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LEADERSHIP COMPETENCES IN SLOVENIAN HEALTH CARE

VODSTVENE KOMPETENCE V SLOVENSKEM ZDRAVSTVU

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ABSTRACT

Background. Leadership competences play an important role for the success of effective leadership. The purpose of this study was to examine leadership competences of managers in the healthcare sector in Slovenia.

Methods. Data were collected in 2008. The research included 265 employees in healthcare and 267 business managers. Respondents assessed their level of 16 leadership relevant competences on a 7-point Likert-type scale.

Results. Test of differences between competences and leader position of health care professionals yielded statistically significant differences between leader and non-leader positions. Leaders gave strongest emphasis to interpersonal and informational competences, while regarding decision making competences, the differences between leaders and other employees are not that significant. When comparing competences of healthcare managers with those of business managers, results show that healthcare managers tend to give weaker emphasis to competences related to all three managerial roles than business managers.

Conclusions. The study showed that in Slovenian health care, leaders distinguish themselves from other employees in some leadership competences. In addition, all three dimensions of leadership competences significantly distinguished the group of healthcare managers from the business managers, which indicates a serious lag in leadership competences among leaders in Slovenian healthcare.

Keywords:
leadership, competences, health care, management, Slovenia

IZVLEČEK

***Izhodišča**. Vodstvene kompetence igrajo pomembno vlogo pri zagotavljanju uspešnega vodenja. Namen obstoječe raziskave je bil preučiti vodstvene kompetence menedžerjev v slovenskem zdravstvu.*

***Metode**. Podatki so bili zbrani leta 2008. V raziskavo je bilo vključenih 265 zaposlenih v zdravstvu in 267 poslovnih menedžerjev. Anketiranci so ocenili svoja raven po 16 različnih vodstvenih kompetencah na 7-stopenjski Likertovi lestvici.*

***Rezultati**. Test razlik med kompetencami in vodstvenim položajem zaposlenih v zdravstvu je pokazal na statistično značilne razlike med vodji in drugimi zaposlenimi. Vodje so bolj poudarili medosebne in informacijske kompetence, medtem ko so razlike med vodji in drugimi zaposlenimi pri odločevalskih kompetencah manj izražene. Primerjava med kompetencami menedžerjev v zdravstvu in poslovnih menedžerjev je pokazala, da imajo menedžerji v zdravstvu manj poudarjene kompetence na vseh treh menedžerskih vlogah.*

***Zaključki**. Raziskava je pokazala, da se vodje v slovenskem zdravstvu od drugih zaposlenih razlikujejo po nekaterih vodstvenih kompetencah. Menedžerji v zdravstvu pa se od poslovnih menedžerjev razlikujejo po vseh treh dimenzijah vodstvenih kompetenc, kar kaže na resno zaostajanje vodstvenih kompetenc menedžerjev v slovenskem zdravstvu.*

***Ključne besede**:
vodenje, kompetence, zdravstvo, menedžment, Slovenija*

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1 INTRODUCTION

1.1 Leadership: from attributes to relations

With the rise of the New Public Management (NPM) paradigm in the early 1990s, leadership has become an important issue in the public sector (1). With rising pressures on public spending, political elites have felt increasing urgency to justify the use of public funds for the provision of public goods and services in business terms. The new emphasis on efficiency and effectiveness of public service delivery has led to many structural changes in public organisations modelled on what were believed to be good business practices of commercial companies in the private sector. The transfer of management practices from the private to the public sector became one of the main preoccupations of the NPM. With it came the emphasis on public sector leadership that was required to inspire business like attitudes among the ranks of public employees and their supervisors.

A wide variety of approaches to understanding leadership have been proposed over the past decades (for full review on leadership theories, see 2, 3). Researchers have been interested in distinctive aspects of leadership ranging from personal characteristics of effective leaders and their behaviour, often summarised as leadership styles, to unique impacts of effective leadership such as leaders' capacity to motivate and inspire people to bring about fundamental change in organisations.

Our understanding of leadership follows the prevalent perspectives on leadership-management relationships that understand these two functions as complex, multifaceted, somewhat independent but largely intersecting processes that share considerable competences in common (4). Distinction is primarily one of scope and vision, as leadership emphasises broader meaning and purpose and is a process of motivating people to work together collaboratively to accomplish great things (5). Therefore, it can be conceived of as an interaction between two or more members of a group (2). This suggests that leadership is actually enacted through relationships with others. It has been demonstrated that leaders stimulate emotional responses in employees in work settings (6) and beyond (7). In order to create change in organisations, leaders need to persuade followers and gain their commitment and therefore need good management skills to transform their vision into action.

1.2 Leadership competences

Studies reviewed in Kirkpatrick (8) and Hogan et al (9) point out that leaders do differ from non-leaders in a number of attributes, and that these differences contribute significantly to leader effectiveness. In the 1960s, Katz (10) introduced the idea that managers need to possess sets of skills rather than individual skills for successful performance in organisations. In 1970, competency research and applications that built upon earlier work on skills, abilities, and cognitive intelligence arrived. Competence is defined as "the underlying characteristic of a person that leads to or causes effective and outstanding performance" (11, p. 21). What makes the competency approach particularly useful is the insistence that particular behaviours and individual skills are linked directly to business outcomes. Thus, leadership competences are always viewed in terms of their benefits for the implementation of a specific strategy in a given organisation (12). However, numerous studies have shown that there are clusters of leadership competences that have been proven time and again to lead to greater performance (10, 13-15). These include the competency of vision and goal setting, self-knowledge, interpersonal competency and technical, business specific skills. However, the competency lists can be much more expansive and varied.

Competency frameworks and models have been challenged in the leadership literature during recent years (16, 17). These authors argue for a practice orientated perspective when exploring leadership to better capture the complexity of interaction and interrelation rather than an individualistic perspective, since competences shift the responsibility onto the individual leaders with little concern for the context and relationships in which they find themselves. The emphasis should be given more to reflection, discussion and experience. As we noted above, the importance of the relational concept of leadership is not new to the leadership literature. Bass (18), with his distinction between transactional and transformational leadership, highlights this perspective on leadership. While transactional leadership involves primarily the focus on tasks, transformational leadership is about raising colleagues, subordinates, followers, clients or constituencies to a greater awareness about the issues of consequence. Leaders are identified as uniquely flexible, open minded, team- and growth-oriented and socially astute (21). Since leadership is a process of motivating people to work together collaboratively and leaders work in a complexity of relations, they inevitably need the skills or competences to establish, maintain and manage relations with others.

Competency frameworks are flexible and complex and vary according to the demands of a particular business strategy of an organisation. To link leadership competences with organisational context, it is useful to use Mintzberg's model of managerial roles (19). He proposed that top managers' job can be described in terms of three sets of roles they have to perform in organisations. The three roles - interpersonal roles, informational roles and decisional roles - contribute to integrated job performance. Interpersonal roles involve establishing and maintaining relations with subordinates, liaising with peers and other people outside their chain of command and representing the company to outside constituencies. Informational roles include gathering information and transmitting information throughout the organisation and beyond its boundaries to the external constituencies. Decisional roles involve problem solving, resource allocation and negotiation with internal and external constituencies. Each role requires a set of skills and competences for their effective performance. Mintzberg provided a list of leadership competences (he called them managerial skills) (Table 1). It is interesting to note that in spite of their usefulness, they were used much less than his trio of managerial roles.

Table 1. List of managerial roles and skills.

Roles	Skills
Interpersonal	Motivating subordinates
Figurehead	Developing peer relationships
Leader	
Liaison	
Informational	Establishing information networks
Monitor	Disseminating information
Disseminator	
Spokesperson	
Decisional	Making decisions in conditions of
Entrepreneur	extreme ambiguity
Disturbance handler	Allocating resources
Resource allocator	Resolving conflicts
Negotiator	Carrying out negotiations

Source: derived from Mintzberg

A notable feature of managerial roles is the emphasis on interpersonal and informational roles. It is too often that leadership is associated only with decision making (this is particularly evident in the great men tradition). While leaders are deeply involved in the decision making process, Mintzberg is right to emphasise that their role is not only to make decisions but to organise the decision making process itself by providing and facilitating the flow of information and by motivating, developing and involving the right people within and outside the organisation in the decision making process. Relational and informational roles are increasingly important in modern nonindustrial companies such as professional organisations working in the service sector and knowledge industries that face new levels of business, market and technological uncertainties and have to depart from a classic bureaucratic model toward markets and clans (20). Managers do not give equal attention to each role, but interpersonal, informational and decisional roles still remain inseparable and complementary.

1.3 Leadership competences in healthcare

The importance of leadership in healthcare has come to prominence relatively recently. The emphasis on leadership and the need for training and development of new leaders in healthcare now occupies a prominent position in strategic documents issued by the government departments of health care around the world (21). One of the early examples is the NHS Leadership Qualities Framework issued by the UK Department of Health in 2001. Today, the competences and knowledge sets required for different health professions are more or less well-known. Studies found that competences needed by effective physician-leaders are a combination of general leadership skills and skills that are particularly needed to address the challenges of healthcare. A study of a team of top executives in a highly innovative mental hospital, carried out in 1965, provided a description of an executive role constellation in a US hospital as a "matrix of interpersonal relations, with its specialisation, differentiation, and complementarity of roles" (22, p. 12). Stoller (23) provides an extensive overview of the surveys on physician-leaders' competences and notices that competences range from very general to much more specialised and have been assessed on different populations both in terms of profession and size. Jennings et al (24) identified 10 managerial competences for nursing leaders: personal qualities, interpersonal skills, thinking skills, setting the vision, communicating, initiating change, developing people, healthcare knowledge and management and business skills. Here we can see that social capacities are of distinctive importance for leadership functioning, as noted by Zaccaro (25), also in the healthcare sector.

Most of the leadership roles in healthcare are occupied by health practitioners who are facing an added challenge in that they are expected to provide leadership to other medical colleagues but are also required to carry out their role as medical professionals. Until the late 1970s, this situation was commonplace throughout the world. Despite the high significance of leadership in healthcare systems, several studies investigating this issue point out that when appointing managers emphasis is still given mostly to clinical expertise. A study in New Zealand hospitals (26) demonstrated that charge nurse managers were appointed into a management role with clinical expertise but without management skills. Several studies, reflecting on the situation in Slovenian healthcare organisations (27-31), provide evidence of the lack of leadership skills. Nursing leaders in the study conducted by (27) reported to be aware that they did not have enough management and leadership knowledge. Most of them had not acquired knowledge before taking up a leadership position, which means that they either acquired it later or that they only improved it with workplace experience. In Slovenian hospitals, education of employees for leadership roles is still not perceived as a necessary investment for improving work processes (29). Evidence from Slovenian studies also point to the problematic issues that stem from a leader-subordinate relationship. A study (32) of head nurses in Slovenian hospitals, primary healthcare centres and social welfare institutions showed that their clearly defined vision was significantly lower than that of the employees' readiness to follow. Nursing leaders in the study conducted by (27) reported not to have good communication skills and showed a lack of concern for good interpersonal relations, although they and the employees both highly valued good interpersonal relations.

The aim of our study was to assess perceived leadership competences of Slovenian healthcare managers. Based on the discussion above, we hypothesise that healthcare managers will emphasise competences that indicate interpersonal and informational skills, while their classical decision making, control and command competences will be less present. Since health care managers face a more complex environment of professionals, they need to build their leadership on relational skills rather than formal authority. We also hypothesise that health care and business managers will differ primarily by the former giving more emphasis to relational competences and the latter to stronger use of decisional competencies.

2 METHODS

Data used in our survey were collected in 2008 as part of a large international study on higher education called Hegesco that was carried out in 4 EU countries and Turkey (for a detailed report on the study, see 38). It was based on a large Reflex project from 2006 that included 14 EU countries and Japan. Results from both studies were reported on different occasions, mainly to present the labour transition of higher education graduates but not in the field of management and organisational behaviour. Participants included in the survey were randomly selected and approached by post.

The response rate for Slovenia was relatively high, with 49% coverage of the total population, which amounted in 2,919 respondents in total. A mailed questionnaire was used that included educational experiences before and during higher education, the transition to the labour market, characteristics of the first job, characteristics of the occupational and labour market career up to the present, characteristics of the current job and current organisation, assessment of skills and evaluation of educational program. Our research explored leadership in the Slovenian healthcare sector and combined two different job segments to illuminate characteristics of leadership in each segment. In our survey, we included data on competences of employees in Slovenia having up to 5 years of working experience (general criteria of survey population).

In order to understand leadership competences in the Slovenian healthcare sector, we explored the competences of healthcare managers and compared them with those of the business managers. We used a comparative approach to consider two different perspectives on leadership competences. The first focused on differences in competences regarding the leader/non-leader position in the healthcare sector. We included in our sample 265 Slovenian employees on the job as health (associate) professionals or nursing (associate) professionals. Each person was assigned to a leader or non-leader position depending on whether they reported to have subordinates or not. We ended up with a sample of 101 leaders in healthcare in Slovenia. Out of those, 84% worked in a public sector organisation. For the second perspective in our study, we included a sample of 267 Slovenian employees on the job as business managers. Here, we wanted to illuminate business managers, i.e. directors, chief executives and other managers that reported to have subordinates and compared them with the leaders from the healthcare sector. All employees on the job as business managers met the leadership criteria and 81% of them worked in a private sector organisation.

In our analysis, we also included some additional countries in order to look at whether we can detect some patterns of leadership competences of healthcare professionals across countries. We included the following countries with representative samples of healthcare sector professionals: Italy, Finland, Norway, Czech Republic, Portugal and Belgium.

The concept of leadership competence was operationalised based on the conceptualisation of managerial skills provided by Mintzberg (19). To comply with Mintzberg's list of skills, we included in our survey 16 management/leadership competences: mastery of own field or discipline; knowledge of other fields or disciplines; analytical thinking; ability to rapidly acquire new knowledge; ability to negotiate effectively; ability to perform well under pressure; alertness to new opportunities; ability to coordinate activities; ability to use time efficiently; ability to work productively with others; ability to mobilise the capacities of others; ability to make meaning clear to others; ability to assert authority; leader as authoritative source of advice; leader keeps professional colleagues informed about new developments in their field of work and leader takes initiative in establishing professional contacts with experts

Table 2. Differences between competences of employees holding non-leader or leader positions in healthcare in Slovenia.

Roles	Competence	t[1]
Interpersonal	I take the initiative in establishing professional contacts with experts outside the organisation	3.501***
	Ability to make your meaning clear to others	.944
	Professional colleagues rely on me as an authoritative source of advice	4.696***
	Ability to mobilise the capacities of others	2.681**
	Ability to negotiate effectively	2.362*
Informational	I keep my professional colleagues informed about new developments in my field of work	3.079**
	Alertness to new opportunities	1.531
	Ability to rapidly acquire new knowledge	.949
	Mastery of your own field or discipline	1.445
	Knowledge of other fields or disciplines	1.073
Decisional	Ability to work productively with others	1.558
	Ability to assert your authority	2.362*
	Ability to coordinate activities	1.752
	Ability to perform well under pressure	1.690
	Ability to use time efficiently	1.679
	Analytical thinking	1.952*

Notes:
Subsample of Slovenian respondents whose Current job = health (associate) professional or nursing (associate) professional.
N=101 (supervisors in health (associate) professional or nursing (associate) professional) and N=164 (non-supervisors in health (associate) professional or nursing (associate) professional)
[1] Independent samples test; Equal variances assumed; *** $p \leq 0.001$; ** $p \leq 0.01$; *$p \leq 0.05$

outside the organisation. In assessing their skills, participants were asked to assess their level of competence on a 7-point Likert-type scale (1= very low – 7 = very high).

3 RESULTS

Starting with the assessments of leadership competences, we found several significant differences in competences between occupants of leadership vs. non-leadership position. Table 2 presents the results of the t-test of differences in emphasis on a particular leadership competence between leader and non-leader positions in healthcare in Slovenia. We find that they differed in 7 out of 16 competences. Differences in the assessment of competences were significant with a low p-value ($p \leq 0.05$).

The results show that leaders in healthcare, in comparison with non-leaders, placed stronger emphasis on competences in all three managerial roles, underscoring the idea of their high complementarity. In other words, leaders require competences in all three roles. However, consistent with our hypothesis, the leaders gave strongest emphasis to interpersonal and informational competences while placing a weaker emphasis on decision making competences. The ability to establish professional contacts with experts outside the organisation, being an authoritative source of advice to their colleagues and the ability to mobilise the capacities of others were the three most emphasised relational competences. Keeping professional colleagues informed about new developments in their field of work was the most important informational leadership competence.

To explore to what extent leadership competences of healthcare managers differ from competences of business managers, we compared the two groups of managers. Results of the test of differences are presented in Table 3.

The results show that healthcare managers tend to give weaker emphasis to competences related to all three managerial roles than business managers. Business managers attach significantly higher importance than healthcare managers to the five competences. Among relational competences, two were cited as more important by business managers: taking initiative in establishing contacts with experts outside the organisation and ability to negotiate effectively. Among informational competences, business managers placed a higher value on alertness to new opportunities. Finally, among the decisional competences, business managers emphasised analytical thinking and the ability to coordinate effectively. Healthcare managers emphasised only two competences more strongly than business managers, namely mastery of their field of expertise and the ability to use time efficiently. These results do not confirm our second hypothesis. They indicate that the level of leadership development is lagging behind the standards achieved by business managers. The two competences in which health managers surpass business managers have both an explanation in the fact that Slovenian health managers are appointed to leadership positions in which they continue to practice clinical work.

In order to be able to generalise our results, we looked at the leadership competence assessments across different countries. Based on the correlations between leadership and competences of health professionals from different countries, we could not find any significant distinctions between the countries. Slovenian health professionals showed similarities in the correlations of all relational competences with health professionals from other countries. Furthermore, Slovenian healthcare professionals made similar assessments of informational and decision making competences to professionals from other countries.

Table 3. Differences between competences of healthcare managers and business managers in Slovenia.

Roles	Competence	t[1]
Interpersonal	I take the initiative in establishing professional contacts with experts outside the organisation	-4.444***
	Ability to make your meaning clear to others	.891
	Professional colleagues rely on me as an authoritative source of advice	-1.231
	Ability to mobilise the capacities of others	-.636
	Ability to negotiate effectively	-4.389***
Informational	I keep my professional colleagues informed about new developments in my field of work	-.657
	Alertness to new opportunities	-3.993***
	Ability to rapidly acquire new knowledge	-.418
	Mastery of your own field or discipline	3.466***
	Knowledge of other fields or disciplines	-1.668
Decisional	Ability to work productively with others	1.397
	Ability to assert your authority	-.466
	Ability to coordinate activities	-1.969*
	Ability to perform well under pressure	-.282
	Ability to use time efficiently	2.912**
	Analytical thinking	-3.046**

Notes:
Subsample of Slovenian respondents whose Current job = professional managers or Current job = supervisors in health (associate) professional or nursing (associate) professional
N=101 (supervisors in health (associate) professional or nursing (associate) professional) and N=267 (professional managers)
[1] Independent samples test; Equal variances assumed; *** $p \leq 0.001$; ** $p \leq 0.01$; *$p \leq 0.05$

4 DISCUSSION

Our study provides insights into the leadership competences of healthcare managers in Slovenia. Comparisons of leadership competences among Slovenian healthcare professionals yielded significant results between leaders and non-leaders. Professionals holding a leadership position in Slovenian healthcare organisations were significantly higher in their assessment of leadership competences in all three managerial roles than their medical colleagues. This is in line with the modern conception of leadership with emphases on communicating a vision (informational role), developing relations inside and outside the organisation, motivating people to accomplish organisational goals (relational role) and getting things done (decisional role). The results show that leaders in Slovenian healthcare have stronger interpersonal compared with decision making competencies. Their leadership is built on professional authority rather than on formal roles; they rely on mobilising their colleagues more strongly than on bossing them around; and they provide key knowledge resources by building professional links to experts outside of the organisation. And by virtue of being experts themselves, they also emphasise their informational role by providing their colleagues with information on developments in their field of expertise. Overall, these results indicate that leaders in Slovenian healthcare emphasise leadership competences in all three managerial roles, with strongest emphasis given to relational competences. These results reveal a positive picture of leadership in Slovenian healthcare.

However, when the state of leadership in Slovenian healthcare is benchmarked to the subsample of business managers, a more critical picture emerges. Strong differences found between the business and healthcare mangers indicate that there is little convergence between healthcare and business sectors, a convergence advertised by new public management literature. Furthermore, business managers put stronger emphasis on all three groups of leadership competences: relational, informational and decision making. This indicates that the differences between the business and health sectors are not just a matter of specialisation but rather a matter of the level of leadership development. While Slovenian business managers seem to be aware of the need for balanced leadership development in all three managerial roles, Slovenian health managers seem to lag behind business managers in their assessment of leadership challenge in all three roles.

These results suggest that leadership in Slovenian healthcare is seriously underdeveloped. The key reason for this is delayed professionalisation of health management in Slovenia. As noted by prior research, the recruitment into the leadership ranks in Slovenia is primarily based on medical excellence rather than managerial competence. While this assures professional authority among their colleagues, this practice systematically undermines the development of professional management in Slovenian healthcare. The results suggest the perverse effects of this practice. Health managers lag behind business managers in most leadership competences but stand out in emphasising just two: mastery of their discipline and efficient use of time. Together they illustrate how Slovenian health care leaders perceive the leadership challenge. Promoted to leadership positions by virtue of their medical expertise, they are, more than business managers, concerned with keeping current with their medical field and with trying to find time to both lead their organisations and continue with their medical work.

5 CONCLUSIONS

The results of this study paint a challenging picture of leadership in Slovenian healthcare. The results suggest that while leadership competences within the healthcare sector seem to have been developed in the expected direction, the comparison with the business sector indicates a serious lag in leadership competences among the leaders in Slovenian healthcare._

This situation is most likely the result of the fact that most managers in the Slovenian health system are medical professionals who see their leadership roles of healthcare organisations as a step in their medical careers rather than a departure from medical practice and entry into professional management. This career pattern means that managers need to maintain their medical expertise while acting in leadership roles, because they tend to return to the practice once their leadership mandates run out. As managers they constantly struggle to manage their time effectively, as they need to continue to work with patients in order to retain their excellence in their field of medical specialisation. As a result, leadership of healthcare organisations in Slovenia is highly competent in medical areas but seriously lacking in managerial competences.

Another important challenge for leadership in Slovenian healthcare relates to the complexity of different organisational levels of the healthcare system. Multiple hierarchies of professionals require additional leadership skills for leaders to be able to coordinate activities among different groups and to establish good working relationships with them, the two fields in which business sector managers excel. Both skills would enable Slovenian healthcare managers to integrate internally and to overcome the seemingly chaotic internal coordination of healthcare organisations.

Several countries noticed that insufficient numbers of health managers are graduating from health administration programs, resulting in a shortage of managers whose training and experience would qualify them to assume these positions. In response, countries like Great Britain and Germany have started to improve medical qualifications of different groups of health professionals by supplementing their curricula with managerial areas such as leadership. Lately, these changes became present in many other countries, including Canada, where in 2005 the government updated and simplified the key Leadership Competences Profile that reflects the leadership skills, abilities and characteristics that are needed in the public service by managers at all levels. The challenge of educational institutions to provide health managers with adequate skills is even greater due to the fact that competences needed by an effective physician-leader combine general leader-

ship skills as well as skills that are particularly needed to address the challenges of healthcare.

We recommend that the Slovenian government, which is responsible for the appointment of top leaders of most Slovenian healthcare institutions, should begin to acknowledge the leadership gap in the health sector and launch a serious national leadership development initiative modelled on successful examples of countries such as the UK and Canada. The biggest challenge, however, is not to train doctors in leadership skills. While this effort might lead to quick results, the ambition should be broader, namely to start on the path of professionalisation of health care management. This will require a culture change in Slovenian healthcare. First, the career paths of health care leadership should change. The entry of management professionals into health care is already taking place with small steps. The reverse process of migration of health professionals into leadership ranks should be supported by leadership development programs. Second, culture change requires demonstration of positive effects of implementing managerial practices in health care organisations. This requires the use of consultants that can be instrumental for the transfer of best practices from well managed organisations into Slovenian health care. Third, investment into the development of fully accredited leadership development programs could eventually lead to fully fledged professionalisation of health care management as the legitimacy of management professionals becomes well established and accepted in Slovenian healthcare.

CONFLICT OF INTEREST

The authors declare that no conflict of interest exists.

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REFERENCES

1. Hood C. A public management for all seasons? Pub Admin 1991: 69: 3-19.
2. Bass B. M. Bass & Stogdill's handbook of leadership: theory, research and managerial applications. New York: The Free Press, 1990.
3. Yukl G A. Leadership in organizations. New Jersey: Prentice Hall, 2010.
4. Simonet DV, Tett RP. Five perspectives on the leadership – management relationship: a competency-based evaluation and integration. J Leadersh Organ Stud 2012; 20: 1 –15.
5. Vroom VH, Jago AG. The role of the situation in leadership. Am Psych 2007; 62: 17-24.
6. Dasborough MT. Cognitive asymmetry in employee emotional reactions to leadership behaviors. Leadership Quart 2006; 17: 163-78.
7. Kellerman B. Followership: how followers are creating change and changing leaders. Harvard: Business Review Press, 2008.
8. Kirkpatrick SA, Locke EA. Leadership: do traits matter? Acad Manag Exec 1991; 5: 48-60.
9. Hogan R, Curphy GJ, Hogan J. What we know about leadership: effectiveness and personality. Am Psychol 1994; 49: 493-504.
10. Katz RL. Skills of an effective administrator. Harvard Bus Rev 1955; 33: 33-42.
11. Boyatzis RE. The competent manager: a model for effective performance. London: Wiley, 1982.
12. Spencer LM, Spencer SM. Competence at work. New York: John Willey & Sons, 1993.
13. Mintzberg H. The nature of managerial work. New York: Harper & Row, 1973.
14. Bennis W, Nanus B. Leaders, the strategies for taking charge. New York: Harper and Rowe, 1985.
15. Boyatzis RE. Competencies as a behavioral approach to emotional intelligence. J Manage Dev 2009; 28: 749-70.
16. Carroll B, Levy L, Richmond D. Leadership as practice: challenging the competency paradigm. Leadership 2008; 4: 363-79.
17. Bolden R, Gosling J. Leadership competencies: time to change the tune? Leadership 2006; 2: 147-63.
18. Bass BM. Leadership and performance beyond expectations. New York: The Free Press, 1985.
19. Mintzberg H. The manager's job: folklore and fact. Harvard Bus Rev 1990: 163-76.
20. Ouchi WG. Markets, bureaucracies, and clans. Admin Sci Quart 1980; 25: 129-41.
21. Peck E. Leadership and its development in healthcare. In: Walshe K, Smith J, editors. Healthcare management. London: Open University Press, 2006: 323-341.
22. Hodgson RC, Levinson DJ, Zaleznik A. The executive role constellation. Boston: Harvard Business School, 1965.
23. Stoller JK. Developing physician-leaders: key competencies and available programs. J Health Admin Educ 2008: 307-28.
24. Jennings BM, Scalzi CC, Rodgers JD, Keane A. Differentiating nursing leadership and management competencies. Nurs Outlook 2007; 55: 169–75.
25. Zaccaro S. Trait-based perspectives of leadership. Am Psych 2007; 62: 6-16.
26. McCallin AM, Frankson C. The role of the charge nurse manager: a descriptive exploratory study. J Nurs Manag 2010; 18: 319-25.
27. Lorber M, Skela Savič B. Perceptions of managerial competences, style, and characteristics among professionals in nursing. Croat Med J 2011; 52: 198-204.
28. Pavlin S, Švab I, Kovačič H. Ugotavljanje in razvijanje ključnih področij usposobljenosti (kompetenc) zdravnikov kot izhodišče za modernizacijo izobraževalnega programa. Zdrav Var 2008; 47: 106-16.
29. Skela Savič B, Robida A. Capacity of middle management in health-care organizations for working with people-the case of Slovenian hospitals. Hum Resour Health 2013; 11: 1-15.
30. Vadnjal J, Bernik J, Baričič A. Some aspects of the health care institutions management in Slovenia. Organizacija 2009; 42: 95-102.
31. Filej B, Skela-Savič B, Vicic VH, Hudorovic N. Necessary organizational changes accordin g to Burke – Litwin model in the head nurses system of management in healthcare and social welfare institutions—the Slovenia experience. Health Policy, 2009; 90: 166-174.
32. Van der Velden R, Allen J. Skills for the 21st century: implications for education. Maastricht: ROA, 2012.