Leadership as a management competency in rural health organisations

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Abstract

The management competency of leadership was measured on 34 middle and senior health managers from the Murray Health Service, using Situational Leadership Questionnaires. Using self-analysis, the managers found their leadership behaviours to be entrenched, inflexible and less effective than they might otherwise be. This conclusion was supported by results of the questionnaires completed on each manager by their followers. In almost half of the cases, followers had a different perception of their manager's leadership style than did the manager. This paper discusses these findings in the context of management assessment centres and the Charter for Change now facing all health organisations.

Introduction

There is a growing interest, worldwide, in the notion of management development. The literature abounds with papers on management, both theory and practice. Despite this abundance, Australian managers are portrayed through the popular press and other media as being less skilled (and therefore, by implication, less effective) than their international counterparts. While technically sound, the difficulty appears to be partly in the 'soft' or people skills (Karpin 1995). Arguably, translating theory into management practice does not seem to have worked well in Australia, partly (or largely even) because of the relatively low education levels of Australian managers.

Despite the various controversies surrounding the management debate, there is considerable consensus that good managers lead. Saville and Higgins (1994)

define leadership as the process of influencing staff to work willingly towards group objectives. Thus it is the interpersonal process by which managers influence staff to accomplish set tasks and goals. As such, leadership differs from management, and at the same time is part of it. In other words, it is just one of the many competencies that make for a good manager; some might argue that it is the major competency of top managers.

Of the five major leadership interventions in vogue – Managerial Grid, Situational Leadership, Leader Match, Vroom and Yetton and LMX – the first two have scant theoretical or empirical support, whereas the remaining three require further theoretical development and/or empirical support (Tetrault, Schriesheim & Neider 1988). Without doubt, each has its drawbacks; each its strengths.

The one increasingly being used by the New South Wales Health Department (one of the largest employers in Australia) is Situational Leadership (Hersey & Blanchard 1982). Its essence is that the amount of direction (task-directive behaviour) and the socio-emotional support (relationship behaviour) a leader must provide vary according to the situation and level of task maturity of the follower (in relation to each task). The principle underpinning Situational Leadership is that it is the follower's behaviour with each task that largely dictates leadership style. There are four styles: S1 (directing), S2 (coaching), S3 (supporting) and S4 (delegating), each determined by the relative mix of directing and supporting behaviour on the part of the leader.

According to the Karpin Report (1995), less than half of the companies surveyed used the notion of management competencies. Only 12 per cent assessed management competencies using management assessment centres; in fact, 40 per cent of companies were not even aware of the concept. Against this background, New South Wales Health has a demonstrable commitment to assessing and developing the management competencies of its middle and senior managers. The Australasian Management Competencies Assessment Centre^{R} illustrates this commitment. A three-days workshop, designed and validated by Southern Sydney Conference Centre, addresses the key management competencies of leadership, influence, communication, people orientation, strategic planning, innovation, analytical reasoning, decision-making, achievement and resilience. The workshop identifies individuals' strengths and development needs. A series of simulations replicate management tasks and activities. These provide participants with the opportunity (using video and audio tapes) to assess performance against set criteria or indicators of expected behaviour, from which development plans are formulated. This workshop has been run in several rural locations around New South Wales. North West Health Service, based around

Tamworth, has committed all of its middle and senior staff to complete the assessment centre by the end of 1996.

However, data emerging from these workshops suggest considerable room for improvement among rural health managers, at least in terms of their leadership competency. The purpose of this paper is to report on the leadership competencies of middle and senior managers in one small, but typical, rural health district in New South Wales, as diagnosed using Situational Leadership Questionnaires. The opportunity to undertake this study arose in the context of running a one-day seminar on Situational Leadership for the Murray Health Service at Deniliquin, in which the majority of managers from the service attended. It was a unique opportunity to capture the current leadership status of this organisation and to use these data as a basis for suggesting possible changes in training managers to better implement the Charter for Change now facing all health organisations.

Materials and methods

The sample consisted of 39 managers from Murray Health Service in south-west New South Wales. The Murray Health Service employs some 400 staff. The Situational Leadership Questionnaires (LBA11) were completed as part of a one-day workshop on the subject, run by the Rural Health Education and Research Centre. The questionnaires pose 20 management situations and ask respondents to choose from one of four actions that the manager could do in each case. From completed questionnaires, information about leadership style, flexibility, effectiveness and adaptability can be inferred. Five copies of the questionnaire were completed for each participant: one by the manager's supervisor, three by followers (team members) and one by participants themselves.

Results and discussion

Self-perceptions

Thirty-four data sets were returned for analysis. As expected from data previously recorded from participants undertaking the Australasian Management Competencies Assessment Centre^{R} in North West Health Service, the primary leadership style of the Murray Health Service managers, as diagnosed by participants themselves, was S3 or supporting (79 per cent), followed by S2 or coaching (27 per cent) and S4 or delegating (12 per cent). Interestingly, none of the participants diagnosed their primary leadership styles as S1 or directing

(see table 1), a common finding. Six participants (18 per cent) had two primary leadership styles based on self-perceptions, thus accounting for the discrepancy in the percentages reported above. No participants diagnosed as having three or four primary leadership styles. The theory underpinning the questionnaires, and hence Situational Leadership itself, is that ideally participants ought to diagnose as having all four leadership styles, that is, directing, coaching, supporting and delegating.

Table 1: Summary of self-perception of 34 middle and senior health managers on leadership styles based on Situational Leadership Questionnaires

	Leadership style			
	S1 (Directing)	S2 (Coaching)	S3 (Supporting)	S4 (Delegating)
Primary leadership style				
% participants	–	27	79	12
Average score (ex 20)	–	8.2	10.0	7.8
Range	–	7–10	6–16	6–10
Secondary leadership style				
% participants	18	41	21	44
Average score (ex 20)	4.3	5.3	6.1	4.7
Range	4–6	4–7	5–7	4–9
Developing leadership style				
% participants	79	32	–	47
Average score (ex 20)	1.2	2.4	–	2.3
Range	0–3	0–3	–	0–3

The fact that the majority of Murray Health Service managers had but one primary leadership style, based on their own perceptions (that is, how they completed the questionnaire), suggests much opportunity for development in relation to this competency (leadership). Using the one leadership style irrespective of the situation can be counter-productive and can lead to frustration on the part of both the manager (for undersupervising, generally) and the team they are leading (for oversupervising, generally).

Having said this, it was noteworthy that the majority of participants did have a secondary leadership style (85 per cent); a third had two. Secondary leadership styles were either S4 or delegating (44 per cent of participants) or S2 or coaching (41 per cent of participants). This suggests some degree of flexibility in leadership styles on the part of managers, based on their own perceptions, namely, the ability to move from one leadership style to the other, presumably when the first was not working. Again the S1 or directing style scored lowest, a mere 18 per

cent of participants. These data suggest very strongly indeed that among health managers in the Murray Health Service there may be much discomfort in using a leadership style that is perceived to be directing (S1), that is, one that involves instructing followers about what to do, how to do it, and what a good job would look like. The fact of wanting to be perceived as the caring manager could be another consideration.

In terms of the two leadership styles, participants themselves diagnosed directing (S1) and delegating (S4) as most wanting attention; 68 per cent and 47 per cent of participants respectively. At least half of the participants identified two leadership styles as needing attention or development. Three participants identified three styles and only one diagnosed as being flexible among all four leadership styles (the ideal result). The average flexibility score for all participants, a measure of the ability to use all four leadership styles, was 18.4 out of a possible 30 (range 8 to 26). On the other hand, average effectiveness, a measure of using each style appropriately, was 54.3 out of a possible 80 (range 42 to 66). So, based on self-diagnosis, the managers from the Murray Health Service have some capacity to improve both the flexibility and effectiveness of their leadership.

Others' perceptions

Interesting as self-diagnosis can be for participants, bringing with it much angst in some cases, the real value of the Situational Leadership Questionnaires lies in their capacity to diagnose how others perceive a manager's leadership style. In this regard there was strong agreement among the perceptions of the managers' supervisors and team members and their self perceptions (see table 2). S3 or supporting style was diagnosed by all three groups as the primary leadership style (60, 67 and 79 per cent for supervisors, team members and self respectively). S2 or coaching style was identified by all three groups as the second most used style, with S4 or delegating as the third most used style. Two supervisors and three teams identified S1 or directing to be the dominant leadership style used by their managers, a result at odds with these particular managers' self-perceptions.

Table 2: Summary of perceptions of managers' supervisors and team members on leadership styles based on Situational Leadership Questionnaires (expressed as percentages)

	Leadership style			
	S1 (Directing)	S2 (Coaching)	S3 (Supporting)	S4 (Delegating)
Supervisors' perceptions of manager's leadership styles				
%	12	24	60	20
Average	18.0	23.0	38.0	20.8
Range	0–85	5–45	0–80	0–45
Team members' perceptions of manager's leadership styles				
%	7	19	67	7
Average	12.6	26.8	40.5	19.3
Range	0–43	10–55	5–70	5–40
Self perceptions of leadership style				
%	0	27	79	12
Average	0	41	50	39
Range	0	35–50	30–80	30–50

In slightly less than half of the cases did a manager's supervisor diagnose the same primary leadership style as the manager did, compared with 60 per cent in the case of team members. These data suggest considerable discrepancy between how the managers perceive their own leadership styles and how others perceive them. According to the managers' supervisors, only one manager had three primary leadership styles and one had two. The remainder had but the one. Similarly with team perceptions. Only two managers had more than one primary leadership style (two styles only). None had three or four styles. The picture emerges even more strongly of the need or opportunity for the majority of managers to develop their leadership competency. The fact is that they had diagnosed this conclusion for themselves, and the people they lead subsequently reinforced these very same conclusions. Strong evidence indeed of a need for change regarding the important management competency of leadership.

Less than half of the participants were able to conclude that they perceived their own leadership styles accurately, that is, a match between self-perception and that of team members. Only three could claim to be flexible in their use of the different leadership styles, in that they used more than just one or two leadership

styles. Half were able to claim that they managed each team member differently – a key aspect of Situational Leadership.

Implications

Leadership as a competency is about taking control and managing people; delegating appropriately; encouraging and motivating staff; recognising and using team members' skills; and using a management style conducive to the changing nature and needs of the organisation. As such, it is a mixture of directive behaviour and supporting behaviour. Health workers seem proficient with the latter; much less so with the former.

Just why there appears to be an aversion to using S1 or the directing style of leadership in health settings is unclear. It could reflect the empathetic nature of health professionals – after all, health is a helping profession, unlike many other professions. Or it may be related to the egalitarian nature of the Australian psyche. A third possibility could be that younger managers have been socialised into the modern participative style of management culture.

For many managers there appears to be a similar, but not so pronounced, reluctance to use S4 or the delegating style of leadership. Anecdotal evidence from past workshop participants suggests two possible explanations for this phenomenon: fear of mistakes on the part of followers and absence of staff to whom to delegate. Other possibilities might be a lack of trust in followers or simply the 'hard worker' mentality. Either way, it seems clear that the notion of delegation is not clearly understood. Appropriate delegation involves followers who have both the required competency to finish the task and the commitment to see it through. And it involves trust on the part of the manager. Delegation is not dumping work onto someone else, a commonly held view, it seems.

As previously argued, leadership development has received considerable attention in the literature, though controversy does surround use of the Situational Leadership diagnostic on which the current study was based (Goodson, McGee & Cashman 1989; Nicholls 1985; Norris & Vecchio 1992; Tetrault, Schriesheim & Neider 1988; Vecchio 1987). Nonetheless, results from diagnosing leadership styles of the 34 managers in this study suggest very strongly that there could be much gained from incorporating Situational Leadership into the management culture of public health services. While the present data refer specifically to rural health managers, one wonders whether the same conclusions would be just as applicable to metropolitan managers.

There is much to be said about health organisations seriously embracing the notions of management competencies and, indeed, management assessment

centres which are designed specifically to measure these same competencies. As mentioned before, leadership is but one of many management competencies, possibly the most important. At the same time, it is one which can be measured objectively. The attraction of this, and of Situational Leadership in particular, is that it gives managers the opportunity to reassess performance after instigating a personal development plan to become more proficient in leadership. This can be very rewarding and validating to the manager seriously attempting to master people management in the 1990s.

Arguably what is needed from our health managers nowadays is leadership to see us through the radical changes currently facing the health industry. Wave after wave of changes confront staff – this can be and is demoralising for staff, which in turn impacts on client services, customer satisfaction and possibly health outcomes. With so much uncertainty about change, the need now is for leaders who are both flexible and effective in their leadership. Leaders who can direct, coach, support and delegate and do so appropriately.

Fundamental to Situational Leadership theory is the notion that all four leadership styles are appropriate, the key being the ability to choose the most appropriate style for the task at hand and for the follower chosen for that task. As a theory it has intuitive appeal, for undoubtedly we may need to lead people differently depending on their level of skill and commitment to the task at hand.

Finally, the Australian Council of HealthCare Standards strongly embraces quality care and health outcomes in its Charter for Change. To gain accreditation in future, health services will be much more accountable to surveyors for quality management and leadership to name but a few standards; more so than previously. Chief executive officers will be required to demonstrate how their organisation supports the provision of care. The Situational Leadership model is ideally placed to help managers go some way to meeting the Charter for Change. One of the many attractions of Situational Leadership is that leadership is driven by the followers themselves, rather than something imposed on them from above. Controversial as this may seem, it is for the leader to respond to the development level of followers for each given task. In other words, the followers' diagnoses of their own development levels are first acted on. If this turns out to have been unrealistic, then it becomes the manager's role to renegotiate leadership styles, with justification and explanation. Thus leadership becomes a partnering agreement between managers and team members, to the benefit of both, and with positive outcomes for the culture of the organisation. Indeed, is it conceivable to have it any other way?

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