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Full Length Research Paper

Perceived competencies of nurse managers: A comparative analysis of the public and private sectors in South Africa

Rubin Pillay PhD, MSc, MBA, MBChB, BSc. Hon (Pharm)

Alex G. McKenna School of Business, Economics, and Government, 300 Fraser Purchase Road, Latrobe, Pennsylvania 15650 – 2690. E-mail: rubin.pillay@email.stvincent.edu. Tel: 800-782-2150.

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To reduce the disparities between the public and private sectors, it is important to discern first where gaps exist in nursing managers perceived competencies. This paper provides insight into the managers' perspectives on their strengths and weaknesses, and where they believe they require training. Despite nursing managers playing a central role in ensuring the quality of health care in South Africa and elsewhere, there has been a paucity of research into their perceptions of their skills and competencies, and what their training needs are. A survey using a self administered questionnaire was conducted among 175 nursing managers in South Africa. Respondents were asked to rate their proficiency in 51 management competencies. Public sector nurse managers felt most competent in self management, planning and controlling and relatively less competent in ethical/legal aspects and task related skills. Private sector managers felt most competent in leading, self management and planning and relatively less competent in specific health delivery skills and ethical/legal competencies. Private sector managers perceived themselves to be significantly more competent than their public sector colleagues. Informal training was positively related higher perceived competency levels. This research confirms that there is a significant disparity in perceived management capacity between the public and private sectors in South Africa and also identifies the areas in which the lack of knowledge or skills is most significant for each of the sectors.

Key words: Nursing managers, managerial competency, public sector, private sector.

INTRODUCTION

South Africa's health system comprises a large public sector and a smaller, well-developed and well resourced private sector. The government owned and managed public sector facilities which serve the indigent population are often characterized as being inefficient and ineffective as evidenced by anecdotes of patient dissatisfaction and disaffection (Lehman et al., 2003; Cullinan, 2006 in Health Care Review, 2007). In contrast, the private sector which serves the insured population and those who can afford care on an out of pocket basis, compares favorably with the best in the world (Harrison et al., 2007). This sectoral disparity is underscored by the mal-distribution and migration of health personnel. The public sector which serves over 80% of the population comprises less than 30% of doctors and just over 50% of nurses (Sanders and Lloyd, 2005). In addition there is a constant outflow of nurses from the public to the private sector (Padarath et al.,, 2003), due in part to the public sector nurses' dissatisfaction with their pay, the work load and the resources available to them (Pillay, 2009).

Given that nurses are a critical component of health systems, especially within the primary health care philosophy, it is imperative that they manage and are managed in a way that ensures the effective and efficient delivery of care in a sustainable manner. The overall negative perceptions of care in the public sector, coupled with the fact that public sector nurses appear to be significantly more dissatisfied with their work context and their managers, than their private sector colleagues (Pillay, 2009), raises questions about a potential gap in nursing management capacity between the sectors. This study aimed to ascertain the perceived skills and competency levels of nursing managers in South Africa as determined by self assessment and to determine whether there were any significant differences in perceived proficiency levels between managers in the different sectors.

Knowing the perceptions of nurse managers is a first step in rectifying any disparities among them. The findings will therefore be useful in all countries where national health systems are attempting to bridge the gap between public and private sectors and thereby enhance efficiency and effectiveness in the delivery of care, by assessing management proficiency as part of an overall management development process.

All managers, irrespective of where or what they manage, need to develop several competencies that will enable them to effectively perform the 4 generic functions of planning, organizing, leading and controlling (Lussier, 2006; Hellriegel et al., 2006). The field of health care management however, poses unique challenges as managers are expected to integrate modern business management practices with clinical and healthcare knowledge. The national centre for health care leadership (NCHL) defined 3 domains - transformation, execution and people - comprising 26 competencies which they believe encapsulate health management today. Transformation competencies equipped managers with strategic skills to envision and inspire new models of healthcare and wellness; execution competencies enabled managers to translate strategies into performance; and people related competencies endowed managers with skills to energize employees by creating an optimal organizational climate and by inspirational leadership (NCHL, 2006). Shewchuck et al., (2005) identified healthcare operations, a patient focus, financial/economic, legal/ethical and medical relationships, in descending order of importance, as domains important for competent healthcare executives. Earlier, the American college of Preventive Medicine had defined a list of health management competencies and performance indicators related to the delivery of health care, financial management, organizational management and legal and ethical considerations to assist in the development of training programs in medical management (Lane and Ross, 1998). Competencies related specifically to health care, including clinical preventive skills, were rated highly by American medical directors, relative to generic management competencies (Halbert et al., 1998). Similar studies in the UK also identified financial, medical and people related skills as the most important for inclusion in management development programs for hospital managers (Walker and Morgan, 1996; Mahmood and Chisnell, 1993). Hospital managers in South Africa felt that people management and self management skills were the most valuable for the efficient and effective management of hospitals, followed by ‘hard management skills’ and skills related to the ability to think strategically. Specific health/clinical skills or knowledge were perceived to be least important (Pillay, 2008).

The literature pertaining specifically to nursing management is relatively sparse and focuses predominantly on developed nations, with none differentiating between public and private sectors. The general consensus does however support the general management and health management literature as described above (Lin et al.,, 2007; Loo and Thorpe, 2004; Mathena, 2002; Oroviogoicoechea, 1996; American Organisation of nurse executives (AONE) 1996; Chase, 1994). The AONE defined nurses management functions as including management of care delivery, personnel development, management of human, fiscal and other resources, strategic planning, compliance with regulatory and professsional standards and fostering of interdisciplinary, collaborative relationships. Lin et al., (2007) defined 4 factors related to human resource management (HRM), operations management, planning, and material and environment management. They demonstrated that these managerial activities and therefore competencies required varied according to the level of the nurse managers with top and middle managers more focused on HRM and planning, and supervisors more on materials management. HRM and leadership skills were also found to be the most important by Mathena (2002), Oroviogoicoechea (1996) and Chase (1994).

Although specific clinical or health delivery skills were not found to be an essential prerequisite for nursing managers (Duffield, 1993; Pedersen; 1993; Lewis, 1990), some authors still found them to be useful in managing nursing services (Mark, 1994, Chase, 1994, Werkheiser, 1990). Mathena (2002) also found that the ability to balance work and home life and other self management skills were also important to succeed as a nurse manager while many authors also acknowledge the importance being able to confront ethical issues given that there will be an increasing need to allocate resources parsimoniously (Kelly-Heidenthal, 2003, Sullivan and Decker, 1988).,

Despite nursing managers being central to achieving improved health service delivery in South Africa and indeed the rest of the developing world and in spite off the government’s human resources plan for health identifying management and leadership development in both the public and private sectors as a key pillar for strategic investment, there has been a paucity of research that systematically analyses whether nurse managers in South Africa have the requisite skills and competencies and what their training needs were. Schaay (1998) emphasised the importance of determining the level of current management capacity and training required as part of an overall management development process in our quest to improve policy implementation and health systems functioning. This paper aimed to evaluate nursing managers’ perceptions about their developed abilities for their current role as well as their needs for further training and development. In addition it compares and contrasts the perceptions of hospital managers in the public sector with those in the private sector regarding these competencies and needs. It is hoped that the information gleaned will help in the conceptualization, design and delivery of appropriate programs aimed at

enhancing management and leadership capacity in the nursing profession in South Africa and other developing nations.

METHODOLOGY

Data for this study came from a cross-sectional self-administered survey of senior nursing managers in the public and private sectors in South Africa. In total, 420 nursing managers were surveyed, of whom 215 were senior nursing managers in public hospitals in 6 of the nine provinces in South Africa (3 provinces did not respond to the call to participate) and 205 were senior nursing managers in private hospitals registered with the hospital association of South Africa, who represent 94% of private hospitals in the country, were surveyed. The survey instrument was designed by the author and comprised a specially developed and pre-tested questionnaire comprising 2 parts. Part one included bio-demographic attributes and exposure to health management training. In part 2, respondents rated their proficiency in each of a list of 51 management competency items on a Likert type scale, from 1(very poor), 2 (poor), 3 (reasonable), 4 (good), to 5 (excellent). (Table 1). These competencies were derived from the literature (Pillay, 2008; Lin et al., 2007; Lussier, 2006; NCHL 2006; Braithwaite, 2004; Loo and Thorpe, 2004; Mathena, 2002; Lane and Ross, 1998; Halbert et al., 1998; Walker and Morgan, 1996; Oroviogoicoechea, 1996; AONE 1996; Chase, 1994; Mahmood and Chisnell, 1993;) and several other stakeholders with an interest in hospital management.

Questionnaires were mailed in October 2007 and non-responders were sent questionnaires 4 and 8 weeks later. Data collection was terminated 6 weeks after the final mailing. The results of a sample of primary non-responders were compared to that of the primary responders to assess non-response bias. Data for individual variables were summarized using frequency distributions and focused on the central tendency (mean) and the dispersion (standard deviation). Factor analysis using principal components analysis was used to extract factors from the 51 competency items. The eigenvalue rule was used to determine the number of factors to be extracted. Item selection for the factors was based on the psychometric quality as well as the conceptual appropriateness of the item as determined by the researcher (Everitt and Landau, 2004). Reliability of scales was estimated by assessing the internal consistency of the scales using Cronbach's alpha. Relationships between variables were analyzed using Chi-square tests for categorical variables and one way analysis of variance (ANOVA) for quantifiable variables.

RESULTS

Questionnaires were returned from 94 of 202 valid addresses of public sector nursing managers. This represents an overall response rate of 44.64%, with a response rate of 46.53 and 40.53% from the public and private sectors, respectively. Four respondents indicated that they worked in both sectors. Although they were included in the total analyses, they were excluded from the sectoral analysis. There were no significant differences between primary respondents and the sample of primary non-respondents in terms of demographics, institutional characteristics and ratings of competencies.

As shown in Table 2, most public sector respondents were female (95.6%), older than 50 years of age (63%) and had been in their current positions for less than 5 years (39.8%). Private sector respondents were also predominantly female (93.5%), between the ages of 35 and 50 (50%), with a similar proportion (40.3%) having been in their positions for less than 5 years.

Close to a 100% in both groups reported having nursing as their primary formal qualification. Formal training in health management, in the form of a certificate, diploma or degree was higher among public sector managers (94.7%), relative to their private sector colleagues (80.5%). Both groups reported equally high levels of informal training in health management (around 90%). These include mentoring, in-service training and non-certified programs. Almost 70% of public sector managers reported an intention to pursue further training in health management while less than 56% of private sector managers expressed this intent.

Bivariate analysis of the categorical variables and sector of employment showed only one significant association. Public sector nurses were significantly more likely to be older than their private sector colleagues (Chi sq 13.247, $p = 0.010$). There was no significant relationship between sector and qualifications, health management training or intention to seek training.

Factor analysis combined with selection of items based on conceptual appropriateness, on the 51 competency items listed in Table 1 yielded 7 factors, all with Cronbach's alpha greater than 0.7. The reconstituted scales are presented in Table 3.

Items in the 'specific health/clinical skills' factor pertain to clinical and public health skills important in health management. 'Planning skills' included items pertaining to creating a vision and preparing strategic plans as well as skills relating to needs assessment and program planing based on an understanding of what is happening inside and outside the organizations. 'Task related skills', or core management functions included functions such as finance, human resources and information technology. People management skills included the ability to be a team player, to work with people from different backgrounds, resolve conflicts, delegate tasks and share information. Self-management skills included items pertaining to awareness of ones strengths and weaknesses as well as one's ability to take responsibility for one's life at work and beyond. The 'controlling' factor comprised items pertaining to monitoring and evaluation of the effectiveness and efficiency of processes and outcomes within their organisations, while the 'ethico-legal' factor comprised items relating to understanding the legislative environment and medical ethics.

Self assessment of levels of proficiency (Table 3) showed that nurse managers on the whole felt most competent in terms of self-management (4.155), planning (4.056) and leading (4.005) and relatively less competent in specific health delivery skills (3.686) and ethico-legal competencies (3, 692). Public sector nurse managers felt most competent in self management (4.048), planning (3.883) and controlling (3.782) and relatively less competent in ethico-legal aspects (3.535) and task related skills

Table 1. List of management competencies important for nursing management.

	Competencies
1	Use of tools to standardise patient management.
2	Evaluating medical necessity and effectiveness of products or interventions
3	Planning and implementation of health promotion programmes.
4	Use of epidemiological data.
5	Assessing the impact of health services delivery on health of population.
6	Delivery of primary preventive services.
7	Integration of nursing services with district health system.
8	Delivery of curative services.
9	Nursing standard and guideline setting.
10	Planning programmes.
11	Creating a vision for the hospital.
12	Planning further needs and developments.
13	Developing organisational goals.
14	Preparing of a strategic plan.
15	Implementing doctors' orders.
16	Budgeting.
17	Controlling and allocating financial resources.
18	Using management information system.
19	Using health service technology.
20	Using HRM principles appropriately.
21	HR planning.
22	Managing personnel.
23	Planning nursing training.
24	Planning of resources.
25	Structure Health Service organisation
26	Managing teams.
27	Communicating organisational goals
28	Motivating employees.
29	Managing conflicts.
30	Managing workforce diversity.
31	Labour relations.
32	Setting organisational culture.
33	Measuring of organisational performance.
34	Assessing the quality of care.
35	Assessing patient satisfaction.
36	Providing feedback to patients and staff.
37	Evaluating health service delivery programmes.
38	Evaluating financial performance.
39	Implementing health quality improvement systems.
40	Managing of nursing quality.
41	Managing of environmental safety and sanitation.
42	Identification and analysis of an ethical issue in a health care setting.
43	Identification and analysis of a liability issue in a health care setting.
44	Labour-related legislation.
45	Health-related legislation.
46	Learning from experiences.
47	Time management.
48	Acting independently.
49	Awareness of personal strengths and weaknesses.
50	Balancing work and life issues.
51	Self-development.

Table 2. Respondent characteristics.

		Public (N = 94)		Total (N = 175)		Private (N = 77)	
		Frequency	Valid Percent	Frequency	Valid Percent	Frequency	Valid Percent
Response rate		**94**	**43.72%**	**175**	**41.67%**	**77**	**37.56%**
Gender							
	Male	4	4.3%	9	5.2%	5	6.5%
	Female	89	95.7%	165	94.8%	72	93.5%
	Total	93	100%	174	100%	77	100%
Age							
	<35	0	0%	6	3.5%	6	7.9%
	35-50	34	37%	73	42.4%	38	50%
	>50	58	63%	93	54.1%	32	42.1%
	Total	92	100%	172	100%	76	100%
Number of years in current position							
	<5	37	39.8%	69	39.7%	31	40.3%
	5-10	32	34.4%	58	33.3%	25	32.5%
	>10	24	25.8%	47	27%	21	27.3%
	Total	93	100%	174	100%	77	100%
Primary formal qualification							
	Nursing	73	77.7%	128	73.1%	53	68.8%
	Other	1	1.1%	2	0.6%	1	1.3%
	More than one qualification	20	21.3%	45	25.7%	23	29.9%
	Total	94	100%	175	100%	77	100%
Formal/certified training in HCM							
	None	5	5.3%	21	12%	15	19.5%
	Certificate	7	7.4%	15	8.6%	8	10.4%
	Diploma	27	28.7%	50	28.6%	22	28.6%
	Degree	34	36.2%	53	30.3%	19	24.7%
	Other	3	3.2%	7	4%	4	5.2%
	More than one qualification	18	19.1%	29	16.6%	9	11.7%
	Total	94	100%	175	100%	77	100%
Informal training in HCM							
	None	11	11.7%	18	10.3%	7	9.1%
	Mentoring	2	2.1%	6	3.4%	3	3.9%
	Non certified courses	3	3.2%	6	3.4%	3	3.9%
	In-service training (workshops, seminars)	50	53.2%	79	45.1%	27	35.1%
	Other	1	1.1%	2	1.1%	1	1.3%
	More than one qualification	27	28.7%	64	36.6%	36	46.8v
	Total	94	100%	175	100%	77	100%
Intention to attend training							
	Yes	65	69.1%	111	63.4%	43	55.8%
	No	29	30.9%	64	36.6%	34	44.2%
	Total	94	100%	175	100%	77	100%

Table 3. Reliability of management competency scales and mean scores for total sample.

Management Competency Variables	No of Items	Cronbach's Alpha	Mean total score
Delivery of Health Care (1, 2, 3, 4, 5,6,7,8,9)*.	9	0.849	3.686
Planning (10, 11, 12, 13, 14, 15)*.	6	0.847	4.055
Organizing (16,17,18,19,20,21,22,23,24,25)*.	10	0.929	3.804
Leading (26, 27, 28, 29, 30, 31, 32)*.	7	0.904	4.006
Control (33, 34, 35, 36, 37, 38, 39, 40, 41) *.	9	0.897	3.979
Legal and Ethical Issues (42, 43, 44, 45)*.	4	0.79	3.695
Self Management (46, 47, 48, 49, 50, 51)*.	6	0.806	4.155

Items from Table 1, above.

Table 4. Mean scores per sector and bivariate relationship between sector and competency ratings (ANOVA).

Competency	Sector	N	Mean	F	Significant
Delivery of health care	Public	93	3.655	0.637	0.530
	Private	75	3.711		
Planning	Public	93	3.884	8.783	0.000
	Private	75	4.260		
Organising	Public	93	3.623	7.877	0.001
	Private	76	4.022		
Leading	Public	91	3.768	18.366	0.000
	Private	77	4.293		
Controlling	Public	93	3.783	15.287	0.000
	Private	77	4.222		
Legal and ethical issues	Public	93	3.535	8.733	0.000
	Private	77	3.899		
Self-management	Public	93	4.048	4.002	0.020
	Private	77	4.286		

(3.624). Private sector managers felt most competent in leading (4.297), self management (4.285) and planning (4.260) and relatively less competent in specific health delivery skills (3.71) and ethico-legal competencies (3.90).

Bivariate analyses between categorical variables and self assessed proficiency levels (Table 4) showed significant differences in proficiency between nurses managers in the different sectors and between those that received or did not receive informal training.

Managers in the private sector perceived themselves to be significantly more competent than their public sector colleagues in all of the factors except for the 'delivery of health care' where there was no significant difference between the sectors. Managers who received some form of informal training (mentoring /coaching, in service training and non certified programs) where significantly more likely to perceive themselves as being more competent in planning (F = 3.359, p 0.019), task related skills (F = 2.806, p 0.018) and ethico-legal competencies (F = 2.475, p 0.034) than their colleagues who received no informal training in health care management. There were no significant differences in proficiency levels between the different groups in terms of age, gender, years of management experience and the attendance of formal management programs.

DISCUSSION

Although response rates of self-administered questionnaires in nursing management differ greatly and tend to be much higher in regional and localised studies (Mathena, 2002; Chase, 1994), ours, although modest, compares favourably to the 33.9% obtained by Lin et al. (2007) in their nationwide study. However, the similarity in responses between respondents and a sample of primary non-responders suggests that non response bias was minimal and the sample was therefore represent-tative of all nursing managers in South Africa.

The higher response rate of the public sector managers relative to their private sector counterparts could indicate

that nurse managers from public sector hospitals attached a higher degree of importance to the survey. The relatively poorer working conditions in the public sector coupled with a perceived lack of management capacity in this sector (Pillay, 2098; Lehman et al., 2003; Leon et al., 2001), support this contention. In addition, private hospitals seem to have stricter rules and regulations governing participation in surveys as evidenced by some questionnaires that were returned stating that they needed permission to participate in the survey.

The demographics of the respondents reflect the predominantly female nature of the occupation although the proportional representation of male managers-males comprise 5.67% of registered nurses (Health Systems Trust, 2008) - suggests that males are neither precluded from, nor overrepresented in management. Of greater concern is the predominance of nurse managers older than 50 years of age. Although this reflects the trend in industrialised countries, which face an ageing management workforce in nursing (International Council of Nurses, 2008a), it has implications in terms of the natural attrition and the replacement of these managers and on the return on investment from the development of these managers, given that the retirement age is 60 years. In addition, the fact that public sector nurse managers were significantly more likely to be over 50 years of age is also of concern given the added challenges of limited Resources coupled with an increasing disease burden already experienced by this sector. The fact that public sector managers tended to be older than 50 years yet have less than 5 years experience suggests that hospitals tend to promote their nurses into management positions because of their clinical experience, rather than managerial expertise which has implications in terms of performance (Roach and Smith, 1991). The future sustainability and stability of public sector institutions will therefore depend not only on enhancing current management capacity, but also on the development of individuals with management potential as part of a broader career management and succession planning initiative.

In contrast, the majority of private sector managers are less than 50 years of age with approximately 8% less than 35 years of age. This suggests planned career paths in management and efforts at management development which in turn augurs well for the sustainability of management capacity within this sector.

Overall nurse managers assessed themselves as being good in self-management, planning and leading and at least reasonably competent in controlling, organising, dealing with legal and ethical issues and their ability to deliver health care. This suggests that although they are able to plan and envision the way forward and create an enabling environment for themselves and their staff, they are relatively less adept at translating these strengths into organisational performance. This lack of execution skills should therefore drive the agenda of future management development and training programs aimed at nurse managers.

The relatively high assessment of their ability to self manage is consistent with the findings of Mathena (2002) and is not surprising given that the nursing profession is by nature a very structured and disciplined one (as for all health professions) which often requires nurses to balance domestic and work responsibilities (International Council of Nurses, 2008b; Lee, 2003). It is a critical competency as it allows one to avoid rushed judgments, size up opportunities, capitalise on ones strengths and avoid situations in which you may be likely to fail (Gomez Meija, 2007).

The high self assessment of planning and people management competencies is reassuring given that these competencies have been found to be consistently important for senior or strategic managers across the general management (Lussier, 2006; Hellriegel et. al., 2006), health management (Pillay, 2008; NCHL, 2006) and nursing management (Lin et al., 2007; Mathena, 2002) literature. It is of particular importance in dynamic socio-economic and political contexts such as developing countries where nurse managers continuously have to re-strategise and inspire depleted workforces to get the work done.

The relatively low assessment of their specific clinical and health delivery skills was surprising given that the overwhelming number of nursing managers had a nursing background and that most health management development programmes were housed in departments of health sciences, with a key focus on public health issues (Schaay et al., cited in Pillay, 2008). It does however reflect the results from Chase's (1994) survey where nurse managers ranked their ability to implement clinical skills, care planning, and nursing theories lowest. Although clinical competencies are not regarded as being an essential prerequisite for nursing managers (Duffield, 1993; Pedersen; 1993; Lewis, 1990), this finding could plausibly be attributed to the fact that the sample comprised senior managers whose primary role was more strategic and human resource focussed as opposed to more operational level nursing managers whose roles would be more clinically orientated (Lin et al., 2007).

More disconcerting was their relative lack of competence in identifying and managing legal and ethical issues in the workplace. Given that nursing is a moral enterprise operating in an increasingly litigious environment, and that nurse managers will increasingly have to deal with more questions like the allocation of limited resources, the use of advanced technology, an ageing population and an increase in behaviour related problems, it is important that they equip themselves to perform their functions in a ethically and legally defensible manner (Kelly-Heidenthal, 2003; Marquis and Huston, 2003; Tomey, 2004; Yoder-Wise, 1999). More pertinent to the South African context is that it is a nation in transition. Consequently, the legislative landscape has changed dramatically in the last decade and managers need to be

cognisant of the evolving regulatory environment, especially as it pertains to labour practices and the health sector (Department of Health, 1996). As exposure to informal training was a significant positive predictor of higher competency levels in this facet.

The significantly higher self assessed competency ratings of private sector managers relative to their public sector counterparts support the assertion by Pillay (2008), Lehman et al (2003) and Leon et al. (2001) that there is a lack of management capacity within the public health sector in South Africa. The fact that nurse managers in this sector rated themselves as at least 'reasonably competent but not good' in all but one of the competencies suggests that they lack confidence in their ability either because they don't possess the requisite management skills or because they lack self-belief. Either way, this has the potential to impede service delivery and the transformation of public sector into a more efficient and effective service. In contrast their private sector colleagues have rated themselves as being 'good to very good' in most of the competencies- especially those that relate to the core management functions of planning, organizing, leading, controlling and self-management. This suggests greater self confidence and perceived ability which augurs well for the effective and efficient management of institutions in this sector.

The fact that there is a significant difference in competency levels of managers between the different sectors with private sector managers rating themselves significantly higher on all of the competencies, except for health services delivery where there was no difference, may partly explain the differences in performance between the sectors. Plausible explanations for this discrepancy may be that the emphasis and scope of professional development within the private sector may be better and broader within the private sector (Mediclinic, 2008; Netcare, 2008; Life healthcare, 2008), the migration of more experienced managers from the public to the private sector (Matsebula and Willie, 2007; Goudge et al., 2002), and the difficulty of managing in a public sector milieu characterized by being understaffed, poorly resourced and having higher nurse-patient ratios (Harrison et al., 2007; Padarath et al., 2003).

The self assessed competency discrepancy between sectors does not however corroborate the finding that almost 95% of public sector nurse managers reported having some kind of formal training in health management and suggests, perhaps, a review of management development programs within the sector. This is especially pertinent given that informal approaches were shown to be associated with a significantly better self assessed competency levels. These findings support those of Pillay (2008), Von Vultee and Arnetz (2004) and Latiff (2002) that formal approaches to management development are generally not very effective and that managers are more likely to improve their skills and competencies by informal means based on an experiential approach which may include mentoring and coaching, networking with colleagues and in-house programs. This approach has the benefit of tailoring training to practices and issues relevant within an institution, of exploring issues in a non-threatening environment, of increased acceptability and convenience to participants and of facilitating and enhancing senior managers' contributions to management development (Balderson and MacFayden, 1994). Also of concern is that despite the majority (63, 4%) of respondents intending to seek further training, no significant association was found between those that assessed themselves poorly and those intending to attend further training. This could imply that managers are not aware of their training needs and may therefore make no attempt to develop themselves which also has implications for service delivery

It is important to note that ranking of these competencies by nursing managers was purely subjective and based on a self-assessment, which was not externally validated. It may have been influenced by the respondents lack of knowledge with the topic and therefore a lack of confidence in being able to rate the items, or it may have been based on a self-evident knowledge gap. The competencies listed may also not have fully reflected the scope of hospital management. However, despite these limitations, the study has important theoretical and practical relevance for the improvement of nursing management training in South Africa as programs can be designed based on managers' perceived skills gaps.

In conclusion, as nursing managers have been identified as being pivotal to overcoming the health challenges that we face, it is crucial that we endow them with appropriate and relevant skills to enable them to meet these challenges. This research confirms that there is a disparity in management capacity between the public and private sectors in South Africa and also identifies the areas in which the lack of knowledge or skills is most significant for each of the sectors. This research also provides valuable information, and indeed challenges, for those responsible for the education and training of health care managers. It provides the evidence that there needs to be a paradigm shift from predominantly formal approaches to management development to include more informal approaches.

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