of both hospitals regarding al three questions.

Table 4 indicates the extent to which leaders are willing to assist subordinate workers. It shows direct resemblance to the findings in the previous tables. It appears that the further away the managers are from the hospitals' employees (respondents) in terms of the hierarchy, the lower their ability to assist subordinate workers. This applies to staff of both hospitals. Statistical significant differences exist between the respondents of both hospitals regarding al three questions. Respondents of hospital B were more in agreement with regards to all the statements compared to employees of hospital A.

Table 5 indicates other aspects of leadership. The variable that respondents of hospital A were more in agreement, compared to the other variables was the main culture in the hospital is to build quality relationships with fellow employees and patients. Slightly more than 50% of respondents rated this variable between 'agree' and 'definitely agree'. This variable was also rated fairly high and in second position by respondents of hospital B. In this case, over 58% of the respondents rated it between 'agree' and 'definitely agree'. Statistical signifi-cant differences between respondents of the two hospitals

Table 3. Extent to which leaders care deeply about the well-being of employees.

Leader	Hospital A		Hospital B		Value/Remark
	Mean	**SD**	**Mean**	**SD**	
Departmental management (Ministers at national and provincial levels)	2.99	1.23	1.99	0.95	Df = 1 p-value 0.000 Conclusion: Ho rejected
Institutional/Hospital managers (CEO, superintendents of hospitals, heads of departments)	3.17	1.18	2.26	1.05	Df = 1 p-value 0.000 Conclusion: Ho rejected
First level managers (supervisors)	3.4	1.16	2.91	1.22	Df = 1 p-value 0.000 Conclusion: Ho rejected

Table 4. Extent to which leaders are willing to help subordinate workers, namely to act as coaches (facilitators, developers of people).

Leader	Hospital A		Hospital B		Value/Remark
	Mean	**SD**	**Mean**	**SD**	
Departmental management (Ministers at national and provincial levels)	3.0	1.22	2.29	0.99	Df = 1 p-value 0.000 Conclusion: Ho rejected
Institutional/Hospital managers (CEO, superintendents of hospitals, heads of departments)	3.15	1.2	2.48	1.05	Df = 1 p-value 0.000 Conclusion: Ho rejected
First level managers (supervisors)	3.42	1.19	2.93	1.18	Df = 1 p-value 0.000 Conclusion: Ho rejected

Reliability: Cronbach alpha 0.878

hospitals exist.

On the statement that respondents of hospital A rated second in terms of their level of agreement which was "s*taff generally wants everybody to speak well about their hospital,"* more than 54% of respondents of hospital A rated this statement between agree and definitely agree, while 58% of hospital B's respondents felt the same. Statistical significant differences between respondents of the two hospitals exist.

The statement that "*the competency of the direct supervisor is of an acceptable level,"* was rated third position by hospital A's respondents. More than 42% of respondents rated this variable between 'agree' and 'definitely agree'. Respondents of hospital B, however, rated this variable in the first position in terms of their rate of agreement. Over 53% of respondents rated this variable between 'agree' and 'definitely agree'. No statistical significant differences exist between respondents of the 2

hospitals in terms of this variable.

The variable*, 'management in our hospital manages staff talent efficiently,'* was rated last in terms of level of agreement by respondents of hospital A and in seventh position by respondents of hospital B. In terms of hospital A, 16% of respondents rated this variable between 'agree' and 'definitely agree', while almost 42% of respondents of hospital B rated it between 'agree' and 'definitely agree'. Significant differences between the two respondent groups, in terms of this variable, exist. The variable that respondents of both hospitals rated in eighth position is '*management in our hospital shows appreciation for what the staff is doing'.* A total of 19% of respondents of hospital A rated this variable between 'agree' and 'definitely agree', while over 47% of respondents of hospital A rated this variable between agree and definitely 'agree'. Statistical significant differences between respondents of the two hospitals exist.

Table 5. Other aspects of leadership.

Aspects of leadership	Hospital A		Hospital B		Value/Remark
	Mean	SD	Mean	SD	
The competency of my direct supervisor is of an acceptable level.	3.523 42.6% Agree - DA	1.13	3.321 53.1% Agree - DA	1.22	Df = 2 p-value 0.855 Conclusion: Ho accepted
Our leaders are willing to listen to staff.	3.297 39.7% Agree – DA	1.11	2.944 47.5% Agree – DA	1.12	Df = 2 p-value 0.002 Conclusion: Ho rejected
Mutual respect exists between our leaders and staff	3.385 41% Agree – DA	1.09	2.935 49.7% Agree – DA	1.17	Df = 2 p-value 0.000 Conclusion: Ho rejected
Our main culture in the hospital is to build quality relationships with fellow employees and patients.	3.641 50.1% Agree – DA	1.09	3.222 58.2% Agree – DA	1.07	Df = 2 p-value 0.000 Conclusion: Ho rejected
Staff has a collective identity with other employees and the hospital.	3.514 35% Agree – DA	1.07	2.886 54.3% Agree – DA	1.06	Df = 2 p-value 0.000 Conclusion: Ho rejected
Staff experiences a family-like fabric in our hospital (staff and management act as one family).	3.376 14% Agree – DA	1.14	2.289 47.5% Agree – DA	1.01	Df = 2 p-value 0.000 Conclusion: Ho rejected
Staff generally wants everybody to speak well about our hospital.	3.592 53.8% Agree – DA	1.13	3.222 57.7% Agree – DA	1.07	Df = 2 p-value 0.001 Conclusion: Ho rejected
Management in our hospital manages staff talent efficiently	3.189 16.4% Agree – DA	1.17	2.437 41.9% Agree – DA	1.01	Df = 2 p-value 0.000 Conclusion: Ho rejected
Management in our hospital shows appreciation for what the staff is doing.	3.218 19.4% Agree - DA	1.23	2.358 47.2% Agree - DA	1.08	Df = 2 p-value 0.000 Conclusion: Ho rejected

A = Agree DA = Definitely agree. Figures below means indicate rank order of variables as per hospital.Reliability: Cronbach alpha 0.945

For the other categories, the study shows that leaders are more willing to listen to staff in B than in A; a little more mutual respect exists between leaders and staff in B than in A; staff has a higher level of collective identity with other employees and the hospital in B than in A; and staff experiences a much larger family-like fabric in B than in A.

Conclusion

The main objective of this study was to evaluate expressed levels of staff satisfaction regarding specific leadership characteristics at two public hospitals in South Africa. The survey revealed that staff at both hospitals experience more active leadership abilities (inspire trust; motivate subordinates; care deeply about the wellbeing of employees, assist subordinate workers) from leaders in their workplaces (hospitals) and, to a lesser extent, from leaders at provincial and national level. The leadership abilities of managers further from the workplace (managers at provincial and national levels), are not as active as the managers at the hospitals.

The secondary objective was aimed to determine the

existence of significant differences regarding staff satisfaction variables in terms of specific leadership characteristics between staff members at the two hospitals. It was found that experiences of staff regarding leadership abilities amongst management at hospital A are rated on a much lower level than at hospital B. However, more alarming, the application of leadership abilities is on a relatively low level at both hospitals. Thus, leadership on the three managerial levels should understand and be clear that the application of leadership affects both effectiveness and efficiency of staff.

RECOMMENDATIONS

On the basis on this study, a number of recommendations can be made: (1) Generally, staff in both hospitals experience more active leadership abilities (inspire trust; motivate subordinates; care deeply about the wellbeing of employees, assist subordinate workers) from leaders in their workplaces (hospitals) and, to a lesser extent, from leaders at provincial and national level. Staff members of hospital A are, however, more positive with regard to all four variables that are dealt with in this section. Information sessions should be introduced to different levels of management informing them of the outcome of the research. This should be done in order to address issues of handling inspiring trust, motivating people, care about the wellbeing of employees and willingness to assist subordinates to act as coaches. Hospital B should assume a tougher approach in this regard. Ironically, more leadership abilities would be expected from these levels owing to centralisation of authority at these levels. In general, this phenomenon does not contribute to effective and efficient management on ground level. The result is an ill-motivated and ill-committed staff component. In order to turn this around, more authority and decision-making rights should be afforded to workplace leaders (hospital managers). (2) It is also clear that the experiences of staff regarding leadership abilities amongst management in hospital A are rated on a much lower level than in hospital B. The application of leadership abilities is, however, on a relatively low level in both hospitals and sometimes unacceptably low in hospital A (for example, 14%, 16.4% and 19.4%). These levels of low leadership application could also be owing to centralisation of authority to provincial and national levels. In this situation it is expected from hospital managers to lead and manage, but without the necessary authority given to them. This creates frustration among managers that filters down to the workforce. An opposite picture is possible when hospital managers are empowered with authority. The authority will give workplace managers power to effectively and efficiently manage daily operational aspects and longer term decisions of hospital life. (2) Managers,

especially at provincial and institutional levels, should be informed about the importance of identified staff-related issues and their role in maintaining sound business principles. First level managers should be informed about the importance of their role in building quality relationships with fellow employees and patients; their own competency of an acceptable standard; and an overall acceptable image of the hospital. Prioritising these variables will ensure that a healthy environment is created within the boundaries of the health care environment.

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