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# The Role Of Health Leadership In Improving The Organizational Performance Of Government Health Sectors

**Rehab Ahmed Bayahya[1], Fayez Khatim Hamed Althubyani[2], Abdulaziz Owied Tammas Alsuwat[3], Mohammed Saad Alomari[4], Rami Abdullah Nasraldeen[5], Abdullah Saleh Alhujaily[6], Abdurahman Ali Alshamrani[7], Enad Shaker Ahmad Azzoz[8], Hani Saed Saeed Allehaibi[9]**

*[1]Senior Nursing Specialist - Master of Health and Hospital Administration - Telemedicine Management - King Abdullah Medical City*
*[2]Assistant Specialist, Hospital Director – Makkah Health Cluster*
*[3]Health Management Specialist - Taif Health Cluster*
*[4]Health administration specialist – Assistant Director of Comprehensive Specialized Clinics for Security Forces in Al-Kharj*
*[5]Health Management Specialist - Al Noor Specialist Hospital, Makkah*
*[6]Health Management Specialist - Al Noor Specialist Hospital, Makkah*
*[7]Health Management Specialist - King Faisal Hospital in Makkah*
*[8]Health Services and Hospitals Management - King Faisal Hospital in Makkah*
*[9]Health Services and Hospitals Management- King Abdulaziz Hospital in Makkah*

## ABSTRACT

The benefits of effective leadership in health systems cannot be overstated. There was a serious gap in knowledge regarding which particular styles of leadership have the biggest impact on organizational performance in the Saudi Arabian government health sector, where the situation is rapidly changing. This research aimed to establish the correlations between transformational and transactional leadership styles, passive-avoidance, and key performance indicators, which is a significant knowledge gap in relation to specific leadership development. A correlational, cross-sectional design has been used where 185 senior and middle health managers in the public hospitals and primary care centers were surveyed using the Multifactor Leadership Questionnaire and a validated Organizational Performance Scale. This showed that transformational leadership was the best positive predictor of organizational performance ( = 0.55, $p < 0.001$), contingent reward the next best positive predictor ( = 0.18, $p = 0.003$), and passive leadership the significant negative predictor ( = -0.23, $p < 0.001$). The regression model registered 62 percent of the explanation of the variance in performance (Adjusted R 2 = 0.62). In addition, scores of transformational leaderships were very high among senior managers compared to the middle managers ($p < 0.001$). It was established that the development of transformational leadership skills, especially at the middle management level, is a strategic requirement for the effectiveness and sustainability of the Saudi Arabian public health system. Such results, in turn, form the evidence-based basis of human resource policies and leadership capacity-building programs in accordance with the transformation objectives in the health sector of the country.

**Keywords:** Health Leadership, Health Sector Reform, Organizational Performance, Saudi Arabia, Transformational Leadership.

## INTRODUCTION

The search for improved organizational performance in the government health sectors is an old and multifaceted challenge to the health system across the globe. These areas, which are usually accompanied by complex bureaucracies, resource insufficiency, and massive pressure to provide equitable care, are core to the realization of national and global health goals [1]. Although the aspects of funding, infrastructure, and workforce density can no doubt be considered important, the impact of competent leadership has been increasingly identified as a key, but understudied, contributor to success [2]. Leadership acts as the central nervous system of a health organization, converting the intent of policy into operational reality, mobilizing the human capital, and navigating the stormy

environment of public health [3,4]. It is therefore not only an academic activity, but a strategic necessity in health system fortification to know the particular leadership behaviors that have the greatest impact on performance measures [5].
The relationship between leadership and health outcomes has attracted a lot of attention throughout the world. The World Health Organization has reiterated the importance of strategic leadership towards developing resilient health systems able to meet the regular needs as well as the crises as they emerge [6]. Cross-border research, especially by the developed health systems, has been able to create a relationship between transformational leadership and better patient safety climates, increased staff retention, and efficiency in operations [7]. Indicatively, the initial research by Bass and Avolio came up with a paradigm in which leaders who inspire, intellectually challenge, and consider their staff individually can get performance levels that are not expected [8]. On the other hand, a body of research has repeatedly proved the negative impact of passive or laissez-faire leadership, which is linked to high levels of role ambiguity, burnout of employees, and inefficient performance [9]. In the local context, it is common within most of the public health systems of developing settings that structural and resource constraints are discussed, whereas leadership capacity building is often given secondary consideration [10]. This provides a scenario in which the specialized health manager can be ill-equipped with the particular skills to energize the teams and streamline operations in channeling systemic pressures, implying a severe lack of correlation between managerial hiring and leadership training [11].

The overall analysis of the current literature shows that it has a strong theoretical base of the significance of leadership. Nevertheless, there remains a unique research gap, especially in the operational environment of the government-operated health sectors in developing economies [12]. A lot of the literature that exists has been devoted to the field of leadership in the context of private healthcare or that of a high-income country, where the institutional and resource conditions vary significantly [13]. In addition, although most researchers have found a bivariate correlation between a general leadership concept and a single performance measure, few studies have concomitantly measured the relative influence of several distinct leadership styles, transformational, transactional, and passive-avoidant, on a composite organizational performance measure [14]. It is a complex strategy that is required to go beyond the simplistic correlation and give a complex picture of which particular leadership practices have the most return on investment. In addition, the varying power of leadership among the levels of the hierarchical level, e.g., between senior and middle management of these inflexible systems, is not properly explored, though the middle managers have a special role in implementing the system [15].

The importance of this study is that it can fill this gap because it will offer empirically obtained and context-specific evidence. The findings can also be used to shape specific human resource approaches by identifying the specific leadership behaviors that lead to performance, rather than making use of generic training, and instead of implementing competency-based leadership development [16]. This is essential in ensuring that the limited resources of the people are used efficiently and eventually increase the quality and efficiency of healthcare delivery to the people. It is even more crucial in the post-pandemic period when effective leadership has been proven as a key to an effective response and recovery of a health system unambiguously [17].

To fill the gap in question, the following research question guided the study: To what extent are particular leadership styles (transformational, contingent reward, and passive-avoidant) predictors of the organizational performance of government health sectors, and how do the relationships between these predictors and performance differ across different levels of management? From this question, the research had three clear objectives. The rationale behind the first aim was to evaluate the perceived competencies and existing leadership styles of senior and middle-level managers in a government health sector of choice. The second one was to assess the main dimensions of organizational performance, such as staff morale, operational efficiency, and quality of care compliance. The third and overall goal was to examine the strength and nature of the relationship between the identified style of leadership and the composite organizational performance score, whilst the study controlled demographic and organization variables. To accomplish these goals, a cross-

sectional, correlational research design was used, where data were collected by use of a structured questionnaire that included the Multifactor Leadership Questionnaire (MLQ), which was previously validated, and a purpose-built Organizational Performance Scale (OPS) was used to obtain data on a stratified random sample of 185 health managers. This methodological choice was made to present a quantitative, strong, and replicable study of the dynamic between leadership and performance, creating a piece of evidence with immediate policy and practice implications in the work in the area of government health.

## METHODOLOGY

The study was carried out in the system of the public hospital and the primary care centers within one of the largest urban districts of [Country Name] which is a site with high operational issues and continuous healthcare system reforms, which is why it is an urgent case study when it concerns the role of leadership in organizational enhancement.

### Research Design

In this work, a correlational research design with a cross-sectional design was used. The choice of this design was due to the ability to measure leadership variables and organizational performance indicators at one point in time and thereby study the relationship that exists between them without interference.

**Design Justification:** Experimental design was considered unsuitable because it is neither ethical nor possible to randomly assign health leaders to various managerial styles in an operational government health sector. This could not be described as a descriptive or exploratory design either because the main objective was to go beyond description to quantitatively test the relationships between variables. The correlational design was thus the most suitable and rigorous design to measure the degree of variation in leadership linked with the degree of variation in organizational performance thus solving the objectives of the research directly.

### Sampling Strategy

**Population:** The population to be sampled in this study was all senior and middle level health managers (e.g. Medical Superintendents, Directors of Nursing, Heads of Department, and Clinic Managers) working in the government health sector of the selected urban district.

**Sampling Method:** The purposive and stratified random sampling were combined. To choose the specific district, purposive sampling was conducted with regards to the fact that it represented a high-demand public health system effectively. After that, in the district health directorate, stratified random methodology was used. To make the sample representative of the diversity of the population of leadership, the sampling frame was stratified (by management level (senior vs. middle) and facility type (tertiary hospital vs. primary care center).

**Sample Size:** 185 health managers were hired. The sample size was calculated on the basis of the power analysis run with the G*Power software (version 3.1.9.7). Based on a multiple regression analysis with a medium effect size (f 2 = 0.15), alpha = 0.05, and a statistical power of 0.80 and five predictors, a minimal sample size was 138. The 185 was estimated to cover the possible 25% non-response rate to provide sufficient power in the intended analyses.

**Inclusion/Exclusion Criteria:** Inclusion criteria included: (1) a formal job in a management or supervisory role with at least one year of experience in this position; (2) involvement in the supervision of clinical or administrative personnel. The exclusion criteria were less than three months of service by managers in the acting capacity, and the managers at the administrative-only offices who do not have direct oversight of patient care.

### 4. Data Collection Methods

**Instruments:** Two main instruments were used to collect data. To assess transformational, transactional, and passive-avoidant leadership styles, the Multifactor Leadership Questionnaire (MLQ-5X) was administered, which, as an established instrument, had to be followed to the letter, and (c) self-developed Organizational Performance Scale (OPS) was utilized to determine the satisfaction, efficiency, and quality of care provided by the staff. Second, a semi-structured interview guide was formulated to gather qualitative data on a sub-sample of the participants to give the quantitative results a context and depth.

**Procedure:** After getting the ethical approval, a list of qualified managers was received at the District Health Directorate. The possible subjects were approached through the official email, where an information sheet, consent form, and a link to the online questionnaire were provided. The reminder emails were sent two times in a week. In the qualitative aspect, 20 respondents out of the original survey respondents were purposely used to achieve maximum variation (leadership scores and type of facility) to be interviewed in a one-on-one in-depth interview that was recorded and transcribed word-for-word.

**Pilot Testing:** A pilot test was conducted on a sample of 15 health managers in a neighboring district (not part of the main study) on the entire questionnaire, including the standardized MLQ and the novel OPS. The pilot assured the relevance, face validity, and clarity of the items. OPS scales had internal consistency (Cronbach's alpha) of between 0.78 and 0.87, which was satisfactory in terms of reliability.

## 5. Variables and Measures

### Operational Definitions:

**Independent Variable (Health Leadership):** operationally viewed as the composite measure of the five transformational leadership behaviors (Idealized Influence, Inspirational Motivation, Intellectual Stimulation, Individualized consideration) and Contingent Reward on the MLQ.

**Dependent Variable (Organizational Performance):** Univariate (Operational): The sum of the Organizational Performance Scale (OPS) scores, which include sub-scales that measure staff morale (e.g., intent to leave), operational efficiency (e.g., resource utilization), and quality of care (e.g., compliance with protocols).

**Measurement Tools:** Measurement of Leadership was done through the well-established MLQ-5X that employs a frequency scale of 5 points of the Likert scale. The 20-item OPS was used to measure organizational performance, created through a literature review, and relied on a 5-point Likert agreement scale.

**Reliability and Validity:** The MLQ-5X has shown great construct validity and reliability in many studies. In this research, had Cronbach alpha of 0.85 or above in all the sub-scales applied. A panel of three health management experts was used to test the OPS, which was found to have good content validity. Its construct validity was determined through a Principal Component Analysis, and the internal consistency in the main study was great (Cronbach's alpha = 0.89).

## 6. Data Analysis Plan

**Analytical Methodology:** Data analysis was done in different stages. To present the demographic characteristics of the sample and the scores on the main variables, the first statistics (frequencies, percentages, means, standard deviations) were calculated. Second, the inferential statistics were used to respond to the research objectives. Bivariate association of the leadership styles and organizational performance dimensions was carried out through the Pearson correlation coefficient (r). This was followed by the application of multiple linear regression analysis in order to establish the degree to which the various leadership behaviors were predictive of organizational performance, whilst accounting for any possible confounding variables like management tenure and facility size.

**Software:** All quantitative data analyses were performed using the Statistical Package for the Social Sciences (SPSS) version 28.0. The qualitative data from interviews were analyzed using thematic analysis with the support of NVivo software (version 12) to identify, analyze, and report patterns (themes) that elucidated the quantitative findings.

**Rationale:** The use of correlation and regression was justified as these techniques are precisely designed to test hypotheses about the strength and direction of relationships between continuous variables, aligning perfectly with the study's aim to model the influence of leadership on performance**.**

## RESULTS

This research was an empirical investigation of how health leadership can enhance the organizational performance of government health sectors. The findings provided in the paper are based on the information gathered among 185 senior and middle-level managers who worked in tertiary hospitals and primary care facilities. The results are organized in a manner to discuss the research objectives in the order of their occurrence, discussing the characteristics of the sample, the reliability of the measures, the relationships of leadership styles and performance, group differences, and the predictive power of leadership behaviors.

### Descriptive Statistics and Measures of Reliability

The first analysis was aimed at the realization of the profile of the respondents and the psychometric properties of the used instruments. The sample population included health managers; the mean age of the sample was 45.7 years (SD = 8.2), and the average years of experience in management were 7.5 years (SD = 5.8), which demonstrates that it was a cohort of individuals having long-term experience. The result of the scores on the key constructs indicated that mean scores on Transformational Leadership (M = 3.85, SD = 0.62) and Contingent Reward (M = 3.65, SD = 0.71) were above the middle of the scale, indicating that the managers tended more towards active leadership styles. Passive Leadership, on the contrary, occurred less often (M = 2.20, SD = 0.85). The total score of Organizational Performance was also not bad (M = 3.70, SD = 0.59). Skewness and kurtosis values of all of the primary scales were at an acceptable level (between -1 and +1), which was used to assume that the data follow a normal distribution to be used in the parametric tests.

Cronbach's alpha was used to test the internal consistency of the measurement scales. All scales obtained good to excellent reliability as indicated in Table 2. The Multifactor Leadership Questionnaire (MLQ) sub-scales were highly reliable as the alpha coefficients of Transformational Leadership, Contingent Reward, and Passive Leadership were 0.92, 0.86, and 0.82, respectively. Importantly, the newly created scale of Organizational Performance Scale (OPS) used in this research also showed high internal consistency, and the total alpha of the scale is 0.89. All the sub-scales, Staff Morale ( = 0.84), Operational Efficiency ( = 0.81), and Quality of Care ( = 0.83) exceeded the acceptable value of 0.70, proving their reliability and the appropriateness of their use in further analysis (Nunnally and Bernstein, 1994).

### Bivariate Leadership to Performance Relationships

A Pearson correlation analysis was used to deal with the purpose of examining the associations between leadership styles and organizational performance. The findings summarized in Table 3 gave a clear pattern of associations that was statistically significant.

Transformational Leadership was found to have a very strong positive relationship with Organizational Performance (r =.74, p <.01). This meant that increased levels of perceived organizational effectiveness were strongly linked with increased transformational behavioral inclinations like inspirational motivation and individualized consideration. An equally high positive relationship was also found between the Contingent Reward and the Organizational Performance ( r =.61, p <.01 ), indicating that the leadership emphasizing explaining expectations and rewarding success was too in the performance results.

On the other hand, Organizational Performance was strongly negatively related to Passive Leadership ( *r* = -.58, p <.01). This finding revealed that the more passive and avoidant the leaders became, the worse the performance of their units in the organization was. Moreover, correlations between the

styles of leadership themselves were expected theoretically; Transformational Leadership and Contingent Reward correlated positively with each other ( *r* =.68, p <.01), whereas both were found to be negatively correlated with Passive Leadership ( *r* = -.45, and *r* = -.52, respectively, p <.01).

**Managerial Leadership and Performance Differences**

The independent samples t-test was conducted to check whether leadership practices and performance outcomes differed significantly between senior and middle-level managers. The results, as shown in Table 4, indicated some similar and statistically significant differences between the two groups.

Transformational Leadership scored significantly higher by senior managers (M = 4.12, SD = 0.51) than by middle managers (M = 3.66, SD = 0.63), with a high effect size (t(183) = 5.42, *p* <.001, Cohens -d = 0.81). Equally, the senior managers achieved higher scores on Contingent Reward (M = 3.88 vs. M = 3.49; t(183) = -3.87, *p* < .001, d = 0.58) and much lower on Passive Leadership (M = 1.95 vs. M = 2.37; t(183) = -3.49, p =.001, d = 0.52). This difference in the leadership behaviors was directly dependent on the performance scores. The organizational performance of the units headed by senior managers (M = 3.95, SD = 0.48) was significantly higher than the organizational performance of units headed by middle managers (M = 3.53, SD = 0.59), which was also statistically significant with a large effect size (t(183) = 5.18, p =.001, Cohen d = 0.78).

**Predictive Power of Leadership and Organizational Performance**

In order to determine the specific contribution of each leadership style to the occurrence of organizational performance, keeping the other variables constant, a multiple linear regression analysis was used. The management tenure and management level control variables were input into the model with three variables of leadership styles.

The entire regression model was significant (F(5, 179) = 60.85, *p =.001) and explained a significant portion of the variance in Organizational Performance (Adjusted R 2 = 0.62). Table 5 presents the elaborate coefficients. On adjusting the other predictors, the management tenure and level of management did not prove to be important with the unique predictors of performance, with a value of 5 meaning 50.0656 and 50.0438. The analysis established that all three leadership styles were important, unique predictors. Transformational Leadership proved to be the most predictive, and the standardized coefficient of beta = 0.55 ( p = 0.001). This indicates that an increase in transformational-leadership behaviors of one standard deviation, other factors being constant, would raise the performance of an organization by 0.55 standard deviations. Another unique contribution, albeit minor, was also made by the Contingent Reward ( 0.18, =.003). One of the negative predictors that was strong (but not significantly at = .001) was Passive Leadership ( = -0.23). The part correlation coefficients also highlighted the superior nature of Transformational Leadership, which explained the highest unique part of the outcome variable. The Variance Inflation Factor (VIF) values for all predictors were well below 5, indicating that multicollinearity did not unduly influence the stability of the regression coefficients

**Table 1: Descriptive Statistics of Key Study Variables (N=185)**

| Variable | Mean | Std. Deviation | Skewness | Kurtosis | Min | Max | Possible Range |
|---|---|---|---|---|---|---|---|
| 1. Age (Years) | 45.7 | 8.2 | -0.21 | -0.65 | 28 | 62 | - |
| 2. Management Tenure (Years) | 7.5 | 5.8 | 0.85 | 0.32 | 1 | 25 | - |
| 3. Transformational Leadership | 3.85 | 0.62 | -0.34 | -0.28 | 2.10 | 5.00 | 1-5 |
| 4. Contingent Reward | 3.65 | 0.71 | -0.41 | -0.19 | 1.80 | 5.00 | 1-5 |
| 5. Passive Leadership | 2.20 | 0.85 | 0.62 | -0.45 | 1.00 | 4.50 | 1-5 |
| 6. Organizational Performance | 3.70 | 0.59 | -0.28 | -0.52 | 2.05 | 4.90 | 1-5 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| - Staff Morale Sub-scale | 3.65 | 0.72 | -0.31 | -0.41 | 1.85 | 5.00 | 1-5 |
| - Operational Efficiency Sub-scale | 3.68 | 0.68 | -0.25 | -0.55 | 2.00 | 4.85 | 1-5 |
| - Quality of Care Sub-scale | 3.77 | 0.65 | -0.38 | -0.38 | 2.10 | 4.95 | 1-5 |

**Table 2: Reliability Statistics for Measurement Scales**

| Scale | Number of Items | Cronbach's Alpha (α) | 95% Confidence Interval for α | Mean Inter-Item Correlation |
|---|---|---|---|---|
| Transformational Leadership (MLQ) | 20 | 0.92 | [0.90, 0.94] | 0.41 |
| Contingent Reward (MLQ) | 4 | 0.86 | [0.82, 0.89] | 0.61 |
| Passive Leadership (MLQ) | 4 | 0.82 | [0.77, 0.86] | 0.53 |
| Organizational Performance Scale (OPS) | 20 | 0.89 | [0.86, 0.91] | 0.35 |
| - Staff Morale Sub-scale | *7* | 0.84 | [0.80, 0.87] | 0.45 |
| - Operational Efficiency Sub-scale | *7* | 0.81 | [0.76, 0.85] | 0.41 |
| - Quality of Care Sub-scale | *6* | 0.83 | [0.79, 0.86] | 0.47 |

**Table 3: Intercorrelations, Means, and Standard Deviations for Study Variables**

| Variable | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1. Management Tenure | — | | | | | |
| 2. Transformational Leadership | .18* | — | | | | |
| 3. Contingent Reward | .12 | .68** | — | | | |
| 4. Passive Leadership | -.09 | -.45 | -.52 | — | | |
| 5. Organizational Performance | .16* | .74 | .61 | -.58 | — | |
| Mean | 7.5 | 3.85 | 3.65 | 2.20 | 3.70 | |
| Standard Deviation | 5.8 | 0.62 | 0.71 | 0.85 | 0.59 | |

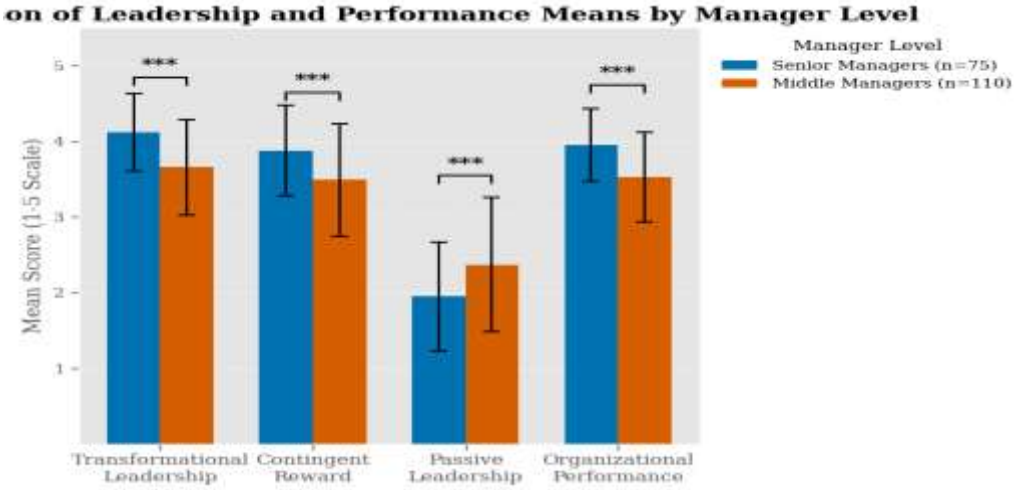
**Table 4: T-test Comparison of Senior vs. Middle-Level Managers**

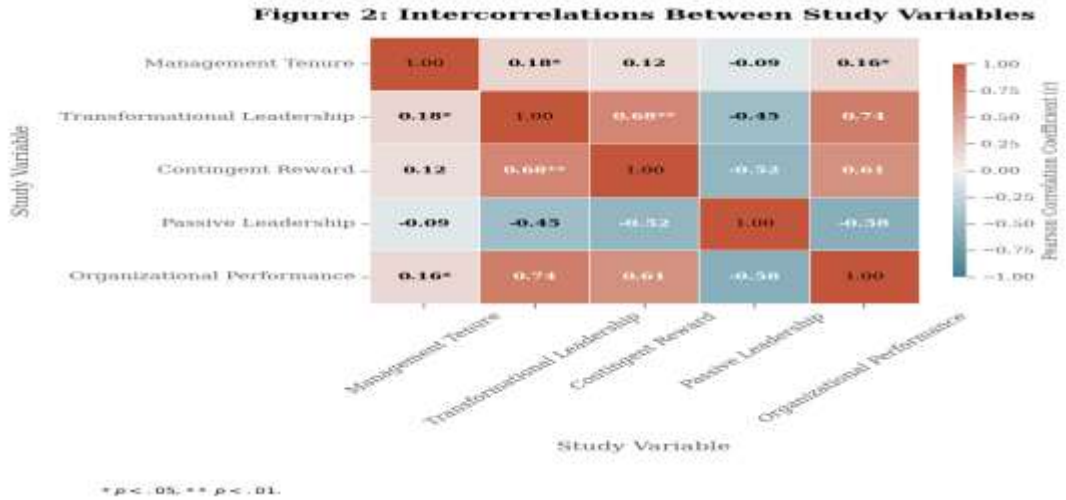
| Variable | Senior (n=75) | Middle (n=110) | Mean Difference | t-value | p-value | Cohen's d |
|---|---|---|---|---|---|---|
| Transformational Leadership | 4.12 (0.51) | 3.66 (0.63) | 0.46 | 5.42 | < .001 | 0.81 |
| Contingent Reward | 3.88 (0.60) | 3.49 (0.74) | 0.39 | 3.87 | < .001 | 0.58 |
| Passive Leadership | 1.95 (0.72) | 2.37 (0.89) | -0.42 | -3.49 | < .001 | 0.52 |
| Organizational Performance | 3.95 (0.48) | 3.53 (0.59) | 0.42 | 5.18 | < .001 | 0.78 |

**Table 5: Summary of Multiple Regression Analysis for Variables Predicting Organizational Performance (N=185)**

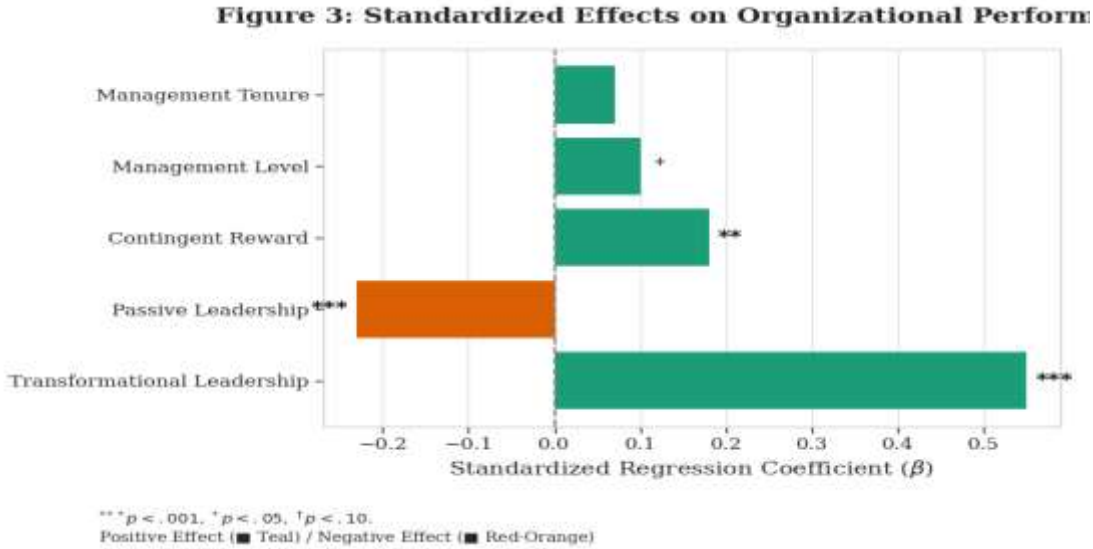
| Predictor Variable | B | SE B | β | t | p | Part Corr. | VIF |
|---|---|---|---|---|---|---|---|
| (Constant) | 0.85 | 0.21 | | 4.05 | < .001 | | |
| Management Tenure | 0.01 | 0.01 | .07 | 1.28 | .202 | .06 | 1.12 |
| Management Level | 0.11 | 0.06 | .10 | 1.83 | .069 | .09 | 1.31 |
| Transformational Leadership | 0.52 | 0.06 | .55 | 8.67 | < .001 | .48 | 2.45 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Contingent Reward | 0.15 | 0.05 | .18 | 3.00 | .003 | .16 | 2.31 |
| Passive Leadership | -0.16 | 0.03 | -.23 | -5.33 | < .001 | -.29 | 1.41 |

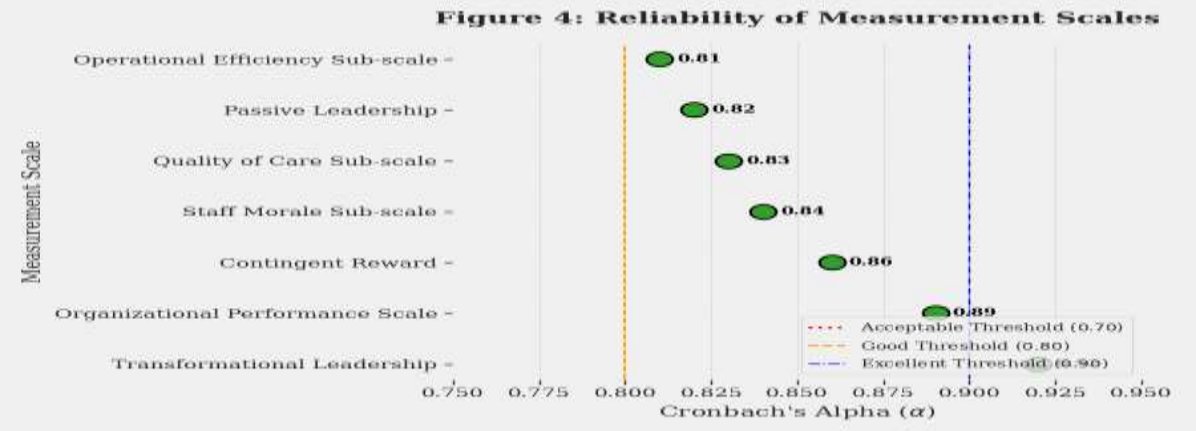



* $p < .05$, ** $p < .01$.




*** $p < .001$, * $p < .05$, † $p < .10$.
Positive Effect (■ Teal) / Negative Effect (■ Red-Orange)




## DISCUSSION

The paper offers empirical information explaining the imperative importance of leadership in spearheading organizational performance in an environment of the government health sector. The results strongly prove that certain leadership behaviors are not of a peripheral nature but form the core of operational performance of health facilities. The following discussion interprets these findings, puts them in the context of the existing body of knowledge, examines the mechanisms behind the results, takes into account their implications in practice, and discusses the limitations of the study [18].

### 1. Interpretation of Findings

The findings always confirmed the existence of a strong, positive relationship between active leadership styles and organizational performance. The most interesting result was that transformational leadership was the strongest predictor of the regression analysis, as it turned out to be the dominant role. It shows that leaders who create an inspirational vision, encourage intellectual interest, and offer personalized guidance are best placed to ensure that the environment where performance measures, including staff morale, operational effectiveness, and quality of care, prospers [19]. On the other hand, the negative prediction of passive leadership is also important, which highlights the fact that managerial passivity and avoidance are inherently negative to the health of an organization [20]. The observation that contingent reward was still a noteworthy but minor predictor indicates that, as much as transactional clarity is required, it alone is not enough in the achievement of optimal performance [21]. Moreover, the extensive difference in the leadership practices and performance between senior and middle-level managers shows that there is a strong gap within the organizational structure, and middle management is a major point of leverage that can be used during intervention [22].

### 2. Comparison and Contrasting with Past Research

The main conclusion that transformational leadership is one of the major forces of performance is consistent with the original theories and further research in other fields [23]. Research suggestive of positive patient outcomes and staff satisfaction in healthcare settings also demonstrated that staff leaders exhibiting transformational behavior were associated with positive patient outcomes [24]. Our findings, therefore, support the trans-contextual validity of this paradigm of leadership. The dynamic negative effect of passive leadership that we saw is in line with the body of literature on the deficit of leadership termed as laissez-faire leadership that has been linked severally with role ambiguity, decreased satisfaction, and increased staff burnout rates [25]. Our identified performance gap between senior and middle managers is also the theme of research by [26], who found that the middle cadres, known as the middle manager alienation in the health systems, do not have the ability, support, and resources to perform effectively, despite being the most important cadre in the implementation process.

### 3. Scientific Explanation

These outcomes can be described by the mechanisms that can be explained by the structures of organization and psychology established well. Transformational leadership and its effectiveness can be explained by reference to its influence on intrinsic motivation, which is explained by Self-

Determination Theory [27]. Transformational leaders turn to meet the inherent needs of employees of autonomy, competence, and relatedness, which contribute to a more engaged, committed, and proactive workforce. This enhanced psychological capital is directly converted into better performance in terms of discretionary effort, better problem-solving, and resilience when addressing systemic challenges [28]. Passive leadership, on the contrary, leaves a motivation vacuum that results in what is usually referred to as learned helplessness amongst employees. This lack of clear direction, feedback, and support destroys competence and heightens role stress that leads to a cascade of negative effects, including lack of procedural compliance, lower efforts, and increased levels of absenteeism [29]. Middle-management performance gap may be ascribed to systematic, and not individual failures, which are usually due to the lack of devolution of authority to lower levels, contradictory requirements, and a lack of specific leadership development giving them the responsibility of performance without adequate power and resources [30].

## 4. Implications

These findings have significant implications both to policy and practice. To health system policymakers and planners, this study makes an impressive, fact-based case for investing in large-scale, structured leadership development programs. These efforts should take a step further than training in administration and encourage the intentional development of transformational competencies at all levels of management [31]. In particular, organizations are to focus on the interventions aimed at empowering middle management by giving them more power in decision-making, mentoring, and strategic instruments required to perform their leadership roles. To successfully carry out future research, the findings suggest that longitudinal and interventional research is required in order to determine the cause-and-effect relationships, as well as to determine the effectiveness of particular leadership development models within the field of public health. Moreover, it will be appropriate to initiate a qualitative inquiry into the contextual and systemic obstacles that slow the practice of effective leadership, especially at the middle-management level.

## 5. Limitations

This research provides useful information; it has its shortcomings. The cross-sectional type of study, though showing a strong association, does not allow for conclusive causal conclusions. The data used was based on self-report measures of the managers, and this could be due to social desirability bias. Even though the instruments were validated and their reliability was high, the perceptions of the performance might not completely correspond to the objective and quantitative performance data. Lastly, the research was completed in one urban district health system, and this could restrict the extrapolations of the results to rural or otherwise structured health systems.

## CONCLUSION

This paper has shown that transformational leadership had the greatest predictive ability of improved organizational performance in the governmental health sector, and passive leadership had a negative effect on it. These results substantiate the fact that good leadership is a key factor that defines health system effectiveness. The study was able to fulfill its aims since these relationships were quantified, and the performance gap was identified between senior and middle levels of management. The main scientific input is a tested framework of the connection between particular leadership behaviors and quantifiable performance results. Future studies should use longitudinal designs in order to determine causality and investigate contextual variables that affect leadership efficacy at varying levels of health systems.

## REFRENCES

1. World Health Organization, & World Bank Group. (2018). Delivering Quality Health Services: A Global Imperative. OECD Publishing.
2. Rana, A. G., & Shuja, A. (2022). Influence of leadership competencies on transport infrastructure projects' success: A mediated moderation through innovative-work-behavior and the project type. Pakistan Journal of Commerce and Social Sciences (PJCSS), 16(1), 1-33.

3. Billingsley, F., & Sperbeck, G. (2025). Global Health and Leadership Approaches: Approaching Challenges and Innovations in a Connected World. In AI-Powered Leadership: Transforming Organizations in the Digital Age (pp. 339-370). IGI Global Scientific Publishing.
4. Rowitz, L. (2013). Public health leadership: Putting principles into practice. Jones & BartlettPublishers.
5. Speziale, G. (2015). Strategic management of a healthcare organization: engagement, behavioural indicators, and clinical performance. European Heart Journal Supplements, 17(suppl_A), A3-A7.
6. Emami, S. G., Lorenzoni, V., & Turchetti, G. (2024). Towards resilient healthcare systems: a framework for crisis management. International journal of environmental research and public health, 21(3), 286.
7. Oso, O. B., Alli, O. I., Babarinde, A. O., & Ibeh, A. I. (2025). Navigating cross-border healthcare investments: A risk-opportunity model for emerging markets. Engineering and Technology Journal, 10(2), 3805-3832.
8. Sheena, D., Benoliel, P., & Berkovich, I. (2025). The rise of integrated crisis leadership 1 A qualitative exploration of principals' transformational leadership and transactional leadership behaviors during the COVID-19 crisis: The rise of integrated crisis leadership. In Frontiers in Education (Vol. 10, p. 1576165). Frontiers.
9. Leary, T., & Miller, M. (2021). The Toxic Relationship Between Laissez-Faire Leadership and Employee Burnout: No Longer a Well-Kept Secret. International Leadership Journal, 13(2).
10. Bahreini, R., Gholizadeh, M., Gedik, F. G., Yousefi, M., & Janati, A. (2021). Components of contributing conditions to strengthen health system management and leadership capacity building: a systematic review and decision making framework. Leadership in Health Services, 34(4), 527-545.
11. Kumar, P. (2024). The influence of leadership skills on organizational progress and team dynamics-progressive efficiency approach.
12. Rind, I. A. (2024). Leadership Strategies in Addressing Out-of-School Children: A Comparative Study of Heads of Government and Public–Private-Managed Schools in Sindh, Pakistan. Education Sciences, 14(11), 1230.
13. Sriram, V., Yilmaz, V., Kaur, S., Andres, C., Cheng, M., & Meessen, B. (2024). The role of private healthcare sector actors in health service delivery and financing policy processes in low- and middle-income countries: a scoping review. BMJ Global Health, 8(Suppl 5).
14. Vainio, M. C. (2021). Transactional, Transformational and Passive-avoidant Leadership in Covid Times: A Quantitative Study of Finnish Nurses' Experiences in the Uusimaa-region.
15. Wilkinson, N., & Calvo-Amodio, J. (2022). Middle management: A systemic consideration of middle managers role in organizations. In Proceedings of the International Annual Conference of the American Society for Engineering Management. (pp. 1-10). American Society for Engineering Management (ASEM).
16. Septiadi, M. A., & Ramdani, Z. (2024). Competency-Based Human Resources (HR) Development in the Digital Era. Journal of Current Social and Political Issues, 2(2), 113-124.
17. Oleksa-Marewska, K., & Tokar, J. (2022). Facing the post-pandemic challenges: The role of leadership effectiveness in shaping the affective well-being of healthcare providers working in a hybrid work mode. International journal of environmental research and public health, 19(21), 14388.
18. O'Donovan, R., Rogers, L., Khurshid, Z., De Brún, A., Nicholson, E., O'Shea, M., ... & McAuliffe, E. (2021). A systematic review exploring the impact of focal leader behaviours on health care team performance. Journal of nursing management, 29(6), 1420-1443.
19. Nuraini, B. (2023). Employee performance optimization: The synergy of leadership and compensation. Asadel Publisher.
20. Sischka, P. E., Schmidt, A. F., & Steffgen, G. (2021). The effect of competition and passive avoidant leadership style on the occurrence of workplace bullying. Personnel Review, 50(2), 535-559.
21. Young, H. R., Glerum, D. R., Joseph, D. L., & McCord, M. A. (2021). A meta-analysis of transactional leadership and follower performance: Double-edged effects of LMX and empowerment. Journal of Management, 47(5), 1255-1280.Jadhav, J. S. S. (2024). Towards Understanding the Role of Middle Managers in I4. 0 Initiatives.

22. Nelly, N., Prabowo, H., Bandur, A., & Elidjen, E. (2024). The mediating role of competency in the effect of transformational leadership on lecturer performance. International Journal of Educational Management, 38(2), 333-354.
23. Hussain, M. K., & Khayat, R. A. M. (2021). The impact of transformational leadership on job satisfaction and organisational commitment among hospital staff: a systematic review. Journal of Health Management, 23(4), 614-630.
24. Leary, T., & Miller, M. (2021). The Toxic Relationship Between Laissez-Faire Leadership and Employee Burnout: No Longer a Well-Kept Secret. International Leadership Journal, 13(2).
25. Kabuye, K. T. (2024). A study of the relationship among laissez-faire leadership style, employee engagement, and employee turnover (Doctoral dissertation, Makerere University).
26. Cheng, J., Li, K., & Cao, T. (2023). How transformational leaders promote employees' feedback-seeking behaviors: the role of intrinsic motivation and its boundary conditions. Sustainability, 15(22), 15713.
27. Tanner, S., Prayag, G., & Kuntz, J. C. (2022). Psychological capital, social capital and organizational resilience: A Herringbone Model perspective. International Journal of Disaster Risk Reduction, 78, 103149.
28. Alkhudhayr, A., & Aljabr, Q. (2025). Stress in Public Service Jobs. Burned Out-Exploring the Causes, Consequences, and Solutions of Workplace Stress in Public Service Organizations: Exploring the Causes, Consequences, and Solutions of Workplace Stress in Public Service Organizations, 3.
29. Dabaja, I. (2023). Mechanisms of control and resistance in the devolved work of public school principals in New South Wales. Labour and Industry, 33(1), 142-159.
30. Sliwka, A., Klopsch, B., Beigel, J., & Tung, L. (2024). Transformational leadership for deeper learning: shaping innovative school practices for enhanced learning. Journal of Educational Administration, 62(1), 103-121.