KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,

KUMASI - GHANA

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF HEALTH POLICY, MANAGEMENT AND ECONOMICS

EFFECT OF LEADERSHIP STYLE ON CLIENTS SATISFACTION IN HEALTH FACILITIES IN BANTAMA SUB-METRO OF ASHANTI REGION, GHANA

BY

JERRY ADU-AMANKWAAH, M D

NOVEMBER, 2019

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A THESIS SUBMITTED TO THE DEPARTMENT OF HEALTH POLICY, MANAGEMENT AND ECONOMICS, COLLEGE OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH, KNUST IN PARTIAL FULFILMENT FOR THE

AWARD OF MASTER IN PUBLIC HEALTH.

NOVEMBER, 2019

DECLARATION

I hereby declare that this submission is my own work towards the Master of Public Health (Health Service Planning and Management) and that, to the best of my knowledge, it contains no material which has been accepted for the award of any other degree in the University, except where due acknowledgement is been made in the text.

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ACKNOWLEDGMENT

My greatest appreciation goes to God Almighty, who took care of me and saw me through conceptualisation and completion of this programme.

My heartfelt gratitude goes to Dr. Kofi Akohene Mensah, my supervisor, who provided guidance throughout the study, perfect guidelines, supporting me from the beginning till the end of project. Without his comments, timely corrections and valuable suggestions, I would not have been able to complete this work in time.

I am also thankful to the lecturers and staff of the Kwame Nkrumah University of Science and Technology, KNUST, school of public health and the staff of Suntreso Government Hospital for their cooperation in various ways.

My special thanks goes to every individual who contributed directly or indirectly to the success of this project including my dear wife and class mates, may God bless you all.

DEDICATION

I dedicate my work to the many people who inspired me and made this dissertation possible. To my parents, Rev. (rtd) Andrew and Mrs. Agnes Adu-Amankwaah, who imparted on me the value of education and personal development through their individual pursuits and attainments, for their patience and dedication to see me improve in grade through school, teaching me that I could accomplish difficult achievements with time and to all my siblings.

To my wonderful wife, Deborah, without whom I could not have embarked upon and finished this journey. Thank you „D" for your patience, love, words of encouragement, and personal sacrifices that made it possible for me to pursue this dream.

Finally, to all who ever said a prayer for me, through which I am who I am today.

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ABSTRACT

Introduction

The state of client satisfaction in a hospital could be largely seen to be dependent on the type of leadership style exercised by top management of the hospital. Patient satisfaction enhances hospital image, which translates in increased patronage of the services of a particular hospital. Therefore, this study was aimed at assessing the effect of leadership style on client‟s satisfaction in Suntreso Government Hospital in the Bantama Sub-Metro in the Ashanti Region of Ghana.

Methods

The study was quantitative using cross-sectional study design. A total of 292 clients and 150 staff from the hospital was interviewed using structured questionnaire. The data were analysed using Stata version 12. Chi-square was used to establish any association between the various leadership styles and clients‟ satisfaction. Statistical significance for all testing was set as 0.05.

Result

The Health care managers employed both transformational leadership styles and transactional leadership styles. Also, a high proportion of clients (84.2%) were satisfied with the service received.

Finally, transformational leadership styles such as Individual Consideration (p-value =0.0141), Intellectual Stimulation (p-value = 0.0221) and Inspirational Motivation (pvalue =0.0337) had significant relationship with the level of clients satisfaction.

Finally, the relationship between transactional leadership styles such as Contingent

Reward (p-value =0.0235), Management by Exception – Active (p-value =0.0311), Management by Exception – Passive (0.0167) and client satisfaction was statistically significant.

Conclusion

Leaders were practicing both transformational and transactional leadership styles and this translated into a high level of clients‟ satisfaction. Therefore, management should continue to encourage the use of both leadership styles in order to sustain the level of client‟s satisfaction.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Patient safety has become a crucial topic among health care professionals, policy makers and even the public (Canadian Nurses Association, 2004). This is might be as a result of the widespread publication of healthcare errors that result in negative situations. Over the years, several studies have attributed major deaths in the hospitals to be caused by preventable issues (Thomas et al., 2000). Some of these preventable causes are; gaps and errors in communication, errors as a result of omission, treatments given wrongly, errors resulting from diagnosing wrongly, and failure to furnish referral hospital with the relevant information to follow up on medical cases that are transferred from one hospital to the other (James, 2013).

There are various reasons why patients will choose one facility over another in their search for healthcare. Encompassing these reasons are the primary needs for satisfaction in health care regardless of the type of disease condition which they suffer. Patient satisfaction is a highly desirable outcome for most persons who seek clinical care in the hospital setting. The client‟s expression of satisfaction or dissatisfaction is a judgment on the quality of hospital care, reflecting their abilities/strengths and limitations/weakness. Client satisfaction is an indicator that should be indispensable to the assessment of the quality of health care in hospitals. It involves putting measures in place to minimize the likelihood of errors to the client and maximise the likelihood of stopping them, when they occur (Alrubaiee &

Alkaa'ida, 2011).

The level of client satisfaction in any hospital is a reflection of the style of leadership displayed by the managers of the hospital. This agrees with the widely known quote by

John C. Maxwell that “everything rises and falls on leadership (Inc, 2015). Also, Mott, a renowned global leader among students believes that a leader is one who knows the road, keep ahead and pulls other along after him (Sermon Illustrations, 2019). President Harry S. Truman (1945-53) said cogently: A leader is a person who has the ability to get others to do what they don‟t want to do, and like it” (Forbes Quotes, 2015). Therefore, leadership can be defined as the act of bringing together the ideas, people, time and abilities of others to accomplish predetermined objectives. The leader knows where he is going and takes his followers along. The type of leadership style employed by managers is very crucial since all the workers commitment and output is dependent on the leadership style. This plays an important role in ensuring quality healthcare and patient safety in our health facilities. There are different types of leadership style which include transactional, transformation, autocratic, breaucratic, charismatic, laissez-faire, democratic/participative, people-oriented or relationsoriented leadership, servant leaderhip, leadership amongst others, just to mention but a few. Leadership styles vary from organisation to organisation and may influence the level of client satisfaction in healthcare facilities.

1.2 Problem statement

Satisfaction of patient improves upon the image of the hospital which translates to high patronage of the services of a particular hospital (Andaleeb, 1998). Satisfied clients are likely to show favourable intentions which in the long-run will benefit the success of the health care institution. However, on the other hand, a negative word of mouth or unfavourable state of the patient will negatively affect the image and reliability of the health facility. In coming out with the final result that is client satisfaction, managerial impact cannot be detached from the equation. That is to say that the nature and manner with which the hospital facility is managed by the leadership of the hospital will directly

or indirectly determine whether the clients of the hospital will be satisfied or not. There is nothing as true as the quote by John C. Maxwell that everything rises and falls on leadership. The nature of the leadership will determine whether the workers will be in the positive state of mind to render unhindered services with enthusiasm or the reverse, the latter always being detrimental. Various authors have propounded diverse theories on leadership (Khan, Nawaz, & Khan, 2016). Some of the theories of leadership are; the Trait theory, contingency theories, behavioural theories, process leadership theories, transformational theory, transactional theories, and Great-man theories amongst others (Matthew, Deary &Whiteman, 2003). However, limited studies has been conducted to assess any association between leadership style and client satisfaction.

This study therefore focused on the effect of leadership style on client satisfaction. This would serve as a lesson leaning for the sub-metro, the Region and the country as a whole.

1.3 Significance of the study

Whiles there is widespread literature on leadership style and its effect on corporate institutions, little has been done about leadership style and its effects within the healthcare industry. Thus, the result of this study will result in knowledge for the management of the Suntreso Government hospital in ensuring appropriate leadership style to improve client satisfaction. Also, it will again serve as a guide, training material and lesson learning to policy makers and the top- level managers of hospitals on the appropriate leadership practice to engage for long term satisfaction with clients. The study will contribute to the body of knowledge on leadership style and client satisfaction within the healthcare industry. This will serve as reference materials for researchers, students and academicians. The findings can be published in a peer review

journal which would unravel the gaps associated with leadership style and client satisfaction within the healthcare industry for future research.

1.4 Conceptual Framework

Figure 1.1 presents the effect of Leadership Style on Client Satisfaction. Leadership styles can be either transactional or transformational and may eventually lead to client‟s satisfaction as detailed in figure 1.1

Transactional leadership is characterised by contingent rewards by the leader, active management by exception and passive management by exception (Bass & Avolio, 1990). Transformational leadership is characterised by idealised influence, individual consideration, inspirational motivation and intellectual stimulation as explained by Bass & Bass (1985). Either of these leadership styles affect the satisfaction or dissatisfaction of clients.

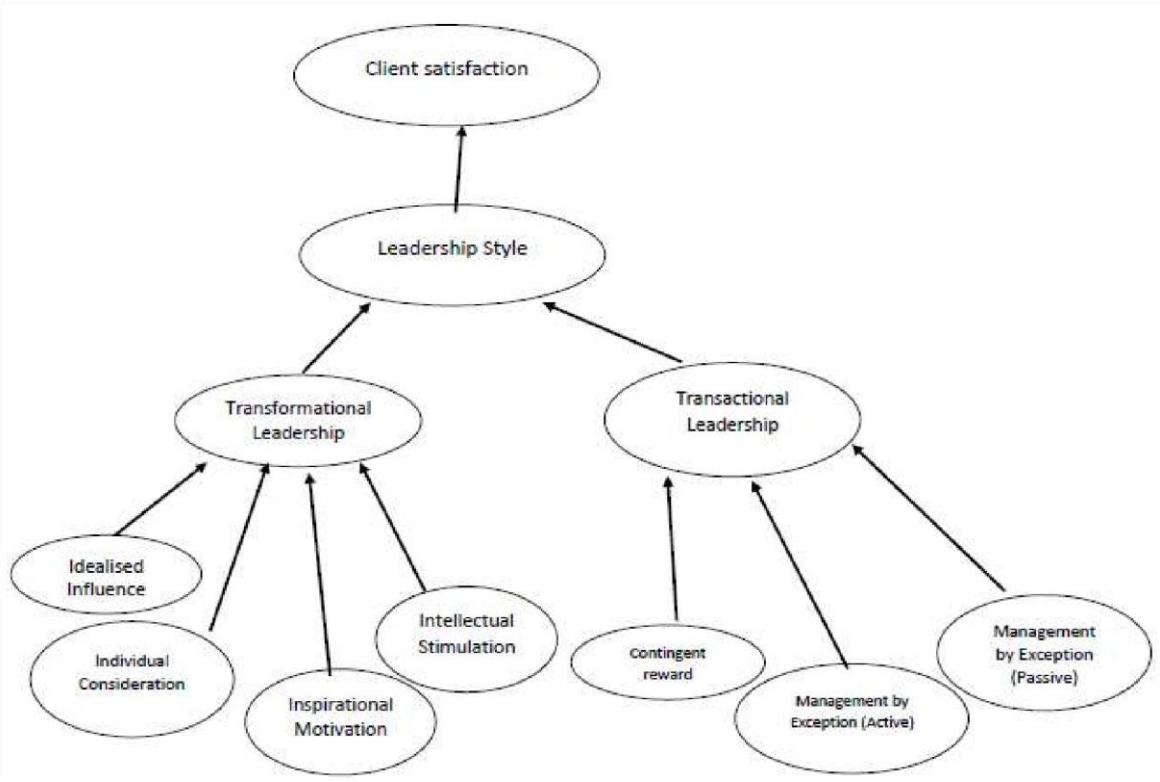

Figure 1.1: Effects of Leadership Style on Clients Satisfaction.

Source: Authors survey, 2019.

1.5 Research questions

1. What are the various leadership styles employed by healthcare managers in Suntreso Government Hospital in the Bantama Sub-Metro in the Ashanti Region of Ghana?
2. Are clients satisfied with the services provided at Suntreso Government Hospital in the Bantama Sub-Metro in the Ashanti Region of Ghana?
3. Are there any association between the various leadership styles and clients satisfaction in Suntreso Government Hospital in the Bantama Sub-Metro in the Ashanti Region of Ghana?

1.6 Study objectives

1.6.1 Main objective

To assess the effect of leadership style on clients satisfaction in Suntreso Government Hospital in the Bantama Sub-Metro in the Ashanti Region of Ghana.

1.6.2 Specific objectives

1. To assess the various leadership styles employed by healthcare managers in Suntreso Government Hospital
2. To assess the level of clients satisfaction on services provided at Suntreso Government Hospital
3. To establish any association between the various leadership styles and clients satisfaction

1.7 Profile of study area

1.7.1 Profile of Bantama Sub-metro

Kumasi is recognised as the second largest city in Ghana, situated 300km from the National Capital, Accra. Politically, Kumasi is divided into five sub-metropolitan areas namely: Bantama, Manhyia North, Manhyia South, Nhyiaeso and Subin.

For the purpose of Health Administration, it is allocated three sub metros namely Bantama, Manhyia and Subin.

Bantama is the second largest sub-metro in Kumasi. It forms 36.9% of the metro population from the 2019 annual projected population with an annual growth rate of 2.7%. There are fifty societies within the sub-metro. Most of the inhabitants are into the trading profession.

The sub-metro has the highest sub-districts which are five namely Abrepo-Ohwim, Adiembra-Santasi, Ahodwo-Danyame, Bantama-Bohyen, Patasi-Suntreso.

Bantama sub-metro is positioned at the western side of Kumasi metropolisiwth Atwima Kwanwoma on the North West and Kwadaso on the South West. Asokwa is on the Eastern side and Manhyia and Subin are on the Western side.

The sub-metro is located at the western part of Kumasi (between Latitude 6.35^{o}N and 6.40^{o}S and Longitude 1.30^{o}W and 1.35^{o}E and elevated 250 to 300 meters above sea level.

Health Service: There are about 170 government hospitals, 71 mission hospitals, 281 private health facilities, in the Ashanti region of Ghana with Kumasi, as the capital.

Kumasi has 38% of health facilities in Ghana (service availability mapping survey). Geographically all health facilities are spread across the Sub-Metro. The Sub-Metro has

one Government Hospital, two health posts, one quasi-government and all the others are privately owned. Consequently collaborating with the private sector in health service delivery will be essential to ensuring the provision of quality and equitable healthcare for all people in the Sub-Metro. (Bantama Sub-Metro Profile, 2019).

1.7.2 Profile of Suntreso Government Hospital

The initial name of the hospital was Suntreso Urban Health centre, established on 22nd November, 1963. It was given a Polyclinic Status in 1985. In the year 2000 the facility again was given a District Hospital status within the Bantama sub-metro. The hospital has the following wards. Mother and Baby Unit (MBU)-16 beds, Female ward 15 beds, Male ward 16 beds, Emergency ward 3 beds, children‟s ward 6 beds, antenatal ward 4 beds, and Lying-in ward 13 beds. Others are female surgical ward 13 beds, labour wards 2 beds, and theatre recovery 2 beds. These total 90 beds. There are a number of departments in the hospital, they include Internal medicine, surgery, paediatric, obstetrics and gynaecology, eye, ear, nose and throat, dental, public health, diagnostics, theatre /anaesthesia, administration. The services rendered in the hospital includes, General Out Patient Department, Inpatient Care, Disease Surveillance, Surgery, Dental Care, ENT, STI/HIV care, Ultrasound, General Administration, Laboratory, Obstetrics/Gynecology, Pediatrics care, Pharmacy, Psychiatry, Dermatology, X-ray, General Administration, Herbal Medicine and Family planning.

Table 1.1 shows the distribution of the collective workforce level.

Table 1.1 Number and category of staff for Suntreso Government Hospital

Staff Category	Number	Staff Category	Number
Specialists	6	Public Health Nurses	4
Medical Officers (General)	7	Community health nurses	31
Medical Officers (Dental)	2	Enrolled Nurses	26
Biomedical Scientist	5	Pharmacist	5
Radiologist	0	Lab Technicians	5

Mortuary Worker	0	Midwives	29
General Nurses	83	Optometrist	1

Source: Brief profile of Suntreso Government Hospital (as at Dec 2016)

1.8 The scope of the study

This study contextually covers amongst others the various kinds of leadership styles used in health facility and its influence on client satisfaction. Specifically, the study will assess the various leadership styles employed by healthcare managers, level of client satisfaction and any association between the various leadership style and clients satisfaction. Geographically, this study will cover Suntreso Government Hospital in the Bantama Sub-Metro in the Ashanti Region of Ghana.

1.9 The organisation of the study

This Study is presented into six chapters; the first chapter provides the introduction of the study which consists background of the study, the statement of the problem, significance of the study, research questions, research objectives, conceptual framework and profile of the study area. The second chapter presents the review of both theoretical and empirical studies and theories regarding the topic of discussion. The third chapter present the methodology of the research. This consists the research design, the population, sample and sampling technique. It also consists the inclusion criteria for selecting the samples, exclusion criteria, study variables, data collection techniques and tools, data handling, data analysis and ethical considerations, limitations of the study and assumptions. Chapter four presents the data analysis. Chapter five presents discussion of the findings. Chapter six presents the conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the discussion of literature in relation to the topic of study. Issues discussed were both theoretical and empirical revolving around leadership styles, client satisfaction, client satisfaction in hospitals and the relationships between leadership style and client satisfaction.

2.2 The Concept of Leadership

This subsection present the discussions on the definition and purpose of leadership.

2.2.1 Leadership defined

The discourse on leadership and followership has been a prevailing issue over the years within societies. Many authors have discussed and defined leadership from various perspectives, however the central theme is that leadership is a process or a means and not an end in itself. concluded that leadership requires the ability to influence people in a group too share singular goals and vision. (Schreuder et al.,
2011; Jensen & Luthans, 2006). Northouse (2010) defined leadership therefore as a "process where an individual influences a group of individuals to achieve a collective goal". Crosby (1997) also defined leadership as the deliberate act of driving the actions of people in a planned technique so as to achieve the agenda of the leader. Kelloway & Barling (2010) also defined leadership as the process whereby people in a structured setting, say, supervisors and managers influence other people socially in an organisation. They were quick to comment that leadership is not practices and observed in a formal setting; it can also be practiced in an informal setting. In addition to the existing definitions of leadership, Jong and Hartog (2007) defined leadership as the act of influencing people in order to achieve the outcomes desired. Anderson (2016)

mentioned that it is the leaders who demonstrate the practice of stimulating, motivation, encouraging and acknowledging the efforts of workers so as to get the targeted work done. A leaders does not stick to one style of leadership in their leadership practice, they tend to vary it based on the situation and the kind of followers they lead. Lok and Crawford (2004) claimed that the leadership practice of an organisation can be used to predict whether and organisation will fail or be successful.

2.2.2 Which leadership is important or worth studying.

Graen and Scandura (1987) mentioned that leadership can be viewed as a communicative process between a leader and followers. It is mostly held that leaders of the organisation are the source or bearers of the vision and they attract followers who come around them to transform that vision into realism (Kao, 1989). Leadership is required to grow and sustain the organisation over the lifetime of the vision. Hence, it can be said that leaders conceive vision, and vision builds an organisation. This organisation will then need a leader to keep the vision going. Luthans (2006) cited Hinterhuber and Krauthammer (1998) who commented that leadership is needed now more than ever because of the turbulent environment and the growing demands from continual innovation and radical expansions regarding customer satisfaction. The authors noted that leadership is supported by three main foundations. The first is the ability to see-envision. The second is the ability to lead an exemplary life and the third is the ability to increase value of an organisation.

2.3 Theoretical Framework

A lot of studies have propounded models for leadership; studying whether leadership is a function of an inborn character or it is taught (Chapman, Johnson, and Kilner, 2014; Northouse, 2017; Hernandez et al., 2011; Adair, 1973). The major classifications of leadership theories are; behavioural, traits, contingency theory, transformational

leadership, and power theories (Chapman, Johnson, and Kilner, 2014; Northouse, 2007; Hofmann & Morgeson, 2004). Early leadership theorists also identified power or influence leadership approaches and noted transformationaltransactional leadership and leader-member exchange theories as dominants ones (Bass, 1985; Dansereau, Graen & Haga, 1975). One emerging leadership theory is authentic leadership (Avolio, Griffith, Wernsing, & Walumbwa, 2010). These different leadership theories are discussed in the following sections. Despite the fact that these theories elucidate the roles and job requirements of employees it has not been able to handle the nature of stress that consists the modern environment (Saeed, Almas, Anis-ul-Haq, and Niazi, 2014).

2.3.1 Trait theory of leadership

Primitive theories on leadership was established on the notion that leadership is effective based on the personality of the leaders (Northouse, 2007). The author discussed that it was primarily believed that leaders possess some inborn traits and characteristics that make them who they are. And it is these inborn traits that make them attractive to followers and differentiates them from followers. Some of these traits identified are; ability to tolerate frustration, stress coping ability, confidence, problem solving skills and goal oriented (Glendon, Clarke & McKenna, 2006; Stogdill, 1974). This is also known as the theory of leadership by birth. However, on major limitation with this theory is that it claims that when a leader is challenged with diverse circumstances it will make the leader operative. In addition, specific studies have not revealed any unique traits to support this assumption because there is no definite trait or sets of traits for any given situation (Yukl, 2010). In conclusion, one other limitation of the trait theory is that since the theory establishes that leadership traits are inborn and not learned, then that goes to say that leaders cannot be made. In other words leadership cannot be taught (Northouse, 2010).

2.3.2 The behavioural theory

Another theory that emerged aside the trait theory was the behavioural theory. This theory aimed to explicate what leaders do and how the followers tend to react; both behaviourally and emotionally (Northhouse, 2007). Contrasting the trait theory, the behavioural theory emphasises the behaviour of the leader rather than an innate trait and how the followers interpret these behaviours.

In the 1950s, researchers of the University based in Ohio studied this theory and noted that there are two main leadership behaviour types; the initiating and the consideration behaviour types (Fleishman and Harris, 1962 as cited in Glendon et al., 2006). The theory explains that those leaders who tend to be considerate in their behaviour tend to consider the feelings and the needs of their followers whiles focusing equally on establishing mutual relationship and operative communication. In the same vein Michigan University researchers also identified two leadership behaviour types; the production orientation leadership and the employee orientation leadership. Employee orientation means that the leader leads the followers but is guided to give attention to the needs of the followers also. This is closely related to the consideration behaviour propounded by Ohio state researchers (Northouse, 2010). Blake and McCanse (1991) mentioned that the ability to manage a team is notably the best behavioural leadership style since it focuses on the interpersonal relationship whiles equally focusing on the collective objective. It can also be seen as the practice of ensuring an equitable balance between production and people. This theory also has its limitations. The first is that with regards to the effectiveness of this theory no empirical study has concluded about it because the relationship amid task, relationship behaviours and effort aftermaths such as performance has not yielded reliable behaviours (Yukl, 1994 as cited in Northouse, 2010). In addition, empirical studies have not been able to establish the premise of

behavioural theory which purports that when task and management of relationships are effective it depicts that leaders are effective (Bass and Bass, 2008).

2.3.3 Theory of Contingency

Within the 1960s and 1970s the theory of contingency became popular. It was focused on study how leaders can be effective giving the specific situation they find themselves. Hence the study of leadership is context specific, or better still leadership effectiveness can be seen from the management of specific situations (Yukl, 2010). Two major theories of contingency are the Least Preferred Co-worker (LPC) contingency theory and the Path-Goal theory. The LPC was developed by Fielder in 1967. It concerns the combination of different situational traits and leadership styles and behaviour. His theory established that the effectiveness of a leader is dependent on the specific situation as well as the combination of the leadership style. Hence leadership style is dependent of the situation at hand. From the model, situations are described by three factors;

1. Leader-member relations. This is where trust and confidence is the underlying factor between subordinates and superior relationships.
2. Task organisation. The degree of difficulty associated with a task.
3. Position power (strong or weak). This has to do with the extent to which a leader can reward or punish subordinates.

2.3.4 Path-goal theory

This theory was developed by House (1971) and it focused on how the performance and level of fulfilment of subordinates has an influence on the behaviour of leaders. It tends to describe the impact leadership makes on followers through motivation. The theory is largely based on Vroom‟s theory of motivation. It establishes that the result

or outcome of an individual is a reflection of the work they invest in the job. For instance, higher reward in the form of salary will tend to motivate employees to put in more effort, in order not to attract low salaries (Yukl, 2010). This theory establishes that when followers sense that their efforts are considered valuable, they give off their best to accomplish the task. There are four major leadership behaviour types;

1. Supportive leadership. With this leadership style, supporting the subordinates is a major concern for the leader. This is in agreement to the position existing in the considerate leadership style.
2. Directive leadership. With this style, the subordinates are delegated with tasks.
3. Participative leadership. With this style of leadership, the subordinates are given the opportunity to contribute in corporate decision making.
4. Achievement oriented leadership. With this style. The subordinates are motivated to achieve the set organisational targets.

This theory has been criticised that it is too complex to comprehend and even study, hence it has limited practical value. Furthermore, there is no specific guideline for implementing the contingency theory (Yukl, 2010).

2.3.5 Power/Influence Theories of Leadership

The Power or influence theory of leadership establishes the effect of subordinates by the actions of the leaders. The major approaches engaged by leaders considered by this theory are transformational- transactional leadership (Bass, 1985). The other major approach engaged is the leader-member exchange theory (Dansereau, Graen & Haga, 1975).

2.3.6 Leader-Member Exchange (LMX) theory

This theory focuses on the relationship existing between leaders and their followers. It establishes that various relationships exist between leaders and subordinates. Based on the relationships, their outcomes are also affected. This theory established that all followers are not treated in the same way by the leaders (Glendon et al., 2006). Going forward LMX theorists moved away from studying the differing relationships between leaders and their followers into studying the quality of LMX relationship on both the individuals and the organisation. (Northouse, 2010). In line with this, studies have revealed that a mutual relationship between leaders and their followers established on trust and mutual respect goes a long way to improve upon the level of organisation output (Gerstner & Day, 1997; Graen et al., 1995). Other scholars have endeavoured to elucidate how the relationship have developed over time. Graen & Uhl-Bien (1991) observed that the relationship undergoes three stages; the stranger stage, the acquaintance stage, and leader member exchange stage (Northouse, 2010).

One critique on the theory is that it failed to explain the formation as well as development of the subordinate-leader relationship (Northouse, 2010; Yukl, 2010). The concept established that trust, respect and sense of obligation are key building blocks for effective LMX although it could not explain how these come to be.

Furthermore, in an organisation setting the issue of equality is not considered, especially how it affects productivity. One other criticism is that the theory fails to quantify what is high or low quality of relationship among leaders and their followers. Finally, the theory does not consider the effect of circumstances to the relationship between leaders and their followers (Yukl, 2010).

2.3.7 Authentic Leadership Theory

This is a growing theory in leadership which is grounded in constructive organisational behaviour. This theory focuses on the use of positive people skills and mental competences. These can be measured and managed effectively for organisational performance (Luthans, 2002). Authentic leaders can be seen as those who are confident, aware of themselves, optimistic, transparent, uphold high moral/ethical standards, and are honest and balanced in terms of their decision making (Avolio, Griffity, Wernsing, & Walumbwa, 2010). These leaders have a clear understanding of their values and their beliefs and are therefore transparent in their relationship with others. As a result they build trust among the followers (Bass &

Bass, 2008). This theory appears to be confirmed in literature (Avolio, Walumbwa, Gardner, Wernsing, & Peterson, 2008; Avolio, Walumbwa & Weber, 2009). They established a list of characteristics demonstrated by leaders regarded as authentic.

1. They are slow to run in conclusions resulting from their desire to receive and estimate information from a fair perspective before they make any decision.
2. Also, they are open and transparent to their followers
3. They do not submit to influences of their peers or the demands of the organisation.
4. They are aware of their abilities and their flaws and they consider how other people observe them.

Regardless of what has been known regarding this theory, more needs to be done to understand it. One study that needs to be carried is on how to distinguish it from the other leadership theories. Furthermore, other ways could be established on how authentic leadership relates with organisational expectations and individual

expectations. Recently, Avolio et al (2010) revealed that authentic leadership relates several positive expectations and this has increased the performance of a group and their behaviours as a whole.

2.3.8 Transformational and Transactional Leadership

Transformation and transactional leadership could be categorised under behavioural approaches but Hofmann & Morgeson (2004) viewed the approaches as having unique effects. This is because they are focused on the effect of the subordinates as a result of the leader‟s behaviour since the leader is attempting to get followers to agree with corporate vision for its accomplishing (Yukl & Van Fleet, 1992)

Burns (1978) defined transformational leaders as people who possess the ability to motivate other individuals to meet goals beyond their own self-interests enabling them to understand the meaning of those corporate goals. Bass & Bass (1985) further expanded the definition made by Burns. Bass observed the transformationaltransactional leadership and viewed is as a scale which moved from transformational to transactional and to laissez-faire on the scale of leadership. However, transformational leaders act as coaches who challenge and encourage employee performance. Transactional leaders are more focused on achieving the collective goals of the organisation and they do this by exchanging rewards for high performance. They are not so keen on the personal life of the employees. Bass & Bass (1985) explained further that at the very end of the scale is the Laissez-faire leadership style which is typified by the tendency to evade leadership responsibilities. Bass & Bass (1985) identified four major components that characterise the transformational leadership style. These are; intellectual stimulation, inspirational motivation, idealised or charismatic influence and individualised consideration.

Furthermore, they identified three main factors forming the transactional leadership model. These are; management by exception – active, management by exception-passive and contingent rewards. Contingent reward is where leaders reach a consensus with followers and establishes clearly the rewards that go with the performances of followers. As a result, when the expectations/targets are achieved the followers are rewarded. Management by exception is seen as a form of correction employed by leaders. It is concerned with the level to which a leader takes corrective action such as negative feedback, disapproval on the basis of followers" behaviours. Active management by exception has to do with when leaders monitor the behaviour of subordinates actively, responding to situation and making sure that deviations from standard are controlled quickly. Passive management by exceptions also has to do with a relaxed state taken by leaders in dealing with situations in the organisation. Leaders only intervene after the problems have occurred (Bass & Avolio, 1990).

Laissez-faire leadership also known as avoidance of responsibility model of leadership is characterised with the state that leaders avoid making decisions, overlooks subordinate problems and needs and does not reward or give feedback to followers. This is a laid back form of leadership (Northouse, 2010).

Criticisms to the transformational and transactional leaders also exist. It has been established that in the bid to achieve the organisational goals, the leaders will tend to be deceptive. After a considerable succession of experimentations, it was established by Maner & Mead (2009) that leaders with high level of dominance motivation were more prone to risking the group performance target by withholding relevant information. In addition, they tend to dismiss valuable team members that pose as threats to their position.

2.3.9 The effectiveness of Leadership styles

Academics and professionals have been studying the effectiveness of leadership styles for a long period of time, and it has been an issue of concern (Avolio et al., 1988; Howell and Avolio, 1993: Bass and Avolio, 1994; Avolio, 1999). Dunkerley (1972) identified four studies which argued that leadership styles has a positive and significant relationship with leadership effectiveness. This results in drastic improvement in output. They suggested that it can contribute between 7 and 15% to production levels when mediated with factors like financial incentives, nature of job and supervision.

Lippitt and White (1940) performed one of the earliest studies on leadership effectiveness from Ohio University and they found out that Laissez-faire leadership style was the least productive styles of leadership. Furthermore democratic leadership style registered a little lower performance level compared to autocratic leadership style. Katz and Kahn (1949) concluded that the democratic leadership style was the most effective style, however technical knowledge and skills of the leader is also crucial determinant on effectiveness. A democratic leadership style of leadership which is strongly focused on employees concentrates more on creativity and innovation from the employees, whereas authoritarian leaders are strict and more accepted among large groups than small groups (Vroom, 1964). Furthermore, Fiedler (1996) identified that successful leaders in the informal circles are those with least emotional dependence on the group. He further established that there are certain leadership styles that are more effective compared to other leadership styles. In addition, leadership which tends to be quick to punish increase frustration among employees which will reflect in decrease in involvement (reflected in mental and physical withdrawal) or to retaliatory aggression (aggression directed against productivity) (Dunkerley, 1972). Kunchinke (1998) also

identified that various leadership styles result in various levels of readiness amongst employees for extra engagements.

2.3.10 Recent studies on leadership effectiveness

Recently, various leadership styles and organisational effectiveness have developed certain results. Asrar-ul-Haqan & Kuchinkeb (2016) have established that transformational leadership behaviour positively affects work performance and transactional leadership negatively affects long-term performance. Other studies have established that transformational leadership positively affects employee motivation, creativity, employee productivity and organisational performance. (Bronkhorst, Steijn, & Vermeeren, 2015; Bronkhorst et al., 2015; Kim & Yoon, 2015). In another view (Epitropaki & Martin, 2005; LePine, Zhang, Crawford, & Rich, 2015) found out that job satisfaction is enhanced by transformational leadership and transactional leadership. Literature abounds to support the fact that performance increases with the combined performance of transformational and transactional leadership. Other writers have established that transformational leadership positively affects the relationship between followers and their performance (Spano-Szekely, Griffin, Clavelle, & Fitzpatrick, 2016; Yahaya & Ebrahim, 2016). In contrast leaders who are laid back or who adopt laissez-faire leadership style are considered as the least effective. Yahaya
& Ebrahim(2016).

2.4 Determinants of leadership style choices

There are various factors that determine what leadership style is chosen and implemented in an organisation. Alabi and Alabi (2010) identified some of these factors as the nature of the organisation, the background of the leader and the type of followers in the group or organisation

2.4.1 Leaders and their personalities and experience.

Basing on the theory of (Northouse, 2010). The personality of the leader includes the know-hows, ethics, values, understanding and other factors that are personally initiated from the leader. Over the years, more experiences have been related to styles of leadership. A lot of principles that have been practise over the years have effective leadership style (i.e., Transformational & Transactional styles), and according to Cohen, 2015, very few experience was interpreted into the passive and ineffectual leadership style

2.4.2 Gender

In the early 1990s, there was an increasing research that established that gender differences in leadership style was not vital. Powell (1990; 1993) and Bass (1981) and other well-known researchers in management also agreed with this certainty. A publication of a Harvard Business Review article in 1990, argued that previous literature which established differences between gender and leadership style was arguable. The conviction was so strong that Bass began to think otherwise his conviction on female in leadership (Bass et al., 1996). Despite work done by Rosener additionally, further work was done by Bass which proved otherwise of the earlier inference on the differences in the style of leadership. The evidence however isn‟t decisive (Loden, 1985; Grant, 1988; Rosener, 1990; Rosener et al., 1990; Bass et al, 1996). Early research that explored gender disproportions found a lack of help for the notion that women utilize different leadership styles than do men (Lehman, 1990; Powell, 1990; 1993; Maupin, 1990). Further work, nonetheless, shows that there are differnces in the style of leadership practise my Males and females (Burke & Collins, 2001; Lipman-Blumen, 1996; Lipman-Blumen et al., 1996; Alimo-Metcalfe, 1995).

2.4.3 Culture of Organisation

Alabi and Alabi (2010) stated that a lot of influence is exerted on the leader by the organisation in which he works in, based on the leadership that is assumed. Leadership style is affected by a particular philosophy of an organisation. The values and customs of the organisation. As stated in the various literature, influence on both national and organisational principles applies on the use and choice of leadership (Adams, 2011; Aitken, 2007; Fairholm, 1994). A global ideal appreciated widely across many nations and organisations is Hofstede"s (1980) five culture dimensions. Hofstede"s (1980) idea measures cultural modifications in different countries namely: power distance, individualism, masculinity, uncertainty avoidance, and long term orientation (Hofstede & Bond, 1988).

2.5 Client satisfaction

One very important indicator that measures the performance and effectiveness of a healthcare facility is the level of satisfaction expressed by the clients (Pakdil and Harwood, 2005). Zineldin (2006) defined satisfaction as an emotional reaction. Although service quality and customer satisfaction are two diverse constructs which can be independently evaluated and defined, they seem similar. Whereas both are observed as similar, the concept of customer satisfaction is considered as a wider subject while service quality considers the range of services (Zeithaml & Bitner, 2000). Customer satisfaction is considered as comparatively difficult and complex in relation to service quality. Satisfaction is seen as an attitudinal reply to value the judgements that clients face about their clinical encounter (Kane et al, 1997). Customer satisfaction is regarded as a global response metric used to reflect the level of customer pleasure. Satisfaction is also dependent on the ability to predict customer demands by past studies and putting measures in the future to delight them. Comparing service quality and customer

satisfaction, the former is upgraded at each transaction or service experience and runs into the long term compared to satisfaction which is temporary and simply reproducing and experience type in service (Vinagre & Neves, 2008). Oliver (1997) regards satisfaction as "the customer‟s response to realisation", a verdict drawn after consumption of the service rendered by the service provider. He identified distinguishing factors for satisfaction and service quality and suggested that quality is a measurement that observes a trend of performance which requires service dimensions specific to the service delivered. External signals are therefore noted to influence quality. The PA health care settings normally functions as a good platform for studying patient‟s satisfaction.

Priporas et al (2008) stated that because as medical or health facility is not technically comprehensive, does not mean expectations and perceptions are unrelated. Patients do not normally have a clear idea on their expectations from a clinical setting. As a result the satisfaction of patient is a composition of quality of care. Souelem (1955) and Klopfer (1956) studied client satisfaction as far back as in the 1950s and their results gave an in-depth revelation guide to medical practitioners and their administrators on how to measure quality of care. Linder-Pelz (1982) defined patient satisfaction as an evaluation of dynamic dimensions in health. It could be regarded as one of the expected results from care, and that information on satisfaction is to very crucial to the evaluation of quality within the healthcare system (Turner and Pol, 1995; Naidu, 2009). In addition, there are several arguments to satisfaction of patients in the healthcare sector as a subjective and dynamic discernment of the level to which expected health care is received (Senarath et al, 2006). Satisfaction may also focus on the quality of health services provided which can prove tough to explain and provide a concrete definition. Satisfaction as an experience may be connected to contentment, prosperity, wealth, and quality of life. In a technical acknowledgment, it is a judgement set by the customers

which is provided after service is consumed (Priporas et al., 2008). It could also be said to be a moving target that needs critical attention because customer expectations keep on changing and so does the meeting of their needs ought to change to meet these expectations. Healthcare givers may respond proactively when they comprehend the level and structure patient expectations take and also when these expectations are managed. The organisation may satisfy its customers when their expectations are managed continually and the product or processes they provide are also managed continually (Friesner et al., 2009). Jackson et al (2011) suggested that the communication between doctors and their patient instantly affects their satisfaction level. Furthermore, satisfaction in the healthcare sector also includes the variables as age of the patient and the functional status.

Satisfaction of patients are according to four purposes;

1. For comparing different health care systems or programs.
2. For evaluating the quality of care.
3. For identifying which aspects of a service requires change to increase the level of patient satisfaction.
4. In order to identify customers who are likely to renege.

Numerous studies exist that utilise various factors or combination of measures to represent satisfaction (Rosenheck et al., 1997; Weiss and Seif, 1990). Whereas other authors included satisfaction into their survey instrument by asking respondents directly to reveal their level of satisfaction with care received from the healthcare based on quality (Badri et al., 2009). Woodside et al (1989) noticed other determinants of patient satisfaction, as; care of the nurses, technical services, housekeeping, admissions, discharge and even food at the healthcare centre. Senarath et al (2006) mentioned that

patient satisfaction was measured using a 16-item scale which covered measurements like: accessibility, physical environment, interpersonal care issues, technical issues about care and the outcome of care. Tucker and Adams (2001) also identified that patient satisfaction can be measured considering factors like empathy, care, reliability and responsiveness. Others measurements introduced are suggested by Fowdar (2005) to include customization, professional credibility, core services, communication, and competence. Bowers et al (1994) mentioned that engaging the problems of pain, life threat, disappointments, and anger with warm emotional feelings by healthcare providers create a positive feeling and outcome.

2.6. Level of satisfaction demonstrated by health care clients.

The quality of healthcare received/given is very important to the growth of a country. Healthcare practitioners are encouraged to put in more effort to publicise safety and prevention education on a large scale so as to curb epidemics. Dr. Elias Sory has been a source of motivation within health care system where he encouraged health care workers to follow processes in their various organisations and take advantage of the numerous prospects offered by the universities and other such avenues to improve upon their skills set and get abreast with the prevailing challenges (Ghanaweb, 2010).

The management of health organisations have been encouraged to liaise with ministry of health to draw out a performance agreement contract for various levels of health care delivery so as to observe their activities and improve upon the delivery of service. Health workers equally have been advised to consciously transform their reactions and behaviours they exhibit among their patients since patients are increasingly becoming assertive and their demands have change- they demand value for their monies. The general perception of the Ghanaian populace is one of apprehension because they recall all the inefficiencies and lapses within the healthcare sector (Ghanaweb, 2010). Here in Ghana, most of the health

institutions are controlled by the Ghana Health Services and the Ministry of Health oversees them. Taner and Anthony (2006) and Eiiriz and Figueiredu (2005) admitted the difficulty in conceptualising and measuring customer and service quality in the health sector, although it has become more complex and crucial. Canagarajah et al (2001) identified five major providers of services in the Ghanaian health care sector; the health posts which is recognised as the primary level notable within the rural areas. Others are health centres and clinics, district hospitals, regional hospitals and tertiary hospitals.

The government of Ghana finances the programs through Internally Generate Funds (IGF), donor(s) pooled health fund. Various health care literature exist that establishes the fact that service quality influences patient satisfaction (Conley et al., 2003; Hudelson et al., 2008; Muntlin et al., 2006; Radwin, 2000). Practices targeted at improving customer satisfaction such as cordial communication, conduct of employees, willingness to offer assistant to patients contribute immensely to service delivery. Clients, policy makers, payers, professionals, managers all view quality of healthcare differently. Leebov et al (2003) believe that rendering quality healthcare is the best thing to do. They established that quality healthcare means doing the right thing and making necessary efforts to improve continually. This also involves employing the best and talent workers, ensuring that the financial system is well functioning and ensuring that all customers are satisfied. Various stakeholders have their varying preferences when it comes to quality (Mosadeghrad, 2013). The patients usually focus on interpreting quality as good facilities, clean environment, food and warm provider behaviours instead of technical quality (Wan Rashid and Jusoff, 2009). In another extension, quality is measured using eight rights; Right care in the right way for the right individual in the right place at the right time by the right person and for the right

price to achieve the right results, which are acceptable, necessary, accurate, safe, comprehensive, effective, patient-centred and excellent.

Right way means the provision of services in the most efficient way using the right processes. Right place means that the hospital or health facility is located in a place which can easily be visited by all targeted patient/clients. Right time means that all the necessary medical attention are given to the client at the most appropriate time. Right provider means that the most appropriate professional is the one who administers the care to the health patient, this right means that the person possesses the right knowledge, attitude and attributes. Right price means that the health issues are accessible by the patients at the appropriate amount which is not perceived to be overvalued or undervalued by both parties. Right results mean that the conclusion after all the preceding rights produces the expected and positive results. We can therefore define quality healthcare as continuously ensuring that the customer is elated and satisfied with services by providing efficient and effective healthcare services using modern and generally accepted standards. This definition integrates patient needs and technical healthcare service aspects – this indicates that the level of service should be based on the varying customer prospects and the functions of the process. Mosadeghrad (2013) posited that when we talk about quality in the healthcare sector, it varies from person to person and it is multifarious so attention must be directed during performance.

Atinga et al (2011) noted that providing support for patients, decreasing the amount of time spent in queues with increase the satisfaction among patients towards health care facilities. De Ruyter et al (1998) also noted that the industry under consideration was also a contributory factor the level of satisfaction between service provider and service consumers. For such an industry noted for high switching costs for instance the health system, it will be difficult for customers to switch. Prakash (2015) defined service

quality as the extent to which health service achieves it desired outcome benefits. Gronroos established that how, what and the present image which recognized by current and potential customers is dependent on the service quality they receive. Healthcare metrics such as intangibility, heterogeneity, simultaneity are difficult to measure and define (Ladhari, 2009; McLaughlin, Kaluzzy, 2006, Naveh and Stern, 2005).

The complexity in Healthcare delivery, coupled with its diverse participant interests and ethical issues make it difficult to provide high client satisfaction (Eiriz and Figueiredo, 2005; Rohlin et al., 2002). This is because all the diverse stakeholders have varying interest and interpretation of service delivery and components of satisfaction. Tucker and Adams (2001) found out in their study that there exists a positive relationship between client satisfaction and service delivery in public hospitals. Also, Aaron & Roger (2013) conducted a study with five hospitals in the Greater Accra Region of Ghana and they found out that clients requested higher level of service and satisfaction as compared to what they received. That explains that clients were yet to be satisfied with service delivery of the hospitals that were represented in the study. They measured service delivery using the Service Quality (SERVQUAL) model and found out that the perceptions as against the expectations of service delivery was below expectations. Aaron & Roger found out that access to health delivery facilities, reliability, tangibility of services and prompt attention were regarded as highly important for client satisfaction. With access they meant the ability created for the clients/patient to reach the health provider and the health facility with ease. In some occasion, they could get to the health facility easily, but they would not be given access to the health provider (e.g. doctor) easily. Customer satisfaction can be considered as a moving target since it is based on the customer behavior; and customer behavior keep on changing. Tucker and Adams (2001) condensed

Parasuraman et al (1998) dimensions into two major factors using factor analysis. They classified them as provider performance and access. Provider performance has to do with relations and interactions between patient and care provider. Access has to do with the ease created for the patient to receive care without hindrances within the process. In reality these two dimensions seem to be the most considered factors for patient satisfaction in hospitals. A hospital can be physically appealing but when it lacks ease of access to healthcare delivery, the patients will be dissatisfied.

2.7 Leadership styles and client satisfaction at Health care facilities.

Tracey and Hinkin (1994) are optimistic about the contribution of transformational leadership to the growth of an organisation viewing it as a change agent to the intensifying workload and changing conditions of service in organisations. Their study was into the effect of transactional and transformational leadership on both organisations and the individuals within. Their study revealed that transactional leadership may be effective under circumstance which are stable, but in unstable times transformational leadership is required. They also noted that the prevailing situation in the healthcare sector is one characterised by instability and intense competition and hence this will call for transformational leadership practice. Interesting to note, Bass and Avolio (2004) mentioned that both types of leadership are not mutually exclusive where the same leader can employ a combination of styles in the differing situations. Clark et al (2009) and Hermalin (1998) studied leadership in the hospitality industry and identified that leadership style have a significant effect on the behaviour of employees at the hotel. The result also revealed that shared values inspired by transformational leaders encourage employee satisfaction which is passed on to the clients (Brownell, 2010).

A new practice of leadership is emerging, known as the servant leadership which has similar characteristics as transformational leadership. This is where the leader is driving by a desire to service and endow subordinates. This results in an egalitarian leader-follower relationship (Brownell, 2010). The differences between servant leadership and transformational leadership thus lie with five main measurements; development, means of influence, ethics, motive and mission, and focus. The values of the leader differentiates transformational leaders from servant leaders. Transformational leaders are mostly concerned on the needs of the organisation and creates an empowered culture, while servant leaders focus on developing their followers and so are motivated to empower them. According to Bennet (2007) servant leaders practice leaders as a form of hospitality. Employees inspired by their leaders give selfless and sincere care to the clients which leads to higher satisfaction from customers. The trust placed by the leaders to the customers encourage them to increase their productivity.

Clark et al (2009) observed how managers commit to service quality and leadership style effect on front line employees. They established that when employees are satisfied with their jobs they tend to be committed and hence demonstrate the highest level of quality. This is seen especially when managers demonstrate commitment also. Specific working conditions in the health industry requires innovative techniques to ensure employees are motivated and service is provided to its peak satisfaction. Clark et al. (2009) identified and studied three leadership styles; directive- where there is little or no control, participative – involving shared control between leaders and followers, and empowering which involves extensive control given to employee. It is believed that these leadership styles have different effect on the job behaviour of employees.

As a result of the autocratic, and controlling nature of the directive leadership which is mostly targeted at obtaining results, it dissuades employees from participating actively

in the growth of an organisation and also does not contribute to empowering them. Clark et al (2009) stated that when employees are not encouraged to take part in decision making within an organisation, it creates apathy among them and they are less likely to embrace the mission and vision of the organisation. In this case, it creates more of a servant-master relationship, rather than a relationship of close relations. Yukl(1989) describes the participative leadership style as one that actively includes and engage the thoughts and the intellectual contributions of the employees. This results in more productivity across the organisation because the employees are closely related to the clients of the organisation and hence have first-hand information of the specific needs of clients more than the managers of the organisation. They are the first point of contact for clients and so they can provide better information about the needs of the clients and also communicate better solutions to meet client needs. Therefore, failure to listen to frontline employees of an organisation spells the decay of the organisation. Furthermore, the frontline employees are the face of the organisation, their demonstration of apathy communicates to the clients that the organisation is apathetic to their needs and this will not augur well for the productivity of the organisation (Clark et al., 2009). This calls for the need to empower frontline employees and subordinates, especially in the healthcare facility. This is known as leadership empowerment (Conger and Kanungo, 1998). They defined it as the process of equipping subordinates with authority, independence and necessary skills to make decision in relation to clients‟ needs without the supervision of superiors. This is more or less like promoting the subordinates, but without the title. This is more transformational in an organisation metamorphosis. Contrasting directive leadership and subordinate empowerment the results from both reveal that empowerment of subordinates‟ results in higher satisfaction level in the organisations and encourage higher productivity. Clark et al

(2009) noted that when an employee is empowered, they feel more fulfilled with their jobs because they feel that they have more control of their work which reflects in their work output.

CHAPTER THREE

METHODOLOGY

3.1 Study type and design

The study used a quantitative method with a cross-sectional design. Cross-section design is described as a situation where respondents are contacted with a particular time Campbell, Machin, & Walters, 2007). This design was employed because it is comparatively quick and inexpensive to conduct. The study was conducted from July to August, 2019.

3.2 Study population

The study population was healthcare workers in Suntreso Government Hospital and Clients receiving care from Suntreso Government Hospital, at the time of data collection.

Inclusion criteria

1. All staff of Suntreso Government Hospital who were acknowledged by the database of the Hospital.
2. All clients receiving care from the Suntreso Government Hospital at the out patients level at the time of data collection who were 16years and above.

Exclusion criteria

1. All Health workers who were not employers of Suntreso Government Hospital and were not acknowledged by the employee database of the Hospital.
2. All patients who did not access health services from the hospital at the time of data collection

3.3 Sample size and sampling methods

3.3.1 Sample size

Sample size for Healthcare workers

Using the staff population (N) of 204 and a margin of error (e) of 0.05, the sample size (n) was calculated using the sample size formula developed by Yamane (1967).

The formula: $\mathbf{n = N/1+N\,(e)^2}$, where; N

= population size

n = sample size

e = margin of error

The sample size for Staff was 136.

Therefore, using non response rate of 10%, the sample size was 150 staff of Suntreso Government Hospital

Sample size for the clients

The average population size for patients is 600 so using the formula

$\mathbf{n = N/1+N\,(e)^2}$, where; N

= population size

n = sample size

e = margin of error

where N is 600, and e = 0.05

The sample size for patients will be 240.

Therefore, using non response rate of 10%, the sample size was 264 clients of the hospital which was approximated to 292 clients.

3.3.2 Sampling method

The researcher used simple random sampling as the sample method for this study, where staff were interviewed. In this study the total staff composition was derived from the Human resource department. The data was sorted according to surnames and in a sequential manner. Randomizer online was used to select the samples needed for the study randomly (Ubaaniak and Pious, 2013). In doing so, a sample size of 150 was retrieved with random serial numbers after the total staff size of 204 was put into the software. These 150 staff randomly selected were then contacted using questionnaires.

The clients were selected using systematic sampling method. In this case, the sample frame was calculated by dividing the sample interval of 600 by the calculated sample size of 292 which was approximately 2. In this case, the first client who was exiting the facility after receiving care was interviewed. The next second person after the first interviewee was interviewed. This process was repeated till the required sample size was attained.

3.4 Study variable

Table 3.1: Study Variable

Objectives	Dependent Variable	In ependent Variable	Data Collection Method	Scale Of Measurement	Type Of Statistical Analysis
1. To assess the various leadership styles employed by healthcare managers	Client satisfaction	1. Transformational leadership style 2. Transactional leadership style	Structured Questionnaire	Nominal	Descriptive
2. To assess level of clients satisfaction on the service provided in the Hospital	Client satisfaction	1. Cost of care 2. Patient waiting time 3. Outcome of care/recovery rate 4. Information/communication	Structured Questionnaire	Nominal	Descriptive
3. To establish any association between the various leadership styles and clients satisfaction	Client satisfaction	Transformational leadership: inspirational motivation, individualised consideration, idealised influence and intellectual stimulation. Transactional leadership: management by exception active, management by exception passive and contingent reward	Chi sqaure	Ordinal	Inferential

3.5 Data collection technique and tools

The data were collected from healthcare workers and clients accessing care from the Suntreso Government Hospital using structured questionnaire. The data were collected by the researcher and 4 research assistants who were trained by the researcher and they assisted in the data collection. The questionnaire for the staff and clients was prepared in the English language. However, local language such as Twi was used to administer the questionnaire to clients who did not understand English language. The data were collected at the premises of the Suntreso Government Hospital.

The types of data which were collected from the health workers included; sociodemographic characteristics of the respondents and various leadership style employed by health care managers. Also, the type of data collected from the clients included socio-demographic information, out-patient"s satisfaction with care and staff attitude towards clients.

3.6 Pilot study

The questionnaires were piloted at Methodist Hospital at Aburaso. The feedback we received from the pilot study aided in reviewing the questionnaire.

3.7 Data handling and analysis

The data were analysed using Stata version 12. The descriptive data were presented using frequencies, tables, percentages and charts where necessary. Chi-square test was performed to establish any association between leadership style and clients satisfaction. Statistical significance for all tests will be set at 0.05.

3.8 Ethical consideration

The committee on Human Research Publications and Ethics was contacted for ethical clearance (Ref: CHRPE/AP/536/19). Also, permission was given by the Medical

Superintendent of Suntreso government hospital. The essence of the study was clarified to the participants using an information sheet which was prepared by the researcher. The participants were made to understand that their participation was deliberate and that they could withdraw from the study at any time or decline to answer any question without any penalty. A written informed consent form was obtained from participants willing to partake in the study. Also, Privacy and confidentiality of data was guaranteed. Study subjects was anonymous, no names were required, and therefore no information could be linked to any identity.

CHAPTER FOUR

DATA ANALYSIS

4.1 Socio-demographic characteristics of respondents

4.1.1 Socio-demographic characteristics of staff

Table 4.1 presents the socio-demographic characteristics of staff. Out of the 150 respondents, more than half of the respondents (52.0%) were male and 48.0% of them were female as detailed in Table 4.1. Describing the staff of the hospital based on their age, most of the respondents (36.0%) were within the age group 18 and 29 years, whereas the rest were between 30 and 39 years (28.0%), 50 and 59 years (18.0%), 40 and 49 years (13.3%) and above 60 years (4.7%) (see Table 4.1). On their educational background, most of the respondents (39.6%) had HND/Diploma level of education, 37.6% of them had 1st degree level of education, 11.4% of them had SHS level of education, 8.1% of them had JHS level of education and 3.4% of them had 2nd degree level of education as shown in Table 4.1. On the level of experience of the staff, most of the respondents (36.7%) had worked in the hospital for 4 to 6 years, 32.7% of them had have worked for less than 4 years, 16.0% of them had worked between 7 and 9 years‟ experience with the hospital and 14.7% of them had over 10 years‟ experience in the hospital.

Table 4.1 Socio-demographic Characteristics of staff

Variables	Frequency (n=150)	Percentage (100%)
Gender		
Male	78	52.0
Female	72	48.0
Age of Staff		
18-29 years	54	36.0
30-39years	42	28.0
40-49years	20	13.3
50-59years	27	18.0
60 and above	7	4.7
Educational Level		
JHS	12	8.1
SHS	17	11.4
HND/Diploma	59	39.6
1st Degree	56	37.6
2nd Degree	5	3.4
Number of Years as an Employee of Hospital		
0-3 years	49	32.7
4-6 years	55	36.7
7-9 years	24	16.0
10 years and above	22	14.7

Source: Author‟s survey, 2019,

4.1.2 Socio-demographic characteristics of clients

Table 4.2 shows socio-demographic characteristics of 292 clients. Results reveal that majority of the respondents (63.7%) were female and 26.3% of them were male.

Describing the respondents based on their ages, more than half of the respondents (50.3%) were between 18 and 29 years.

On their marital status, most of the respondents (49.7%) were single, 45.9% of them were married, 2.4% of them were widowed and 2.1% were divorced as shown in table 4.2. Also, based on their educational level, most of the respondent (41.8%) had tertiary level of education, 34.2% of them had secondary level of education, 8.2% had basic level of education and 15.8% of them did not have any formal education.

Based on their employment status, most of the respondents (28.4%) were traders/business people, 21.1% of them were unemployed, 19.9% of them were students, 9.2% of them were private employees, 16.8% of them were government employees and 4.5% of them were farmers. Furthermore, the distribution of the respondents based on their religious affiliation, revealed that majority of the respondents (84.2%) were Christians, 13.4% of them were Moslems and 2.4% of them were traditionalists.

Categorising the respondents based on the mode of payment at the hospital, revealed that majority of the respondents (76.0%) paid by NHIS, 19.5% of them paid cash, 3.4% of them paid using private insurance and 1.0% of them were funded by their corporate entities. Finally, classifying the respondents based on whether that was their first time or not, revealed that majority of them (67.8%) had visited hospital before and 32.2% of them were visiting for the first time.

Table 4.2 Socio-demographic characteristics of Clients

Variables	Frequency (n=292)	Percentage (100%)
Gender Male	106	26.3
Female	186	63.7
Age of Client/patient Less than 18 years	11	3.8
18-29 years	147	50.3
30-39years	71	24.3
40-49years	33	11.3
50-59 years	17	5.8
60 years and above	13	4.5
Marital Status		
Single	145	49.7
Married	134	45.9
Divorced	6	2.1
Widowed	7	2.4
Educational Level None	46	15.8
Basic	24	8.2
Secondary	100	34.2
Tertiary	122	41.8
Employment Status		
Unemployed	62	21.2
Trade/Businessman	83	28.4
Farmer	13	4.5
Private employee	27	9.2
Student	58	19.9
Religion Christian	246	84.2
Moslem	39	13.4
Traditional	7	2.4
Mode of Payment		
Fee for service (out of pocket)	57	19.5

NHIS	222	76.0
Private insurance	10	3.4
Corporate funding	3	1.0
First time to visit hospital Yes	94	32.2
No	198	67.8

Source: Author‟s survey, 2019,

4.2 Various leadership styles employed by healthcare managers

Table 4.3 below describes the various leadership style employed by healthcare managers. On transformational leadership styles, majority of respondents perceived Individualised consideration (88.0%), intellectual stimulation (83.3%), and inspirational motivation (90.0%) and idealised influence (86.2%) as various transformational leadership styles employed by managers as detailed in table 4.3. On transactional leadership as shown in table 4.3, majority of the respondents mentioned contingent reward (84.0%), management by exception-active (95.3%) and management by exception- passive (67.3%) as transactional leadership styles employed by managers.

Table 4.3 various leadership style employed by healthcare managers

Variables	**Yes (%)**	**No (%)**
Transformational leadership		
Individualized Consideration	132 (88.0)	18 (12.0)
Intellectual stimulation	125 (83.3)	25 (16.7)
Inspirational Motivation	135 (90.0)	15 (10.0)
Idealised influence	129 (86.2)	21 (14.0)
Transactional leadership		
Contingent Reward	126 (84.0)	24 (16.0)
Management by Exception-Active	143 (95.3)	7 (4.7)
Management by Exception-Passive	101 (67.3)	49 (32.7)

Source: Author‟s survey, 2019,

4.3 Outpatients satisfaction with care

Table 4.4 indicates the responses of clients on their satisfaction with health care. Majority of the respondents (91.4%) were seated as they waited to receive health care services and majority of them (65.1%) indicated that the seats were comfortable. Also, over seventy percent of the respondents (76.0%) were examined by the doctors. Additionally, majority of the respondents were informed about their diagnosis (71.2%), received instructions about their illness from their Doctors (74.3%), understood doctor‟s instructions (71.9%) and were informed about their review dates (78.4%). Furthermore, more than sixty percent of the respondents (65.8%) received their prescriptions and understood the instructions (80.1%) provided by the pharmacist. Also, less than half of the respondents (32.5%) had visited the hospital on emergency and were seen promptly (29.5%). Majority of the respondents (84.2%) agreed that they were satisfied with the services received and would visit the hospital again (85.0%) based on the services received.

With regards to provider‟s attitude towards client as detailed in table 4.5, more than half of the respondents (53.1%) indicated that medical records service providers performed averagely to their satisfaction. Analysing the results using the means and standard deviations indicated that all the service providers were performing well. The highest rated service provider at the hospital was the pharmacy staff (mean= 2.46, s.d = 0.680). The next highly ranked service providers were the doctors (mean= 2.43, s.d= 0.736), then the medical records (mean= 2.42, s.d = 0.651), diagnostics (mean= 2.41, s.d = 0.743), revenue (mean= 2.38, s,d =0.680), and the least ranked service provider were the nurses (mean= 2.31, s.d=0.729) (see table 4.5). More than half of the respondents (55.5%) indicated that the general attitude of staff towards them was average. While 33.6% of them indicated that staff attitude towards them was poor and

very poor (3.8%), 7.2% of them indicated that general attitude was good. On the cleanliness of the hospital and surroundings, majority of the respondents (88.0%) indicated that the environment was clean, 7.5% of them indicated that the surroundings were very clean and 4.5% of them reported that the surroundings were dirty. On assessing whether services had improved or worsened over the past 6 months, more than half of the clients (56.5%) indicated that services are still just the same but 41.4% indicated that services had improved, whereas 2.1% indicated that services had worsened as shown in table 4.5.

Table 4.4 Outpatients Satisfaction with Care

Items	**Yes (%)**	**No (%)**
Availability of seat at waiting area	267 (91.4)	25 (8.6)
Comfortable seat at waiting area	190 (65.1)	102 (34.9)
Examination of patient done by doctor	222 (76.0)	70 (24.0)
Doctor informed the patient about his/her condition	208 (71.2)	84 (28.8)
Doctor provided instruction to patient about his/her illness	217 (74.3)	75 (25.7)
Patient understood doctors directives	210 (71.9)	82 (28.1)
Doctor told the patient when to come for review	229 (78.4)	63 (21.6)
Patient received all prescribed drugs/medications.	192 (65.8)	100 (34.2)
Patient understood all the instructions from the pharmacist.	234 (80.1)	58 (19.9)
Patient visited the hospital in emergency situation in the past six month including night	95 (32.5)	197 (67.5)
Rendered prompt services to patients	86(29.5)	206(70.5)
Satisfaction of the services received	246 (84.2)	46 (15.8)
Patient would visit the hospital again based on services received.	250 (85.6)	42 (14.4)

Source: Author‟s survey, 2019

Table 4.5 Attitude of service providers to client

	Very Poor	**Poor**	**Average**	**Good**	**Very Good**	**Mean**	**S.d.**
Medical records	1(0.3%)	11(3.8%)	155(53.1%)	113(38.7%)	12(4.1%)	2.42	0.651
Revenue collector	2(0.7%)	15(5.1%)	154(52.7%)	113(38.7%)	8(2.7%)	2.38	0.659
Doctor	1(0.3%)	22(7.5%)	137(46.9%)	114(39.0%)	18(6.2%)	2.43	0.736

Nurse	1(0.3%)	30(10.3%)	151(51.7%)	97(33.2%)	13(4.5%)	2.31	0.729
Pharmacy staff	2(0.7%)	9(3.1%)	149(51.0%)	116(39.7%)	16(5.5%)	2.46	0.680
Diagnostics	3(1.0%)	22(7.5%)	134(45.9%)	119(40.8%)	14(4.8%)	2.41	0.743
General attitude of the staff towards patients.	11(3.8)	98(33.6)	162(55.5)	21(7.2)	-		
Items	**Worsened**	**Just the same**	**Improved**				
Services over the past 6 months been improved or worsened	6 (2.1)	165 (56.5)	121 (41.4)				

Source: Author‟s survey, 2019

4.5 Association between the various leadership styles and client satisfaction.

Table 4.6 shows the association between the various leadership styles and client satisfaction.

On the transformational leadership style, majority of the respondents (88.6%) were satisfied with individual consideration while 12.0% of respondents were dissatisfied. The difference was statistically significant (p-value =0.0141). Furthermore, there was a significant relationship with staff (90.0%) who were satisfied with inspirational motivation, (p-value =0.0337). With Idealised influence, 129(86.2%) indicated that they were satisfied and the results was statistically significant (p-value =0.0112).

On the transactional leadership, most of the respondents (95.3%) were satisfied with management by exception -active. While those who were not satisfied were 4.7%. The difference was statistically significant (p-value=0.0311). On the management by exception -passive, majority of the respondents (67.3%) were satisfied and 32.7% were not satisfied, the result was statistically significant (p-value = 0.0167). Furthermore, a significant proportion of the clients (84.0%) were satisfied with services received (p-value = 0.0185).

Table 4.6 Association between the various leadership styles and clients satisfaction

Variable	Client Satisfaction		Chi-square	p-value
	Yes (%)	No (%)		
Transformational leadership				
Individualized Consideration	132 (88.6)	18 (12.0)	**X^2= 17.01**	**0.0141**
Intellectual stimulation	125 (83.3)	25 (16.7)	**X^2= 14.01**	**0.0221**
Inspirational Motivation	135 (90.0)	15 (10.0)	**X^2= 16.45**	**0.0337**
Idealised influence	129 (86.2)	21 (14.0)	**X^2= 22.10**	**0.0112**
Transactional leadership				
Contingent Reward	126 (84.0)	24 (16.0)	**X^2= 16.13**	**0.0235**
Management by Exception-Active	143 (95.3)	7 (4.7)	**X^2= 14.81**	**0.0311**
Management by Exception-Passive	101(67.3)	49 (32.7)	**X^2= 17.32**	**0.0167**

Source: Author"s survey, 2019

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 The socio-demographic characteristics of respondents

The socio-demographic characteristics of staff reveals a fair balance in gender proportion across the staff in the hospital. This may be explained by the fact that appointment of staff is not dependent on gender, but on the staffs ability and professional capabilities to work in the various units of specialty in the facility, as shown in section 1.7.2 and table 1.1. Also according to the World Bank collection of development indicators labor force, (43% of total labor force) in Ghana was reported at 49.52% in 2017, indicating a very fair distribution in the employment of staff.

Again most of the respondents (36.7%) (see table 4.1) demonstrated appreciable level of knowledge about the hospital‟s working culture and operations. This could explain by the years of experience they have been working in the hospital between 4 - 6 years and 7 -9 years, respectively. This may explain the level of cleanliness which majority of the respondents (88.0%) agree to, shown in table 4.5. this may also account for the reason why more than half of the respondents (56.5%) say that services over time in the hospital has not seen any improvement or worsen but has remained the same, as detailed in table 4.5.

Furthermore, the socio-demographic characteristics of the client, revealed that majority of respondents (63.7%) were females, this could be explained by the general health seeking of women, the reproductive biology of women and specific conditions related to gender, their differences in health perception, reporting illnesses and a greater likelihood of women reporting symptoms and seeking help with prevention of sicknesses (Yeatman, 2018). also most of the respondents (28.4%) indicated in their

employment status as trader/businessmen. This may be explained by the citation of the facility in the city, Kumasi, which is accessible at any time by clients in the city. These clients reported to the facility from their various places of work, in the city, for health care. As indicated in section 1.7.1 and 1.7.2 this may also be seen in the educational level of the clients, where most of the respondents (15.8%) did not have any form of education as they were traders/businessmen, as indicated in table 4.2

5.2 Various leadership styles employed by healthcare managers

The two main leadership styles considered here are transformational leadership style and transactional leadership styles. Table 4.3 show from the responses of the staff that health care managers display transformational leadership by majority of the respondents (90.0%) agreeing to inspirational motivation as the style of management. This is supported by a study conducted by Burns, 1978, where he indicated that, Transformational leadership is displayed when the leaders of the hospital motivate the staff and change their perspectives to look beyond their own personal goals and operate to meet the collective goals of the organisation.

In addition, the leaders display transactional leadership where they tie rewards to achieving of targets. Despite the fact that transactional leaders do not have much interest in personal lives of employees (Bass, 1985), majority of the respondents (95.0%) indicated that healthcare managers used active management by exception as their management style. this may be explained by a study conducted by Bass & Avolio (1990) in that management by exception – active could be seen as when the leaders actively influence subordinate behaviours by directing it to agree with the performance standards of the organisation as presented in section 2.3.8

5.3 Level of client satisfaction on services provided

Describing the level of client‟s satisfaction, majority of the respondents (84.2%) indicated that they were satisfied with the overall services in the facility, this reflecting in 85.6% of them saying they will visit the facility again due to the services they have received. This is supported be the statement made by Oliver (1997) who defined satisfaction as “the customer‟s fulfilment response”. It is the response, especially positive response which a customer reports as feedback for services they have enjoyed. This includes expectations over achieved or under achieved. Priporas et al., (2008) noted about the healthcare setting that because healthcare delivery is not technically comprehensive does not mean that expectations and perceptions are not linked. Patients do not normally have a clear idea on their expectations from a clinical setting. As a result the satisfaction of patient is a composition of quality of care. Which they sought to attain as shown in the services provided by the hospital, in line with holistic quality health care, as shown in section 1.7.2 and table 1.1. The level of client satisfaction reflects the level of health quality that the healthcare facility provides. As it stands, it is easy to understand psychologically, but it is difficult to define. Satisfaction can be linked to joy, quality of life, wealth, prosperity amongst others.

5.4 Relationship between the various leadership styles and clients satisfaction

As a result of the existence of the transformational leadership styles as the management style practiced at the hospital by the mangers, a significant proportion of the respondents were satisfied as revealed in the individual consideration (88.0%), Intellectual stimulation (83.3%), inspirational motivation (90.0%), idealised influence (86.2%) with (p-value = 0.0168) and client satisfaction. This agrees with Burn‟s description of transformational leaders as people who are motivated to encourage individual to go beyond their specific interest so as to achieve the collective goals of

the organisation. Bass improved and expanded this model by viewing leadership on a timeline or scale board with transformational leadership on one side and transactional leadership on the other. He mentioned that transformational leaders act as counsellors, encouraging, inspiring employees and this is shown in the output of the staff which results in client being satisfied.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS FOR THE STUDY

6.1 Conclusions

The socio-demographic characteristics of respondents.

Majority of the staff were within the active workforce of 18 and 39 years, were well educated and had averagely worked for about 5 years. Also, most of the clients were females, were within the economic working class of 18 to 39 years, were educated, were Traders/businessmen, were Christians and were active NHIS membership card holders.

Various leadership styles employed by healthcare managers.

Various leadership style employed by healthcare managers are a combination of transformational and transactional leadership styles. On transformational leadership style, majority of the respondents indicated that the healthcare managers were practising all the four components of transformational leadership; inspirational motivation, individualised consideration, charisma or idealised influence and intellectual stimulation. Similarly, most of the respondents were of the position that their managers were practising all the components of transactional leadership styles such as management by exception – active, contingent reward, and management by exception – passive. .

Client satisfaction on services provided.

Over half of the client respondents indicated that they were satisfied with the hospital services received and would visit the facility again once they fall sick. Also, clients were satisfied with the cleanliness of the hospital surroundings. However, the general attitude of staff were ranked average by majority of the clients.

Relationship between the various leadership styles and clients satisfaction. There was a significant relationship between transformational leadership styles such as Individual consideration, intellectual stimulation, inspirational moltivation, idealised influence and client satisfaction. Also, the relationship between transactional leadership styles such as contingent reward, management by exception – active, management by exception - passive and clients satisfaction was statistically significant.

6.2. Recommendations

As a result of the observations made from this study, the following has been recommended:

1. Staff should make effort in letting the client know that the services of the hospital is always available to the clients to attend at any time including emergencies and at night.
2. Policy makers such as Ministry of Health, Bantama sub-metro should make policies that will help improve the facility in the various units, since some of the respondents responded that services in the facility had not improved for some time.
3. Management and staff of the hospital should clients who were dissatisfied in order to identify their specific needs and provide tailor made services to meet them.
4. Further studies need to be conducted the establish effects of the various leadership styles on clients‟ satisfaction.

REFERENCES

Adair, J. E. (1973). *Action-centred leadership* (pp. 07-084428). New York, NY: McGraw-Hill.

Adams, C. M., Jean-Marie, G. (2011). A diffusion approach to study leadership reform. *Journal of Educational Administration*, *49*(4), 354-377.

Aitken, P. (2007). „Walking the Talk": The Nature and Role of Leadership Culture within Organisation Culture/s. *Journal of General Management*, *32*(4), 17-37.

Alabi, J., Alabi, G. (2010). Factors influencing quality of leadership in public higher institutions of learning in Ghana. *Journal of Business Research*, *4*(1-2).

Alimo-Metcalfe, B. (1995). An investigation of female and male constructs of leadership and empowerment. *Women in Management Review*, *10*(2), 3-8.

Alrubaiee, L., Alkaa'ida, F. (2011). The mediating effect of patient satisfaction in patients' perceptions of Healthcare Quality- Patient Trust Relationship. *International Journal of Marketing Studies*, 103-127.

Andaleeb, S. S. (1998). Determinants of customer satisfaction with hospitals: a mangerial model. *International Journal of Health Care Quality Assurance*, 181-187.

Andersen, J. A. (2016). An old man and the "sea of leadership". *Journal of Leadership Studies*, *9*(4), 70-81.

Asrar-ul-Haq, M., & Kuchinke, K. P. (2016). Impact of leadership styles on employees" attitude towards their leader and performance: Empirical evidence from Pakistani banks. *Future Business Journal*, *2*(1), 54-64.

Avolio, B. J., Griffith, J., Wernsing, T. S., Walumbwa, F. O. (2010). What is authentic leadership development? Teoksessa: Linley, Alex P., Harrington, Susan & Garcea, Nicola 2010: Oxford handbook of positive psychology and work.

Bass, B. M., & Avolio, B. J. (1990). *Transformational leadership development: Manual for the multifactor leadership questionnaire*. Consulting Psychologists Press.

Bass, B. M., Avolio, B. J., Jung, D. I., & Berson, Y. (2003). Predicting unit performance by assessing transformational and transactional leadership. *Journal of applied psychology*, *88*(2), 207.

Bronkhorst, B., Steijn, B. & Vermeeren, B. (2015). Transformational leadership, goal setting, and work motivation: The case of a Dutch municipality. *Review of Public Personnel Administration*, *35*(2), 124-145.

Canadian Nurses Association. (2004). *Nurses and Patient Safety: A discussion paper*. Toronto: University of Toronto Faculty of Nursing.

Chapman, A. L., Johnson, D. & Kilner, K. (2014). Leadership styles used by senior medical leaders: patterns, influences and implications for leadership development. *Leadership in Health Services*, *27*(4), 283-298.

Cohen, E. (2015). Principal leadership styles and teacher and principal attitudes, concerns and competencies regarding inclusion. *Procedia-Social and Behavioral Sciences*, *186*, 758-764.

Crosby, P. B. (1997). *The absolutes of leadership* (Vol. 34). Jossey-Bass.

Dansereau, F., Graen, G., Haga, W. J. (1975). A vertical dyad linkage approach to leadership within formal organizations: A longitudinal investigation of the role making process. *Organizational behavior and human performance*, *13*(1), 4678.

Epitropaki, O., Martin, R. (2005). The moderating role of individual differences in the relation between transformational/transactional leadership perceptions and organizational identification. *The Leadership Quarterly*, *16*(4), 569-589.

Fiedler, F. E. (1966). The effect of leadership and cultural heterogeneity on group performance: A test of the contingency model. *Journal of Experimental Social Psychology*, *2*(3), 237-264.

ForbesQuotes. (2015). *Thoughts On The Business Of Life*. Retrieved from ForbesQuotes: https://www.forbes.com/quotes/3868/

Gerstner, C. R., Day, D. V. (1997). Meta-Analytic review of leader–member exchange theory: Correlates and construct issues.

Graen, G. B., Scandura, T. A. (1987). Toward a psychology of dyadic organizing. *Research in organizational behavior*.

Hernandez, M., Eberly, M. B., Avolio, B. J., Johnson, M. D. (2011). The loci and mechanisms of leadership: Exploring a more comprehensive view of leadership theory. *The Leadership Quarterly*, *22*(6), 1165-1185.

Hinterhuber, H. H., Krauthammer, E. (1998). The leadership wheel: the tasks entrepreneurs and senior executives cannot delegate. *Strategic Change*, *7*(3), 149-162.

Hofmann, D. A. & Morgeson, F. P. (2004). The role of leadership in safety. *The psychology of workplace safety*, 159-180.

Hofstede, G. (1980*), Culture's Consequences: International Differences in Work Related Values*, Sage, London.

House, R. J. (1971). A path goal theory of leader effectiveness. *Administrative science quarterly*, 321-339.

Howell, J. M. & Avolio, B. J. (1993). Transformational leadership, transactional leadership, locus of control, and support for innovation: Key predictors of consolidated-business-unit performance. *Journal of applied psychology*, *78*(6), 891.

Inc. (2015, June 5). *44 Inspiring John C. Maxwell Quotes for Leadership Success*. Retrieved from Inc: https://www.inc.com/peter-economy/44-inspiring-john-cmaxwell-quotes-that-will-take-you-to-leadership-success.html

James, J. T. (2013). A new evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, *9*(3), 122-128.

Jensen, S. M. & Luthans, F. (2006). Entrepreneurs as authentic leaders: Impact on employees' attitudes. *Leadership & Organization Development Journal*, *27*(8), 646-666.

Jyoti, J., Bhau, S. (2015). Impact of transformational leadership on job performance: Mediating role of leader–member exchange and relational identification. *SAGE Open*, *5*(4), 2158244015612518.

Khan, Z. A., Nawaz, A., Khan, I. (2016). Leadership theories and styles: A literature review. *Journal of Resources Development and Management*, 1-8.

Lok, P., Crawford, J. (2004). The effect of organisational culture and leadership style on job satisfaction and organisational commitment: A cross-national comparison. *Journal of management development*, *23*(4), 321-338.

Luthans, F. (2002). The need for and meaning of positive organizational behavior. *Journal of organizational behavior*, *23*(6), 695-706.

Luthans, F., Norman, S. & Hughes, L. (2006). Authentic leadership. *Inspiring leaders*, 84-104.

Northouse, P. G. (2017). *Introduction to leadership: Concepts and practice*. Sage Publications.

Saeed, T., Almas, S., Anis-ul-Haq, M. & Niazi, G. S. K. (2014). Leadership styles: relationship with conflict management styles. *International Journal of Conflict Management*, *25*(3), 214-225.

Schreuder, J. A., Roelen, C. A., Van Zweeden, N. F., Jongsma, D., Van der Klink, J. J., Groothoff, J. W. (2011). Leadership effectiveness and recorded sickness absence among nursing staff: a cross ‐ sectional pilot study. *Journal of nursing management*, *19*(5), 585-595.

Sermon Illustrations. (2019, July 7). *Leadership*. Retrieved from Sermon Illustrations: http://www.sermonillustrations.com/a-z/l/leadership.htm

Spano-Szekely, L., Griffin, M. T. Q., Clavelle, J., Fitzpatrick, J. J. (2016). Emotional intelligence and transformational leadership in nurse managers. *Journal of Nursing Administration*, *46*(2), 101-108.

Stogdill, R. M. (1974). *Handbook of leadership: A survey of theory and research*. Free Press.

Tannenbaum, R., Schmidt, W. H. (1973). *How to choose a leadership pattern* (pp. 312). Boston, MA: Harvard Business Review.

Thomas, E. J., Studdert, D. M., Burstin, H. R., Orav, E. J., Zeena, T., Williams, E. J., . . . Brennan, T. A. (2000). Incidence and types of adverse events and negligent care in Utah and Colorado. *Medical Care*, *38*(3), 261-271.

Yahaya, R. & Ebrahim, F. (2016). Leadership styles and organizational commitment: literature review. *Journal of Management Development*, *35*(2), 190-216.

Yukl, G. A. (1981). *Leadership in organizations*. Pearson Education India.

APPENDICES

Appendix 1: Questionnaire for Staff and Client

QUESTIONNAIRE FOR STAFF

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
SCHOOL OF PUBLIC HEALTH

This questionnaire seeks to collect data for the study ***Effect of Leadership Style on Client Satisfaction in Health facilities in Bantama Sub-Metro of Ashanti Region, Ghana.*** This research is purely for academic purposes and as such **privacy** and **confidentiality of all information** shall be observed. I would therefore be grateful if you could kindly answer the following questions.

SECTION A: SOCIO-DEMOGRAPHIC DATA

1. Gender [ ] Male [ ] Female

2. Age [ ] 18-29 [ ] 30-39 [ ] 40-49 [ ] 50-59 [ ] 60 and above

3. Educational level [ ] JHS [ ] SHS [ ] HND/Diploma [ ] 1st Degree [ ] 2nd Degree

4. Number of years as an employee of the Hospital

[ ] 0-3 years [ ] 4-6 years [ ] 7-9 years [ ] 10 years and above

SECTION B: TRANSFORMATIONAL LEADERSHP

*Please indicate with a **Yes/No** your perspective to the following statements*

Items	**Yes**	**No**
Individualized Consideration;		
My leaders help me develop myself		
My leaders let me know how I am performing		
My leaders give personal attention to others who seem rejected		
My leaders welcome my individual contribution to the realization of the hospital‟s goal		
Intellectual stimulation		
My leaders enable me to think about old problems in new ways		
My leaders provide new ways to look at difficult tasks		
My leaders make me rethink ideas I never questioned before		
My leaders allow me to ask question about problems that bother me		

Inspirational Motivation		
My leaders express in few simple words what we can and should do		
My leaders provide appealing images about what we can do		
My leaders help me find meaning in my work		
I am willing to invest more effort in my task		
I am made to be optimistic about the future and made I am		
Idealised influence		
The Leaders make us feel good around them		
I have complete faith in my leaders		
I am proud to be associated with my leaders		

SECTION C: TRANSACTIONAL LEADERSHIP

Please indicate the extent to which you agree or disagree with the following statements

*Using a scale of **1 – 5,** where **1=Strongly Disagree; 2= Disagree; 3= Neither agree nor disagree; 4=Agree; 5=Strongly Agree;** provide responses on the following issues.*

Items	**Yes**	**No**
Contingent Reward		
My leader provides staff with assistance in exchange of their efforts		
My leader discusses in specific terms who is responsible for achieving performance targets.		
My Leader gives gifts/rewards to staff on achievement of targets		
My Leaders praises the staff on achievement of their targets		
Management by Exception-Active		
My leader makes clear what staff can expect to receive when performance goals are achieved		
My leader expresses satisfaction when staff meets expectations		
My leader foresees mistakes and puts measures in place to reduce them		
My leader is very proactive		
Management by Exception-Passive		
My leader focuses attention on irregularities, mistakes, exceptions		
My leader concentrates his/her full attention on dealing with mistakes, complaints and failures		
My leader directs staff attention towards failures to meet standards		
My leader Fail to interfere until problems become serious		
My leader waits for things to go wrong before taking action		
My leader shows that she/he is a firm believer in “if it is not broke, don“t fix		

My leader demonstrates that problems must become chronic before taking action		

THANK YOU

QUESTIONNAIRE FOR CLIENTS

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
SCHOOL OF PUBLIC HEALTH

This questionnaire seeks to collect data for the study ***Effect of Leadership Style on Client Satisfaction in Bantama Sub-Metro of Ashanti Region, Ghana.*** This research is purely for academic purposes and as such **privacy** and **confidentiality of all information** shall be observed. I would therefore be grateful if you could kindly answer the following questions.

PART 1. Socio-Demographic Information

1. Age in years…… 2. Gender. 1. Male [ ] 2. Female [ ]

3. Marital Status: 1. Single [ ] 2. Married [ ] 3. Divorced [ ] 4. Widowed [ ] 5. Others please Specify……

4. Education 1. None [ ] 2. Basic [ ] 3. Secondary [ ] 4. Tertiary [ ]

5. Other please specify……..

5. Employment status 1. Unemployed [ ] 2.Trader/Businessman [ ] 3.Farmer [ ] 4.Government employee [ ] 5. Private employee [ ] 6.Student [ ] 7. Other [ ] specify…….

6. Religion: 1. Christian [ ] 2. Moslem [ ] 3. Traditional [ ] 4.Other [ ] specify……

7. What is your mode of payment of services? 1. Fee for service (out of pocket) [ ] 2. NHIS [ ] 3 .Private insurance [ ] 4.Corporate funding [ ].

8. Is this the first time you are visiting this hospital? 1. Yes [ ] 2.No [ ]

PART 2. OUTPATIENTS SATISFACTION WITH CARE

9. Did you have a seat as you were waiting? 1. Yes [ ] 2.No [ ]

If yes was the seat (chair) comfortable? 1. Yes [ ] 2.No [ ]

10. Did the doctor examine you? 1. Yes **[ ]** 2. No [ ]

11. Did the doctor tell you what is wrong with you? 1. Yes **[ ]** 2.No [ ]
12. Did the doctor give you instructions about your illness? 1. Yes **[ ]** 2. No [ ] if yes
13. Did you understand what the doctor told you? 1 .Yes [ ] 2.No [ ] 3.A little bit [ ]
14. Did the doctor tell you whether or not you need to return? 1. Yes [ ] 2. No [ ]
15. Did you receive all the drugs/medications that were prescribed? 1. Yes [ ] 2. No [ ]
16. Did you understand your instructions from the pharmacist? 1. Yes [ ] 2.No [ ]

What was the attitude of the following providers towards you?

	Very Poor 0	**Poor 1**	**Average 2**	**Good 3**	**Very Good 4**
17.Medical records					
18.Revenue collector					
19. Doctor					
20. Nurse					
21. Pharmacy staff					
22. Diagnostics					

23. What was the general attitude of the staff towards you?

1. Very Poor [ ] 2. Poor [ ] 3. Average [ ] 4.Good [ ] 5.Very Good [ ]

24. What do you think of the cleanliness of the hospital and the surroundings?

1. Very Dirty [ ] 2.Dirty [ ] 3.Clean [ ] 4. Very Clean [ ]

25. Have you attended the hospital in an emergency including the night during the past six (6) months? 1. Yes **[ ]** 2. No [ ]

a. If yes, were you seen promptly? 1. Yes [ ] 2. No [ ]

b. If no to „**a**", have services worsened or improved? 1. Worsened **[ ]** 2.Just the same [ ]

3. Improved [ ]

26. Overall, were you satisfied with the services you received? 1. Yes [ ] 2. No [ ]

27. Will you visit this hospital for health services again based on services received? 1. Yes [ ] 2. No [ ]

THANK YOU

Appendix 2: Consent Form and Information Sheet

CONSENT FORM

Title of Project:

Effect of leadership Style on Client Satisfaction in Health facilities in Bantama SubMetro of Ashanti Region, Ghana.

Name of Researcher: Jerry Adu-Amankwaah, MD

Please cross box

1. I confirm that I have read and understand the information sheet dated 1st July, 2019 for the above study and have had the opportunity to ask questions. [ ]

2. I understand that my participation is totally voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being infringed upon. [ ]

3. I agree to take part in the above study. [ ]

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Name of subject Date Signature/thumbprint

---------- ---------- ----------

Name of Person taking consent Date Signature

---------- ---------- ----------

Researcher: Jerry Adu-Amankwaah Date Signature

INFORMATION SHEET FOR CLIENTS

You are being invited to take part in a research study, aimed at accessing the effects of the various leadership style (as employed by Hospital managers) on client satisfaction in Health Facilities in Bantama Sub-Metro of Ashanti Region, Ghana.

Before you decide to take part in this study, it is important for you to understand why the research is being done and what it will involve. Please take some time to read the following information carefully and discuss it with others if you wish. Ask the researcher if there is anything that is not clear or if you would want more information. Take time to decide whether or not you wish to take part.

Who is conducting the study?

The study is being conducted by Jerry Adu-Amankwaah, a student being supervised by Dr. Kofi Akohene Mensah of Kwame Nkrumah University of Science and Technology, School of Public Health, Kumasi.

What is the purpose of the study?

The study is about the effect of the various leadership styles employed by hospital managers on client satisfaction, in order to provide important feedback to the relevant policy makers, practicing hospital managers, health workers and providers and the general public as a whole and/to make necessary adjustments to the list. The field work for this study begins in July 2019 and will continue until September, 2019.

Why have I been asked to take part?

You have been chosen to represent the views from the provider‟s perspective, the effect of leadership style on client satisfaction in this facility.

What would be involved?

The structured questionnaire will be administered to you at a designated place of the facility where you will feel more comfortable. The questions will ask about the leadership style on client satisfaction and it should not last more than 20 minutes.

What happens next?

If you are interested in taking part in this study then a consent form will be given to you to sign to affirm your willingness to take part in the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving reason.

What are the benefits of taking part?

There may be no direct benefits of filling the questionnaire. However, you will be providing useful and important information, which will contribute to the improvement of client satisfaction as a whole.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. No names will be recorded and so it will not be linked to you in anyway in the report of this study. However, your participation in this study is entirely voluntary.

What will happen to the results of the research study?

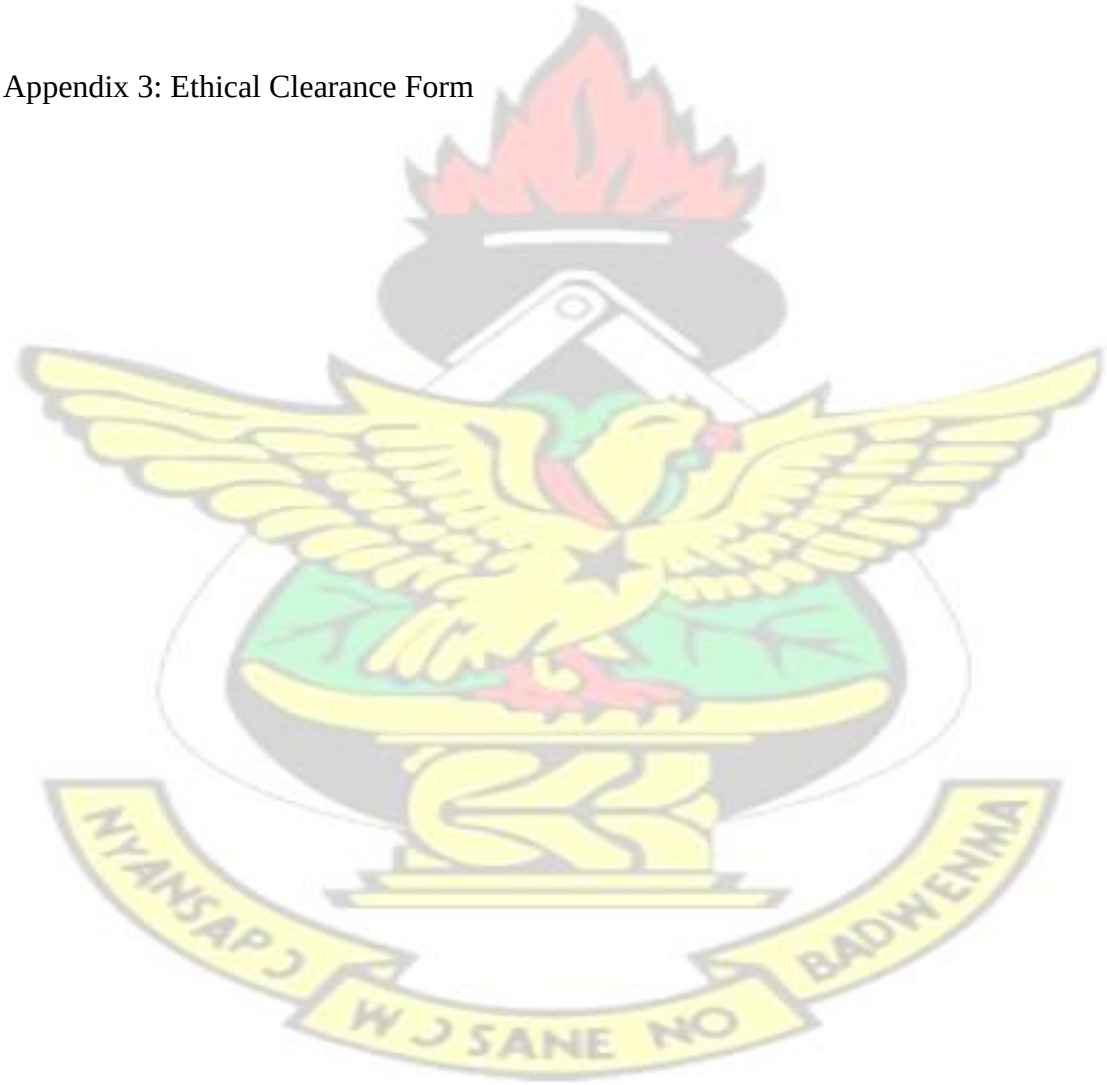
The results of the study will be presented to the School of Public Health of Kwame Nkrumah University of Science and Technology and also published in academic journals. If you wish, you can obtain a copy of the published results by contacting Jerry Adu-Amankwaah. You will of course not be identified in the final report or publication.

Who is organizing and funding the research?

The research is being undertaken by Jerry Adu-Amankwaah, a student at the Kwame Nkrumah University of Science and Technology under the supervision from an academic lecturer. The student is funding this research.

Thank you for reading this.

Appendix 3: Ethical Clearance Form



KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL
COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS

Our Ref: CHRPE/AP/536/19

4th September, 2019.

Dr. Jerry Adu-Amankwaah
Department of Health Policy,
Management and Economics
School of Public Health
KNUST-KUMASI.

Dear Sir,

LETTER OF APPROVAL

Protocol Title: ***"Effects of Leadership Style on Client Satisfaction in Health Facilities in Bantama Sub-Metro of Ashanti Region, Ghana."***

Proposed Site: ***Suntreso Government Hospital.***

Sponsor: ***Principal Investigator.***

Your submission to the Committee on Human Research, Publications and Ethics on the above-named protocol refers.

The Committee reviewed the following documents

- A notification letter of 13th June, 2019 from the Department of Health Policy, Management and Economics seeking permission to conduct the study at the Suntreso Government Hospital (study site) and it was approved.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Protocol.
- Questionnaire.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, beginning 4th September, 2019 to 3rd September, 2020 renewable thereafter. The Committee may however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Thank you, Sir, for your application.

Yours faithfully,

Osomfo Prof. Sir J. W. Acheampong MD, FWACP
Chairman

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