‘The way things are around here’: organisational culture is a concept missing from New Zealand healthcare policy, development, implementation, and research

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Abstract

Internationally, healthcare sectors are coming under increasing pressure to perform and to be accountable for the use of public funds. In order to deliver on stakeholder expectation, transformation will need to occur across all levels of the health system. Outside of health care it has been recognised for some time that organisational culture (OC) can have a significant influence on performance and that it is a mediator for change. The health sector has been slow to adopt organisational theory and specifically the benefits of understanding OC and impacts on performance. During a visit to health research units in the United Kingdom (UK) I realised the stark differences in the practice of health reform and its evaluation.

OC is a firmly established concept within policy development, implementation and research in the UK. Unfortunately, the same cannot be said for New Zealand. There has been unrelenting reform and structural redesign, particularly of the primary healthcare sector under multiple governments over the past 20 to 30 years. However, there has been an underwhelming focus on the human aspects of organisational change. This seems set to continue and the aim of this viewpoint is to introduce the concept of OC and outline why New Zealand policy reformists and health services researchers should be thinking explicitly about OC. Culture is not solely the domain of the organisational scientist and current understandings of the influence of OC on performance are outlined in this commentary. Potential benefits of thinking about culture are argued and a proposed research agenda is presented.

During a visit to prominent health service research units in the United Kingdom (UK) I was struck by the stark differences in the development, implementation and research activity associated with health policy reform.

Discussions with academic leaders and their staff highlighted an understanding and focus toward Organisational Culture (OC) as an important concept within health reform. These individuals have considerable political clout, being advisors to the National Health Service (NHS). To a great academic leaders of this type have ensured that the concept of OC is not a forgotten ingredient of organisational change. They have not allowed the term OC to become a buzzword; confined to the hallways of health service research units or policymaking departments.

These leaders have actively promoted an understanding of OC through their research which influences policymakers and those working at the coal face. The agenda is for OC to assist efforts to improve health systems through a focus on both structural and social change.
A definition of organisational culture

OC has been described in lay terms as ‘the way things are around here’; the commonly held beliefs and values about the ‘way(s) we think and act’ within organisations. The most commonly cited definition of OC in the healthcare literature is one by Edgar Schein:

“…the pattern of shared basic assumptions – invented, discovered or developed by a given group as it learns to cope with its problems of external adaption and internal integration – that has worked well enough to be considered valid and, therefore to be taught to new members as the correct way to perceive, think, and feel in relation to those problems”

OC has been borrowed from anthropology, denoting the collective thinking that drives normal behaviour within a group with common goals. Organisations are human systems that engage in activities that create and distribute value for key stakeholders in order to ensure organisational longevity.

Both structural and human components need to be considered when understanding organisational change. Understanding the way(s) we think and act collectively at the organisational level is important.

Why bother studying the culture—effectiveness link?

When attempting to develop and implement health policy, OC is an important concept for change at multiple levels within the health system. Outside of the healthcare sector, OC is recognised as an important factor in influencing organisational effectiveness and success.

Supported by popular literature, OC has largely been conceptualised as one of many organisational factors that influence success. OC is a variable, easily manipulated by leadership to improve productivity, competitiveness and financial sustainability. The health sector has been slower than other sectors to adopt organisational development strategies.

Slowly, OC has been embraced as an important concept in the USA and the UK. Interest was based on the realisation that to deliver effective health care within a defined fiscal cap, human change is required in addition to structural considerations.

The same cannot be said for the historical development of OC in New Zealand. Here OC is relatively unknown, unspoken, unwritten and under-researched phenomenon in health circles. In this viewpoint I outline the international drive for healthcare transformation; aimed at improving performance.

I argue the importance of OC and present the learning from research predominantly from the UK. The potential impact on New Zealand policy and practice through ignoring the concept of OC is outlined and a research agenda is presented.

Organisational culture as a mediator for change

In recent years the health sector has come under increasing pressure to perform and to be made accountable for use of public funds. Despite subtle differences in developed healthcare systems, one thing is commonplace; the unrelenting thrust by central policymakers for accountability and performance. All the while, disease states...
are becoming increasingly complex, with more therapeutic options and limited resource. This is an international phenomenon and New Zealand has not bucked the trend.

Increased complexity alongside disasters such as the Shipman and Bristol Heart scenarios led to realisation by UK policymakers that safe service provision and greater productivity cannot be squeezed out of the system through structural change alone. OC has become a significant concept for understanding aspects of organisational transformation at all levels.

The definition of culture and the manifestations outlined can be thought about and applied to the context of organisations within the following three levels of the healthcare sector:

- The macro level—policy and policy setting organisations such as the Ministry of Health and the Pharmaceutical Management Agency (PHARMAC)
- The meso level—the health funders and planners including District Health Boards (DHBs) and PHOs
- The micro level—the healthcare providers including organisations such as general practice and community pharmacy

Over two decades policymakers in the UK have made explicit the need for OC transformation in order to reconfigure health care and demonstrate performance gains. The rationale was two fold. First, with regard to implementation, there has been a focus on aspects such as clinical governance which provides a framework for both structural and OC transformation at the ‘meso’ and ‘micro’ levels.

Second, significant research streams have been developed and continue to be well supported by the UK Government. This is through realisation that policy development and implementation will be better informed and more successful through an understanding of OC as a facilitator of change. The focus of these research streams is on the influence of OC on organisational performance, particularly within the secondary care sector.

**New Zealand health reform and the lack of focus on OC**

A system wide shift from a focus on the individual to population health outcomes has not been without its challenges in New Zealand. Improved service delivery and resultant health gains were expected to occur through structural redesign of the health system. This structural change is evidenced by the incremental morph of primary care support organisations, over the past two decades, under Labour and National Governments.

In addition to structural change, the focus has been on applying financial models in an attempt to make the system more efficient. This argument is supported by the introduction in the late 1980s of Independent Practitioner Associations (IPA) and subsequently Primary Health Organisations (PHOs). These structural changes cemented ‘middle’ level structures within the health sector.

Significant resources were allocated for the development of IPAs. Later through PHOs, capitation based funding was being applied in order to shift focus from patient
to population and to increase utilisation of the multi-disciplinary primary care team. Neither of these objectives has been achieved in full; possibly due to divergent professional subcultures found within and across primary and secondary health care. A divide between clinicians and management and the ‘rise of managerialism’ is likely to have contributed to this.

The National Government under the guidance of Health Minister, Rt Hon Tony Ryall calls for Better, Sooner, More Convenient Primary Health Care. The main driver for delivery of care is infrastructure rather than OC change. With the development of large Integrated Family Healthcare Centres (IFHC) there is the expectation that general practices will amalgamate and health professionals will ‘just get on with it’.

The expected gain in sector-wide efficiency is based on the notion that larger, co-located service providers will result in improved integration across all levels of the healthcare sector and higher performance. There is no consideration of history or sub-cultures that have manifest over long periods of time. Improved multidisciplinary teamwork, patient experience and health outcomes are expected through structural change, which masquerades as innovation by service co-location.

There is little evidence cited in government policy to support the notion that structural change and co-location will have the desired effect of improved healthcare performance. The IFHC strategy may prove to be less successful than expected, unless there is greater thought about the human aspects of change. There is an agenda for devolution of services from secondary to primary care but no money set aside for the development of IFHC.

Apart from physical collocation and service design, little thought has been given to the interaction (or lack of) between primary and secondary care; based on fundamental differences in the values, beliefs and behaviour. There is a strong focus on clinical leadership under the National Government and the tension between this and non-clinician management does not seem to have been considered.

There is a literature that advocates for simultaneous change across all levels of the health system, through establishing crises. It is unfortunate that this is represented in New Zealand by ‘rattling the health sector cage’ from above.

There is a completely naive expectation that secondary care will happily devolve half of its activity to PHOs without a struggle and PHOs will easily amalgamate, whilst General Practices with vastly different cultures will also calmly band together in certain locations whilst funding themselves into IFHCs. The notion that DHBs will happily transfer their role to the private sector through this development of a two tier American style healthcare system will be interesting to observe.

The most common reasons for failure of organisational change activities are lack of development of a guiding coalition, not making explicit the short and long term gains and not embedding this into the culture. ‘Because a representative of the government has said so’ or ‘the government wants it done that way’ has been common dialogue bouncing around the corridors of the health sector over the past two years.

Our politicians and their advisors need to rethink the human aspects of their policies; particularly the ‘rattling cage’ approach and the likelihood of healthcare organisations
co-operating because they are all put in the same building. It certainly doesn’t work with politicians so why would it work within the much more complex arena of health care, where there is considerably more at stake.

Within the primary care sector there is no clear plan of how organisations or professional groups with divergent and disparate cultures might work together under one roof. This expectation is not likely to achieve anything more than discontent, a loss of productivity and job satisfaction and the continued mass exodus of the New Zealand health workforce that Professor Gorman the Health Workforce New Zealand Executive Director has talked about.36,37

The tenets of New Zealand primary healthcare policy are not dissimilar to the UK. There has been the call for improvement in access to services alongside the provision of quality health care. This is expected through technological integration and multidisciplinary teamwork.38,39 The difference between the UK and NZ is the realisation in the UK that to effect change one has to understand the ‘way things are around here’ to begin with and how this might change in the future. The concept of OC is understood and deemed to be important.

Organisational culture has been made explicit in UK health policy development, implementation and research for more than a decade. Within the discipline of health services research much financial resource, time and energy and academic brainpower has been devoted to studying the influence of OC on performance. The aim of this work has been to better understand mechanisms of change within the complex environment of healthcare provision at multiple levels. The other main agenda has been to expose the healthcare sector to the realisation that physical system reconfiguration is not the sole lever for organisational change.

UK health policy is currently directing the dissolution of Primary Care Trusts which has a flow-on effect at the ‘middle’ level of planning, as well as for general practices at the coal face. General practitioner (GP) commissioning is expected to be the mechanism for change at these levels. Moving to this approach is likely to require structure and process change in order to achieve the health outcomes expected by policymakers.

For some time, UK healthcare policy has been explicit in its call for cultural as well as structural change in order to achieve delivery of accessible, equitable and high quality health care. There will be a residual understanding of OC as the UK transitions into this next wave of reform; the GP commissioning of services. This is arguably the greatest policy shift which directly affects practitioners at the coal face and the idea that OC change may be required as part of the process will not be a new one, at least not at the policymaking level!

**What New Zealand has missed out on**

A lack of discourse and associated research activity on OC in New Zealand could have significant implications for stakeholders; particularly those who have an interest in healthcare performance. In the UK, healthcare reform has developed with a focus on OC as a significant facilitator of change.1,40–43
This has followed several strands which we could learn from in New Zealand:

**Realisation of the importance of OC by policymakers**—Major disasters relating to patient safety in the UK (Bristol Heart and Harold Shipman) resulted in a re-focus on the place of human activity in health service delivery. The development of clinical governance by policymakers was expected to curb flaws in health service delivery through a focus on culture as a lever for organisational change.\(^1,41,43\)

I am unaware of formal evaluation in New Zealand however, it appears that clinical governance activity has been limited to the mandatory requirement of the District Health Board New Zealand PHO Performance Framework (PPF). In 2005 and 2006 Dunedin based Best Practice Advocacy Centre (BPAC) undertook education sessions about clinical governance as part of the PPF program. This hardly constitutes the embedding of clinical governance as part of OC.

**Recognition of the importance of OC by health service researchers**—It has been increasingly recognised that OC has an influence on the performance of healthcare systems. There has been a flurry of interest in applying organisational theory to the healthcare sector, particularly in the UK and USA. Instruments to measure OC have been assessed\(^44,45\) and the conceptual methodological challenges of studying in this area have been identified.\(^25,28,29\) If culture is conceptualised as *the way(s) we think and act* within organisations\(^3\) then OC must have an influence on performance. It then becomes a matter of determining *in what way(s)* so that levers of change can be identified.

Apart from research within the community pharmacy sector, health service researchers in New Zealand have been relatively naïve to the benefits of pursuing an OC research agenda.\(^3,46\) The energy put into studying OC in the UK has not been replicated in New Zealand. As a result, we have a poorer understanding of approaches to organisational change, how OC manifests, and the ways in which dimensions of OC may mediate performance in both positive and negative ways.

**Recognition by policymakers of the need to understand and evaluate OC change**—The recognition by health policymakers, funders and planners of the need to understand and evaluate OC in health care, and the keen interest by health service researchers to do so, has resulted in a flourishing research agenda in the UK.

Studies suggest that performance in health care is contingent upon particular manifestations of OC. High and low performing hospitals in the UK demonstrate divergent patterns of OC.\(^25,47\) It is also possible that high performance may influence OC in recursive ways. That is, different OC may develop from high performing healthcare organisations over time, although more work is required in this area.\(^47\)

In the UK, Mannion and colleagues have noted a shift in the OC of healthcare organisations as a result of an increasingly market driven sector.\(^48\) Understanding this sought of change is best undertaken through a cultural lens using robust and systematic research techniques. Such an approach has been followed in the UK.

There is a high awareness amongst clinical governance managers in the UK of the need for cultural renewal.\(^49\) One third of managers surveyed were using OC assessment tools.\(^50\) I am unaware of similar data available for New Zealand although I
suspect that the uptake of the notion of OC and the assessment tools will be at a considerably lower level.

**The gaps: A research agenda for New Zealand**

Deciphering the influence of culture on performance is a challenging area to study. Both are difficult to conceptualise, operationalise and separate as distinct concepts. Novel methodological approaches need to be thought about to achieve this. The majority of studies have been undertaken in the context of the secondary care sector and more OC oriented research is required in primary care.

Studies have involved OC associated with leadership with little focus on the collective whole, who carry the culture within an organisation. Some work has been undertaken in the area of professional subcultures but a lot more needs to occur in primary care. There is an increasing realisation that stakeholders contribute significantly to service co-production and are likely to be involved in co-production of service delivery and so OC research that involves patients and communities will be important.

There is a need to consider the place of OC in influencing system-wide change. This is particularly the case under the devolution of services from secondary to primary care and the development of IFHC. I have previously discussed OC as a mediator for change and this section outlines this with respect to unanswered questions in the New Zealand context.

**The micro level – the practice level**—Exploring barriers and facilitators to multi-disciplinary teamwork between general practitioners, primary care nurses, community pharmacists and practice managers will be required under the IFHC model. The potential influence of professional subcultures on performance should be high on the research agenda. The PFP describes a list of performance indicators which reflect population health outcomes that are important to all New Zealanders.

Experience as a clinical governance group member and Chair across a number of PHOs suggests there is marked variation in general practice performance. It is likely that some of the variance in performance is due to the different OCs that manifest as part of these practices. These differences need to be identified and understood. Adopting a cultural lens to achieve this is appropriate.

**The meso level**—At the funding, planning and implementation level clinical governance activities would be one focus of OC shift. Clinical governance groups have been a pre-requisite for PHOs entering the PPF however there is little knowledge of how this is operating in primary care.

Despite top-down health policy, the devolution of services from secondary to primary care organisations may also be influenced by OC; the values and beliefs which underlie each of these organisations which are significantly different. No better is this demonstrated than the recent ‘cage rattling’ at a national level and subsequent restructuring of DHB teams and PHOs across the greater Auckland area.

**The macro level**—Within the macro level—national policymakers; New Zealand healthcare policymaking and evaluation needs to align with other developed countries and be more explicit about the importance of OC as a mediator for change within
complex healthcare environments. Lack of consideration of humanistic aspects of organisational change provides the thrust of this paper.

In other developed countries such as the UK, there has been a systematic approach to the development of quality service provision and the identification of patterns of OC in both high and low performing organisations. UK policymakers have incrementally developed a way forward with respect to healthcare reform.

In New Zealand we have not been so broad or systematic. It appears the recent emphasis on change is at the implementation level where priorities stem from doing things ‘because representatives of government said so’ and ‘government wants it done this way, before the election’. This is a reflection of the ‘cage-rattling’ approach alluded to previously.

Another macro-level issue is the fact there are a large number of PHOs serving disparate communities yet there is little understanding of the OC of these Boards. It would be useful to consider the increased policy focus on ethnic and socioeconomic disparities (‘reducing inequalities’) from the previous Labour Government and to explore whether this policy focus has changed organisational values, behaviours and thinking. It would also be interesting to know whether this has had an impact on organisational performance and if so, in what ways?

Amalgamation of PHOs is occurring, some joining through their own processes of rationalisation, others through government or local DHB coercion. Either way, there is little understanding of or consideration for the differing OCs and how this will affect top-down merger processes, and the implementation of programmes.

Over the years I have seen IPA and PHO amalgamations that seem rational on paper however, they have fractured due to incompatible OCs. The same could occur with IFHC development at the practice level. IFHC are more likely to be a merge of existing general practices, with their own cultures than as new practices outright.

The development of IFHC will be gradual and action research will be required to ensure that new IFHC learn from established centres. More important is the macro-level question of whether IFHC centres will demonstrate improved health gains over the system unchanged.

**Conclusion**

Internationally, healthcare sectors are under pressure to be accountable for the use of public monies and performance. In order to deliver on stakeholder expectation transformation across all levels of the healthcare system may be required. In the UK health sector there has been a focus on structural and systems change and human or social change.

Cultural change was introduced into policy development and implementation from the outset of reform. The UK Government has supported research which helps to understand structural and human change processes that influence health service delivery. In this paper I challenge current health policymakers, funders and planners, primary care support organisations and health research units to embrace the notion that organisational culture is to important to ignore.
Organisational culture does influence organisational effectiveness and determining the ways in which this occurs will impact on the success of all levels of health care in New Zealand.

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