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**ANALYSIS OF PATIENTS' PERCEPTION, WITH GENDER
DISTINCTION, ON THE LEADERSHIP ATTRIBUTES OF MEDICAL
PERSONNEL IN A POST-COVID 19 SCENARIO IN THE PUBLIC
HEALTH SECTOR, COQUIMBO REGION, CHILE**

Abstract:

This research aims to analyze leadership in a post-COVID 19 scenario in the public health sector, in the hospitals of La Serena and Coquimbo, in the Coquimbo region, Chile. A relational model with nine hypotheses is proposed, using structural equations through the method of partial least squares, making a differentiation between men and women, from the patients' perspective. It was determined that the quality of the service is a consequence of the positive, direct and indirect influence of effective communication and the empowerment of the work team, where its variance is explained by 82.4% (Men) and 56% (women). It is concluded that it is important to encourage the development of empathetic leadership within public health organizations and their work teams, not only for good care directed to patients and families, but also as a means to raise institutional reputation.

Keywords:

Public health, COVID 19, Leadership, Quality of care, Hospital management

JEL Classification: I10, L30, M19

1 Introduction

The pandemic caused by Covid-19 has been relentless with the health sector. The physical and mental well-being of medical personnel has been significantly affected, as the dangers associated with the pandemic have forced personnel to face changing challenges resulting from resurgences of the virus. Here, leadership capacity becomes important, as it allows leaders to help the team build psychological resources to face the chaos of the pandemic and, thus, ensure the care of patients (Um-e-Rubbab et al., 2021).

Khan & Raza (2021) identify that, even in developing countries, the shortage of specialists, the lack of medical supplies, the workload on staff and the costs of public health put the affordability of medical care at risk, generating dissatisfaction and distrust towards the health system. In Chile, patients have a regular perception regarding the public health system, presenting a high degree of dissatisfaction and distrust. The OECD, in its summary of 2021 indicators, shows that Chile is below the average of its member nations in population satisfaction/coverage: 39% in Chile vs. 71% the OECD average, practicing doctors (per 1,000 inhabitants): 2.6 vs 3.6 and practical nurses (per 1,000 inhabitants): 2.9 vs 8.8. In health spending as a percentage of GDP, it slightly exceeds the OECD with 9.3% for Chile vs. 8.8%. However, Chile did not increase health spending due to the pandemic, with a growth of only 0.3% in relation to GDP (an increase of 3.22%) (OECD indicators, 2021).

The crisis produced by the Covid-19 pandemic generated the need for a paradigm shift in organizations, where managers and members of the different groups that comprise them must encourage the development of self-leadership in employees, adopt new leadership attributes and strengthen employee empowerment (Ahmad et al., 2022). According to figures from the Ministerio de Salud itself (2020), 58.6% of health workers are at high risk of feeling tired and professional exhaustion, so it is important to analyze the series of competencies that a leader must possess to avoid that situation. As indicated by Troncoso et al. (2021), a professional with a high position must not only have technical knowledge, but also be recognized by his peers due to his competencies and leadership skills to handle difficult situations.

Elkomy et al. (2020) concluded that leadership influences health care outcomes, finding a positive and significant effect between leadership and the quality of hospital service. West et al. (2015) show that leadership development is carried out as a shared and collective process, since a balance is advocated between the improvement of individual skills and the development of organizational capabilities, promoting organizational development and thus avoiding stagnation within the same organization. While Ackerman et al. (2019) indicates that, through the application of principles of innovation and organizational change, multidisciplinary learning should be encouraged in pursuit of the development of professionals capable of understanding, translating and leading complex healthcare organizations. This would allow the generation and application of comprehensive leadership in aspects such as organizational culture, health policies and information technology.

In summary, Chile has average satisfaction with its health system, with the public sector being even lower. Patients feel that their rights are violated due to insufficient communication with health professionals, which is why a change in leadership perspective is required at the national level. However, due to the complexity of relationships and hierarchical conflicts between doctors and health professionals, it is difficult to carry out multivariate research with robust statistical

tools, so studies of these characteristics are only considered exploratory (Kumar and Khiljee, 2016).

But there is a series of additional background information that needs to be detailed to better document this work:

1.1 Comprehensive leadership and Organizational development

A leader is directly responsible for meeting the company's goals and performance (Ariani et al., 2022). Developing high-quality leadership can improve patient and staff satisfaction and clinical quality (Elkomy et al., 2020), the four foci of comprehensive leadership being “focused on tasks, relationships, change, and integrity” according to the same study.

1.2 Organizational development and Effective communication

An organization in which those in charge develop comprehensive leadership generates a better work environment and facilitates greater performance of their duties. An environment open to communication and innovation increases service quality (Elkomy et al., 2020). Additionally, IT allows semi-instant communication between departments and unified access to information (Ahmad et al., 2021; Ministerio de Salud, 2020), which facilitates coordination and access to cross-data.

1.3 Organizational development and Service centered on the patient and his family

Until 2020, there were no records of any strategy that focused on preparing patients so that they could have an active role in their health care; however, in cancer treatment, attention focused on preference is identified, values and well-being of patients (Bravo et al., 2022). Currently, as a result of the pandemic, this type of service has become part of the three fundamental pillars to work in tuberculosis care, the first of which is “Integrated and patient-centered TB care and prevention, through early detection”, treatment and prevention” (Ministerio de Salud, 2020). At the country level, the aim is to address a patient-centered service with the support of telemedicine in order to mitigate access, financial and availability barriers, as indicated by MINSAL in its 2022-2030 agenda “Chile has important telemedicine projects and telehealth, promoted by universities and government agencies, such as the National Center for Health Information Systems (CENS), the Telemedicine Unit of the University of Concepción or the Digital Hospital. The latter is a patient-centered health care model that takes advantage of technologies to bring care closer to people” (Ministerio de Salud, 2020).

1.4 Organizational development and Empowerment of the work team

There is a type of leadership with an authoritarian approach in which leaders make all decisions without consulting others called autocratic leadership, leaders suppress information and make decisions without consulting, this leadership style has a detrimental impact in the workplace, with two of its most serious consequences the generation of conflicts between staff members and the lack of teamwork, playing an important role in the creation of a bad work environment (Ariani et al., 2022). A leader who provides rewards for self-leadership behaviors in the work environment makes followers more inclined to lead themselves, which is why it is recommended in crises such as Covid-19, as it is a useful tool for coping. to temporal urgency and unstructured tasks, and management and project leaders are recommended to generate adequate information flow for

autonomous leaders, ensure clarity of objectives in an empowered environment, and develop a looser organization (Ahmad et al., 2022).

1.5 Effective communication and Service centered on the patient and his family

The medical literature shows that the family has a fundamental role in the recovery of hospitalized patients, it is necessary to establish a good relationship with the families and generate correct and fluid communication with the purpose of forming a comprehensive vision of the patients, in addition to reducing states of anguish, stress and depression (Hidalgo-Fabrellas et al., 2018). Medical staff often forget that receiving information is one of the main needs of patients' families. This may be because the relationship between nurses and families focuses on technical procedures; ICU staff and families perceive the patient's needs in different ways, and nurses underestimate their role in providing information to families, this being very important since the delivery of honest and comprehensive information increases family members' satisfaction and reduces their anxiety, which has a positive effect for the patient, for which the medical staff requires a change in attitude, skills and training of professionals, as well as the commitment to position the patient and their families at the center of care (Regaira-Martínez and Garcia-Vivar, 2021).

1.6 Empowerment of the work team and Service centered on the patient and their family

Paravic Klijn and Lagos Garrido (2021) state that for people who are part of a health organization, it must be a priority and strategic to work as a team, considering its fundamental elements, such as: trust, commitment, exercise of shared leadership and decentralization. hierarchical, where everyone's effort is the joint responsibility in achieving results with high quality standards of health care, and where the nursing professional, as a member of a multidisciplinary team, acts in one of his most relevant roles, managing the quality and safety of health care for users and their families, directly implying that health personnel with greater empowerment will provide better care to both the patient and their families thanks to effective leadership execution and greater commitment to providing quality care.

1.7 Effective communication and Quality of service

Effective communication is essential in the doctor-patient relationship, as it allows a better understanding of the patient's needs and helps establish a relationship of trust between the patient and the health professional, which allows optimal and quality care. , thanks to a better understanding of the patient's needs and expectations, delivering a more precise diagnosis and personalized care (Kourkouta and Papathanasiou, 2014). In addition, it is worth mentioning that effective communication does not focus only on the patient or the doctor but on both, "On the one hand, the doctor identifies his patients' problems with greater precision and on the other hand, lawsuits and litigation initiated in his office decrease. against, leading to the satisfaction of both increasing, possibly allowing the doctor to reduce burnout syndrome (Moore et al., 2010).

1.8 Service centered on the patient and her family and Quality of service

Both variables have a direct and positive correlation, as demonstrated by (Park et al., 2018), a service centered on the patient and their family is considered a high-quality approach in healthcare settings, as patients with families who have The opportunity to participate in some of the main care activities, exchange of information and joint decision making reduces stress,

anxiety and depression, in addition to showing greater satisfaction and improved relationships with professionals.

In Chile, to measure the quality of service of the public system, measurable and evaluable variables are considered through its dimensions, being the following: access, safety, effectiveness, efficiency, acceptability/patient-centeredness, equity and user satisfaction (Ministerio de Salud, 2020), where patient-centered service has its unique factor, reflecting its value at the government level.

1.9 Empowerment of the work team and Quality of service

An empowered staff with high emotional support, involved in important decisions, who demonstrate learning and development initiatives, is capable of individually exercising relationship-oriented leadership and at the same time collaborators work together with the leader, there being a significant correlation between an increase in patient satisfaction and decreased mortality rates, adverse effects and complications, reflected in a better-quality service (Elkomy et al., 2020).

From the background presented above, the following hypotheses are derived, presented in Table 1.

Table 1. Hypotheses

Code	Hypotheses
H1	Comprehensive Leadership (LI) positively and significantly impacts Organizational Development (OD)
H2	Organizational Development (OD) positively and significantly impacts Effective Communication (EC)
H3	Organizational Development (OD) positively and significantly impacts the Service centered on the patient and their family (SC)
H4	Organizational Development (OD) positively and significantly impacts the Empowerment of the work team (EE)
H5	Effective Communication (EC) positively and significantly impacts the Service centered on the patient and their family (SC)
H6	The Empowerment of the work team (EE) positively and significantly impacts the Service centered on the patient and their family (SC)
H7	Effective Communication (EC) positively and significantly impacts Service Quality (CS)
H8	The Service centered on the patient and their family (SC) positively and significantly impacts the Service Quality (CS)
H9	The Empowerment of the work team (EE) has a positive and significant impact on Service Quality (CS)

Source: Own elaboration

Therefore, this article proposes to carry out an analysis of the determining attributes of effective leadership styles from the patient's point of view, through two proposed causal models that establish differences according to the patient's gender, in a post-COVID 19 scenario in which public health sector, from the Coquimbo region, Chile.

2 Methodology

The relevant aspects of the methodology are detailed below, for understanding the study carried out: information gathering, individual reliability of the indicators, and reliability, construct validity and discriminant validity.

2.1 Gathering information

The evaluative instrument, of a polytomous nature, used the Likert scale from 1 (strongly disagree) to 5 (strongly agree) and was applied to 295 people who had attended the La Serena and Coquimbo hospitals between 2020 and 2022. Four responses were eliminated as outlier treatment, for answering everything with "strongly agree" or "strongly disagree." After this filter, the sample is limited to 291 effective surveys. Furthermore, the sampling was random, with $z=1.95$; $p=q=0.5$ (5% error and 95% reliability).

2.2 Individual reliability of indicators

To determine the reliability of the variables, the factor loadings were determined for each one. In addition, the Kaiser-Meyer-Olkin (KMO) and Bartlett sphericity tests were performed. For the interpretation of the KMO index, a KMO value less than 0.5 is considered unacceptable to perform a factor analysis, between 0.5 and 0.7 are mediocre, between 0.7 and 0.8 are good, values between 0.8 and 0.9 are very good and values greater than 0.9 are excellent (Nunes et al., 2020), for Bartlett's test of sphericity if its p-value is less than our chosen significance level (0.05) it can be concluded that the variables are correlated and that our data set is suitable for factor analysis. For the factor loadings, those with values greater than 0.6 will be accepted (Hair et al., 2013), so the indicators Int2, Org4 and ComEf3 would not be considered in the analysis preliminarily, the rest of them being significant. at 95% confidence. As seen in table 2.

Table 2. Individual reliability of the indicators

Construct	Indicator	Item	Factor loading (λ)
Comprehensive leadership KMO: 0,572 Sig. of Barlett: <0,001	Int1	I consider the existence of a balance between technical knowledge, adaptability, commitment and empathy in the doctor to be essential.	0.758
	Int2	A well-rounded leader must empower his or her work team to deal with burnout.	0.580
	Int3	I believe that the trust that a medical leader reflects towards his work group is strongly linked to the quality of the service he provides.	0.801
Organizational Development KMO: 0,831 Sig. of Barlett: <0,001	Org1	I consider that the performance of the hospital's collaborators is efficient (doctors, health professionals, support and administrative technicians).	0.880
	Org2	I consider that the hospital's work groups are adequately integrated into the assigned service area.	0.855
	Org3	I feel that the resources allocated to the different medical areas are used correctly.	0.829
	Org4	I consider it essential that the management of work teams carried out by the medical leader must be flexible so that it adapts to the needs of the patients.	0.315
	Org5	I feel that the hospital collaborators (doctors, health professionals, support and administrative technicians) coordinate adequately between the different areas.	0.836

Effective Communication KMO: 0,511 Sig. of Barlett: <0,001	ComEf1	I feel that the information provided among the medical team, to patients and families is correct.	0.905
	ComEf2	I believe that the medical team always uses clear language to communicate with patients and their families.	0.920
	ComEf3	I believe that it is very important to inform family members so that they have an active role in the treatment of patients.	0.325
Service centered on the patient and their family KMO: 0,611 Sig. of Barlett: <0,001	Serv1	I believe that dignified treatment of patients and their families by the medical team is just as important as their technical knowledge.	0.735
	Serv2	It is important that the treating physician shows genuine interest in the health status of the patient and his or her family.	0.690
	Serv3	I feel that the support of hospital employees (doctors, health professionals, support technicians and administrators) towards patients' families allows them to better cope with a tragedy.	0.713
Empowerment of the work team KMO: 0,669 Sig. of Barlett: <0,001	Empo1	When the responsible doctor has not been present, other hospital collaborators (doctors, health professionals, support technicians and administrators) have been able to adequately care for my condition.	0.782
	Empo2	I feel that all hospital collaborators (doctors, health professionals, support technicians and administrators) ensure that quality care is provided to the patient.	0.846
	Empo3	I have perceived that Hospital employees when carrying out their work actions do not depend significantly on others, they have autonomy to act when necessary.	0.791
Service Quality KMO: 0,796 Sig. of Barlett: <0,001	Qua1	I feel satisfied with the attention, treatments and care provided by the hospital.	0.871
	Qua2	I consider that the waiting time at the Hospital was adequate.	0.780
	Qua3	I prefer to go back to the hospital rather than be treated in the private health system.	0.870
	Qua4	I feel like my mental health had a positive reinforcement after being treated at the hospital.	0.821

Source: Own elaboration

2.3 Reliability, construct validity and discriminant validity

In order to evaluate the reliability and validity of the construct, the criterion established and indicated by different authors (Oviedo and Campo-Arias, 2021) is that a Cronbach's alpha value, between 0.70 and 0.90, indicates good internal consistency. This allows us to analyze the reliability of a set of indicators used to measure a given construct. In addition to Cronbach's alpha, composite reliability (CFI) can be calculated, which considers the interrelationships between constructs. It is recommended that the IFC value be greater than 0.7. To evaluate convergent validity, the average variance extracted (AVE) is calculated. It is recommended that the value of the AVE be greater than 0.5, to indicate that more than 50% of the variance of the construct is due to its indicators.

Only using the Cronbach's Alpha criterion the constructs Reliability in times of pandemic, Comprehensive leadership and Service centered on the patient and their family are not reliable, however, Cronbach's alpha can present problems with data on a Likert scale, so It is not recommended to use it alone. Along with the IFC and the AVE, only the construct Service centered on the patient and her family does not meet the previous standards, however, the variables Int2, Org4 and ComEf3 will be eliminated in the contrast model. Finally, discriminant validity will be evaluated, which indicates to what extent a construct is different from the others that make up the model. One way to check this validation criterion is to show that the correlations

between the constructs are lower than the square root of the average variance extracted. All these values were met.

3 Results

The different types of analysis developed are presented: statistical analysis, univariate analysis, bivariate analysis, multivariate analysis, proposed structural equation model, and validation of the structural model. For statistical, univariate and bivariate analyses, SPSS software was used.

3.1 Statistic analysis

The demographic profile of the total sample is 38.7% male, 59.59% female and 1.71% who prefer not to specify, 40.3% of the respondents correspond to Millennials followed by 27.5% belonging to generation z, 19.3% generation x, 10.2% baby boomers and 2.7% previous. 61.4% were treated at the La Serena Hospital while 38.6% at the Coquimbo Hospital, the predominant type of care corresponds to outpatient care with 34.9% followed by Medical Specialties and Procedures with a 27.5%, 22% for hospitalizations and 15.9% for support and emergency units. Regarding the last year that care was provided in said health center, 73.2% was in 2022, 14.2% in 2021 and 12.5% in 2020.

3.2 Univariate analysis

Simple descriptive data such as the mean and standard deviation were obtained by construct and by gender, to better identify the general behavior of the sample, as seen in table 3.

Table 3. Mean and Standard Deviation by gender

Construct	Men		Women	
	Average	Standard deviation	Average	Standard deviation
Comprehensive Leadership	4.407	0.511	4.402	0.564
Organizational Development	3.430	0.785	3.239	0.817
Effective Communication	3.950	0.698	3.730	0.755
Empowerment of the work team	4.389	0.508	4.469	0.548
Service centered on the patient and their family	2.442	1.281	2.144	1.157
Service Quality	2.940	0.930	2.595	1.084

Source: Own elaboration

Based on the results, the constructs with the lowest scores are Patient-Centered Service (2.442 for men and 2.144 for women) and Service Quality (2.940 for men and 2.595 for women).

3.3 Bivariate analysis

In the case of variance analyses, the null hypothesis is contrasted, that the means of the populations are equal, against the alternative or alternative hypothesis, that at least one of the populations differs from the others in terms of its expected value. The literature states that the null hypothesis is rejected when the calculated F indicator is greater than the tabular F indicator (Ruiz et al., 2010). Using the 0.05 significance level, for $n_1 = \{1, 3, 4\}$ (according to the groups studied)

and $n_2 = \{290, 289, 288\}$ (according to the groups studied) degrees of freedom, the tabular F values are: ANOVA by gender: tabular $F = 3.874$; ANOVA by type of care: tabular $F = 2.64$; and ANOVA by age: tabular $F = 2.40$. Table 4 presents the results.

Table 4. Bivariate Analysis

Factor	ANOVA- Pearson correlation					
	Gender		Type of care		Age	
	F	Sign.	F	Sign.	F	Sign.
Comprehensive Leadership	3.800	0.023	0.729	0.535	2.722	0.020
Organizational Development	4.053	0.018	2.790	0.041	0.813	0.541
Effective Communication	4.490	0.012	6.380	0.000	3.509	0.004
Service centered on the patient and their family	1.810	0.165	0.245	0.865	2.648	0.023
Empowerment of the work team	1.235	0.292	0.048	0.986	1.275	0.275
Service Quality	6.112	0.003	3.600	0.014	4.179	0.001

Source: Own elaboration

3.4 Multivariate analysis

Next, an analysis of structural equations is proposed as a contrast to the previously proposed theoretical model (with the omission of the variables Int2, Org4 and ComEf3), through the PLS (partial least squares) method. After this paragraph, the theoretical model of comprehensive leadership is presented, based on patient-centered care. SmartPLS 3 software was used for the following analyses.

3.5 Validation of the structural model

Once the validity of the measurement model has been studied, the model relationships will then be evaluated using the explained variance of the dependent variables (R^2), which must be equal to or greater than 0.1. According to (Esposito et al., 2008), the most appropriate indicator to evaluate the fit of the PLS method is the global goodness of fit index (GoF). This index is calculated by taking the square root of the product of the AVE (Average Variance Extracted) and R^2 in the endogenous or dependent variables, as shown in table 5.

Table 5. Goodness of fit index of the models

Construct	Men		Women	
	AVE	R^2	AVE	R^2
Comprehensive Leadership	0.102		0.761	
Organizational Development	0.514	0.222	0.603	0.050
Effective Communication	0.426	0.470	0.614	0.492
Service centered on the patient and their family	0.143	0.403	0.636	0.051
Empowerment of the work team	0.547	0.643	0.541	0.564
Service Quality	0.447	0.824	0.526	0.560
GoF	0.431		0.459	

Source: Own elaboration

As can be seen in the previous table, the goodness of fit (GoF) of the model is 0.431 (men) and 0.459 (women), thus meeting the empirical criterion that the Godness of Fit must vary between 0 and 1, where a higher value, better is the fit. The fit of the model in relation to the GoF is measured if it is less than 0.1, there is no fit, between 0.1 to 0.25 there is a small fit, between 0.25

to 0.36 there is a medium fit and greater than 0.36 a high fit (Wetzels et al., 2009), so both GoFs are considered high. Finally, in tables 6, the standardized PATH coefficient is presented, where the variables are accepted when they exceed the minimum accepted value of 0.2 (Chin and Marcoulides, 1998). The standard error of the parameters is also calculated by verifying the T statistic (using the Bootstrap technique), fulfilling $T \geq 1.96$ (Fauzi, 2022). While the models are presented in figures 1 and 2.

Table 6. Hypothesis contrast Model Structural equations

Code	Hypothesis	Men			Women		
		PATH	T-statistics	Contrast	PATH	T-statistics	Contrast
H1	LI → DO	0.472	2.990	Accepted	0.225	2.103	Accepted
H2	DO → CE	0.686	10.036	Accepted	0.702	15.111	Accepted
H3	DO → SC	-0.403	0.538	Rejected	0.048	0.327	Rejected
H4	DO → EE	0.802	13.780	Accepted	0.751	16.481	Accepted
H5	CE → SC	0.282	0.642	Accepted	0.273	1.885	Accepted
H6	EE → SC	0.668	0.940	Accepted	-0.159	1.092	Rejected
H7	CE → CS	0.856	6.637	Accepted	0.249	3.442	Accepted
H8	SC → CS	-0.284	0.843	Rejected	-0.040	0.675	Rejected
H9	EE → CS	0.216	3.296	Accepted	0.563	8.387	Accepted

** : t-value > 1.96

Source: Own elaboration

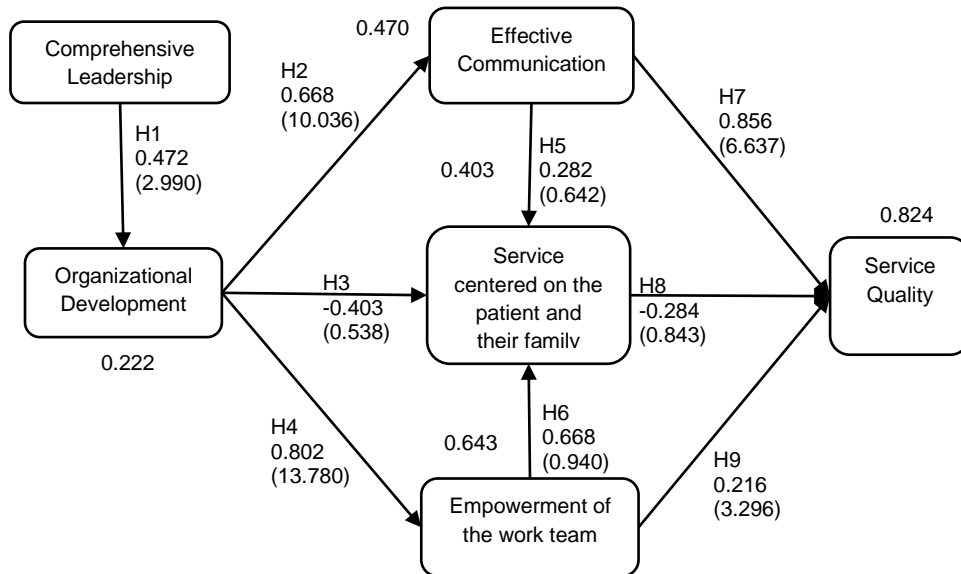


Fig. 1. Causal model – Men

Source: Own elaboration

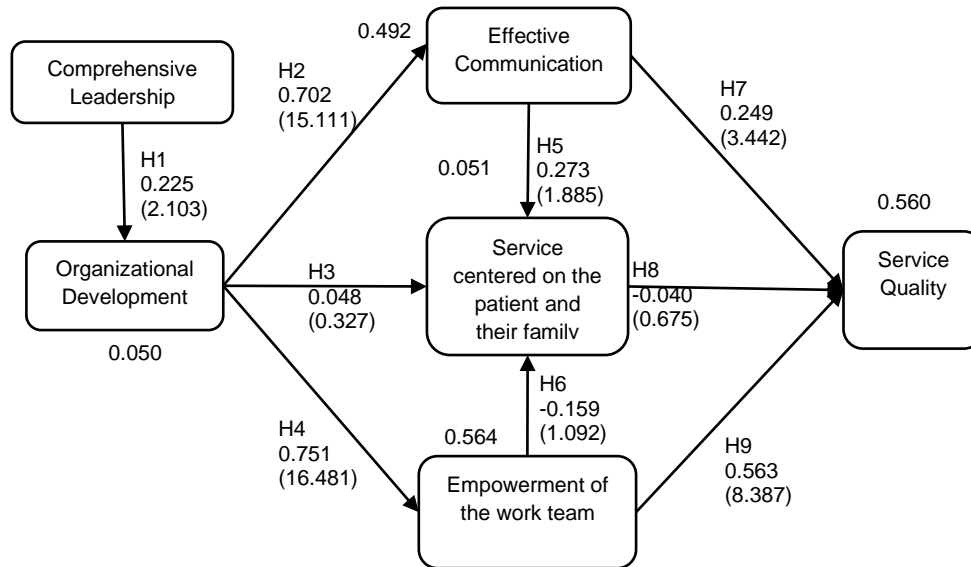


Fig. 2. Causal model – Women

Source: Own elaboration

4 Discussion

The results obtained support the importance of factors such as effective communication (H7, PATH value = 0.856 for men and 0.249 for women) and empowerment of the work team (H9, PATH value = 0.216 for men and 0.563 for women) in quality of the service, therefore, these factors have been shown to have a direct influence on the explained variance of the constructs. This result is aligned with what was expressed by Kourkouta and Papathanasiou (2014), who express that good communication is essential to understand the patient's ailments and achieve optimal quality of care, together with the empowerment of the work team, since they exercise leadership relationship-oriented for customer satisfaction (Elkomy et al., 2020). These results reinforce the need to promote open and effective communication among health personnel, as well as promote the empowerment and autonomy of professionals to improve the quality of service, since this is explained in 82.4% and 56% by the aforementioned variables for the men's and women's models, respectively.

On the other hand, effective communication is explained by 47% (men) and 49.2% (women) by organizational development (H2, PATH value = 0.668 for men and 0.702 for women), reaffirming what was expressed by the Ministerio de Salud (2020), since communication between departments generates unified access to information, facilitating coordination and access to data, which directly impacts the quality of the service provided to patients (H7). While Work Team Empowerment is explained by 64.3% (men) and 56.4% (women) by organizational development (H4, PATH value = 0.802 for men and 0.751 for women), which is aligned with what was said by Ahmad et al. (2022), project leaders generate an adequate flow of information for the autonomous leaders of the work team, guaranteeing clarity of objectives in an empowered environment and developing a looser organization, in order to provide quality service to patients (H9).

Finally, the most notable difference between both models lies in H6, since in the men's model it has a PATH = -0.159, while in the women's model PATH = 0.668, this can be explained with what was stated by Serrano (2017), when the person treated is a woman, better results are obtained,

since it tends to generate more conversation with the medical staff and, therefore, they give more information about their ailments, resulting in a better diagnosis and/or treatment.

Given the results expressed, it is inferred that the aforementioned variables must be reinforced and encouraged and aligned with strategic plans that aim to improve the quality of the service of the public health system. Therefore, it is relevant that leadership is an active part of the intra- and extra-organizational processes in the public health system, thus achieving a better work environment for collaborators and a better service for patients and their families. Therefore, social and political leaders have a duty to provide the optimal and necessary conditions to achieve a better public health system, with programs that aim at organizational development, comprehensive and empathetic leadership, empowerment of the work team and effective communication.

5 Conclusions

According to the results of this study and its discussion, the following conclusions can be drawn: 1) the models show the current scenario of patients in the public health system in the region of Coquimbo, Chile, specifically in the hospitals of La Serena and Coquimbo, where the influence of the empowerment of the work team and effective communication is positive and significant on the quality of the service and, therefore, on the value of the public value system, so these aligned variables must be reinforced and encouraged. to strategic plans that aim to improve the quality of service; 2) it is important to encourage the development of comprehensive leadership within public health organizations and their work teams, not only for good care directed to patients and their families, but also as a means to raise institutional reputation and of the health system, thus enhancing both communication channels inside and outside the organization, as well as the organizational development of the health centers themselves, and; 3) other aspects related to the scope of the public health system should be investigated, such as allocated budgets and availability of specialists.

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