DIFFERENCES BETWEEN LEADERS AND NON-LEADERS IN THEIR PERCEPTIONS OF THE ORGANIZATIONAL COMMITMENT TO QUALITY

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Abstract

The objective of this study was to determine if there were any significant differences between hospital leaders and non-leaders in their perceptions of the organizational commitment to quality in the governmental accredited hospitals in Jordan.

A survey instrument, designed to measure the level of organizational commitment to quality, questionnaire, was administered to the healthcare professionals in the five governmental accredited hospitals in Jordan. Study sample included 1290 employees. The response rate was 83.6 % of the total questionnaires distributed. Of the1079 respondents, 141 were leaders and 938 were non-leaders. Two sample T test was used to compare the responses between these groups.

There were significant differences found between leaders and non-leaders in their perceptions of organization's commitment to quality.

Keywords: Total quality management, organizational commitment to quality, Accreditation, Jordan

Introduction

The role of the hospital leaders is a key ingredient in the success of a TQM programs. The role of the leaders is to provide direction and articulate a commitment to quality in words and action. Leaders' responsibility is to create an environment where employees can perform quality work and take pride in their accomplishments toward organizational excellence (Sooksan and Avery, 2011).

Reinertsen, Joshi, and Nash, 2008 proposed that leadership is important at all levels to improve quality of care for a specific diagnosis or at a systems level to advance knowledge on measures that may impact costs. According to the study of Mc Alearney (2006), the complexity in the healthcare industry makes special challenges for leadership and leadership development. In his study, Ovretveit (2004) focused on leadership as a critical factor in successful implementation of quality improvement initiatives.

In addition to leadership commitment and support, Teams represent a basic for employees to identify problems, exploring root causes, suggest solutions and implement the improvements. According to Deming (2000), teamwork required breaking down barriers between organizational departments and cooperation across different functions, which is needed to improve quality in the organizations.

Organizational commitment to quality

According to Hirtz, Murray, and Riordan (2007), every quality management program requires the support and leadership of top management. In their study, Bradley, Holmboe, and Mattera (2003) emphasized that the leaders have five common roles and activities which evidenced by management in organization quality improvement efforts, suggesting the need for personal engagement, relationships with the clinical staff, promoting a climate for quality improvement, support of quality initiatives within the organizational structure, and allocation of resources for quality improvement.

In their study, Lin et al (2005) reported that the perception of employees with regard to the direction of the organization and the activities and support regarding quality improvement activities are directly related to their perceptions of whether the implementation of quality activities will lead to improvement. Furthermore, the researchers stated that if the organization employee determines that the quality activities is not important to the organization leaders, they will focus less on quality improvement and more on the things they feel are important to the leaders.

According to the study of Patel (2009), organization leaders work to establish unity of purpose and direction. They should create and maintain the internal environment in which people can become fully involved in achieving the organization's objectives.

The study of Padhi (2009) defined the manager commitment towards quality as “requirement to provide an inspiring vision, values that guide employees and make strategic directions that are understood by all employees”. Leadership commitment includes a full understanding of TQM

by top management and supervisors, and believes in it to reveal their commitment, understanding and beliefs through their daily work of TQM.

Ovretveit (2004) stressed that the leadership is a key factor in achieving quality improvement. In the existing healthcare environment, leadership possess the ability to offer the support to transcend quality activities into the highest level of standard performance, furthermore he argued that healthcare leaders have a responsibility to the public to initiate, and support healthcare policies to offer high quality services.

As a result of increasing demands for higher quality of products and services in healthcare sector, it is important to focus on leadership ability to provide a culture for change, and continuous improvement. According to quality leaders, leadership from top management is a key to successful quality implementation. Furthermore, top management needs to personally direct activities and embrace quality management transformation (Juran, 1989; Deming, 2000).

The literature in the field of TQM strongly supports the importance of leadership commitment for successful TQM implementation. The role of organization managers to act upon as leaders is necessary for TQM initiative success (Perles, 2002). This can be achieved through using their official power, In addition committed managers can guide this process by facilitating the resources allocation and supporting those who develop the TQM initiatives. Leaders also create a new atmosphere in the organization by their inter-personal relations. Moreover organization leaders are able to influence the feeling of their subordinates to provoke creativity, develop teams, communicate a shared vision, and create compromise (Goetsch and Davis, 2010). Appropriate administrative leadership is one of the factors that determine the variation in the success rate of TQM activities implementation as agreed by academic researchers and practitioners (Perles, 2002).

Bradley et al (2003) identified five roles and actions of leadership involvement and supporting quality improvement programs. These researchers conducted a qualitative study through interviews with forty-five clinical and administrative staff in eight hospitals. Their findings recognized five common roles and activities of leadership involvement in quality improvement activities, as follow:

1. Personal engagement of senior managers.
2. Promotion of an organizational culture of quality.
3. Management’s relationship with clinical staff.
4. support of QI with organizational structures
5. Procurement of organizational resources for QI efforts.

According to Shipton et al (2008), leadership influences effective healthcare effectiveness and performance, healthcare leaders form effective quality performance results through shared vision and commitment by

healthcare individuals and teams that leads to higher performance on quality activities for the healthcare organization. Furthermore (Kouzes and Posner, 2007) supported the importance of involving the employee and customers, and advocated leaders challenging the process through searching for new opportunities to grow and improve the quality in the organization.

The study of Bradley et al (2003) suggested that study participants indicated hospital managers should be personally engaged in quality improvement efforts and programs, have a significant positive relationship with clinical staff, support a culture of quality, support for quality improvement in the structure of the organization, and ensure that sufficient resources are provided.

Study objective

The main objective of the present study was to determine if there were any significant differences between hospital leaders and non-leaders in their perceptions of the organizational commitment to quality in the governmental accredited hospitals in Jordan.

Methods and subjects

Design of the study

A cross sectional, quantitative design was employed.

Study Population and Sample

The study population represented all health care professionals working in the five HCAC accredited governmental hospitals who were working for more than three years in the same hospital. Study sample included 1290 employees. Returned questionnaires were 1079, and the response rate was 83.6 %. Study sample included:

hospital managers, assistant hospital managers, heads of departments and units, supervisors, physicians, dentists, pharmacists, pharmacist assistant, staff nurses, midwifes, associated nurses, nurse assistants, nutritionists, lab technicians, radiology technicians, anesthetic technicians, and sterilization technicians.

Study Instrument

A structured questionnaire was used, consisting from three parts; professional data, total quality management (the organizational commitment to quality), which was accompanied with a cover letter that contained a brief summary of the study purpose and confidential considerations.

Several similar studies were reviewed to construct the questionnaire (Lai, 2003; Talavera, 2005; Demirbag et al., 2006; Sadikoglu and Zehir, 2010; Khairul et al., 2012; Ul Hassan et al., 2012).

The organizational commitment to quality had 12 variables assigned as:

TQMA1: Hospital leaders devote adequate time and attention to continuous quality improvement.

TQMA2: Hospital leaders create a work environment that encourages employees to perform to the best of their abilities.

TQMA3: Employees know how to define the quality of their services.

TQMA4: Customer satisfaction feedback mechanisms have been implemented.

TQMA5: Internal and external customers are asked for improvement suggestions.

TQMA6: Hospital leaders committed to the values and culture of quality in all plans.

TQMA7: There is visible personal senior management involvement in quality and customer-focus activities.

TQMA8: Written quality plan and policies are known throughout the hospital.

TQMA9: Resources are allocated to quality and customer-focus activities.

TQMA10: Hospital employees are willing to do more than their minimum job requirements to ensure quality patient care.

TQMA11: Hospital leaders accept their responsibility for quality.

TQMA12: Major department heads within our hospital accept their responsibility for quality.

Data Analysis

Data was represented as frequency and percentages for general characteristics of study participants. The impact of TQM on hospital effectiveness was tested using multiple regression analysis.

Results

As shown in table 1, study included 1079 participants of whom 141 (13.07%) hospital leaders and 938 (86.93%) non-leaders. Hospital leaders included 3.54% hospital managers, 2.84% hospital manager assistants, 73.76% head of unit, and 19.86% supervisors. Nurses made the largest sector of non-leader participants (36.35%), followed by associate nurses (12.92%), physicians (12.47%), and midwife (9.62%). The lowest number of non-leaders was for nutritionist (0.64%), followed by sterilization technicians (0.86%).

Table 1: Distribution of study participants by profession

Profession	Frequency (N)	Percentage (%)
Hospital Leaders	141	13.07
Hospital manager (Director)	5	3.54
Hospital manager assistants	4	2.84
Head of unit	104	73.76
Supervisor	28	19.86
Total Number of Managers	141	100%
Physician	117	12.47
Dentist	9	0.96
pharmacist	47	5.02
Pharmacist assistant	23	2.45
Staff nurse	341	36.35
Midwife	90	9.62
Associated nurse	121	12.92
Nurse assistant	50	5.33
Lab technician	63	6.73
Radiology technician	39	4.16
Anesthetic technician	23	2.45
Sterilization technician	8	0.86
Nutritionist	7	0.64
Total number of non-leaders	938	100%

The differences in perception between leaders and non-leaders towards the organizational commitment

As shown in table 2, the mean of the organizational commitment to quality of leaders was 3.97 and this was higher than that of non-leaders 3.69. This difference in means was statistically significant (t=4.956, df=200.77, p=0.000).

Table 2: The differences in perception between leaders and non-leaders towards the organizational commitment for each study variable:

Variable		N	Mean	Std. Deviation	t	df	P value
TQMA1	LEADERS	141	3.91	0.841	3.110	1077	0.002
	NONLEADERS	938	3.66	0.926	3.339		
TQMA2	LEADERS	141	3.71	0.945	2.813	1077	0.005
	NONLEADERS	938	3.44	1.055	3.051		
TQMA3	LEADERS	141	3.87	0.791	2.570	1077	0.010
	NONLEADERS	938	3.67	0.859	2.731		
TQMA4	LEADERS	141	3.94	0.868	3.877	1077	0.000
	NONLEADERS	938	3.63	0.891	3.953		
TQMA5	LEADERS	141	3.82	0.915	3.312	1077	0.001
	NONLEADERS	938	3.53	0.961	3.434		
TQMA6	LEADERS	141	4.01	0.746	4.022	1077	0.000
	NONLEADERS	938	3.70	0.896	4.603		
TQMA7	LEADERS	141	3.97	0.836	3.637	1077	0.000
	NONLEADERS	938	3.67	0.943	3.973		
TQMA8	LEADERS	141	4.27	0.716	4.831	1077	0.000
	NONLEADERS	938	3.93	0.796	5.225		
TQMA9	LEADERS	141	4.00	0.802	3.548	1077	0.000
	NONLEADERS	938	3.72	0.870	3.769		
TQMA10	LEADERS	141	3.99	0.712	2.602	1077	0.009
	NONLEADERS	938	3.79	0.894	3.075		
TQMA11	LEADERS	141	4.06	0.729	4.274	1077	0.000
	NONLEADERS	938	3.74	0.845	4.765		
TQMA12	LEADERS	141	4.08	0.837	3.408	1077	0.001
	NONLEADERS	938	3.82	0.831	3.389		

The differences of perception for all domains of the organizational commitment to quality as perceived by leaders and non leaders

As shown in table 3, there were 12 variables in the domain " the organizational commitment to quality". These variables were assigned as TQMA1- TQMA12. For all variables, the mean of leaders was higher than that of non-leaders. This difference in means was statistically significant for all variables (P<0.05).

Table 3: The differences of perception for all domains of the organizational commitment to quality as perceived by leaders and non leaders

Variable		N	Mean	Std. Deviation	t	df	P value
organizational commitment Domain	LEADERS	141	3.97	0.609	4.956	200.773	0.000
	NON-LEADERS	938	3.69	0.704			

Discussion

This study aims to find out the differences between hospital leaders and non-leaders in their perceptions for the organizational commitment to quality in the governmental accredited hospitals in Jordan.

Jordan is one of the developing countries in which improving the quality of health care services has become not only a concern of patients, but also governments, managers, healthcare workers and hospitals. The expectation of patients from health care services became more, and compares their experiences with those countries with higher quality (Ovretveit and Al Serouri, 2006).

The results of the present study clearly and significantly showed differences in the mean of perception for the organizational commitment to quality (p<0.05) for all variables, when the total perception for the total domains and for each variable within the 12 variables in the domain. Actually, this indicates that there is a gap in the perception. This could be attributed to the nature between leaders and non-leaders. Leaders may be more wishing or dreamers, while the non-leaders are more observable and report what they see rather than what leaders want to achieve.

Other studies including Colin Fuller (1999) indicated that effective management does not depend only on the creation of policies and processes, but also on the employees' perceptions of the level of effectiveness of operational practices. Similar trends have also been indicated by other studies in which morale and performance issues resulting from difficient vision by managers and non-managers and/or performance improvements attributable to manager/non-management alignment (Crotts, Dickson, and Ford, 2005; Gottschalg and Zollo, 2007; Yu-Yuan Hung, 2004; Richbell and Ratsiatou, 1999).

Conclusion

The present study showed that there was a misalignment between the perception of leaders and non leaders for the organizational commitment to quality and this suggested an effective management remains to be more addressed.

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