An assessment of organisational values, culture and performance in Cape Town's primary healthcare services

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Abstract

Objectives: Improving the quality of primary health care in South Africa is a national priority and the Western Cape Department of Health has identified staff and patient experience as a key component. Its strategic plan, Vision 2020, espouses caring, competence, accountability, integrity, responsiveness and respect as the most important organisational values. This study aimed to measure the personal values of staff, as well as current and desired organisational values.

Design: A cross-sectional survey used the cultural values assessment tool. Data were analysed by the Barrett Value Centre.

Setting and subjects: Staff and managers at five community health centres in the Cape Town Metropole.

Outcome measures: Personal values, current and desired organisational values, organisational entropy and organisational scorecard.

Results: In total, 154 staff members completed the survey. Participants reported personal values that are congruent with a move towards more patient-centred care. The top 10 current organisational values were not sharing information, cost reduction, community involvement, confusion, control, manipulation, blame, power, results orientation, hierarchy, long hours and teamwork. Desired organisational values were open communication, shared decision-making, accountability, staff recognition, leadership development and professionalism. Organisational entropy was high at 36% of all values. Only teamwork and community involvement were found in both the current and desired culture. The organisational scorecard showed a lack of current focus on finances, evolution and patient experience.

Conclusion: The organisational culture of the Metro District Health Services is currently not well aligned with the values expressed in Vision 2020, and the goal of delivering patient-centred care.

Introduction

District healthcare services in South Africa face many challenges with regard to attempts to offer effective primary healthcare services. Demand for services from uninsured communities is high. There is a quadruple burden of disease characterised by human immunodeficiency virus/acquired immune deficiency syndrome and tuberculosis; interpersonal violence and trauma, poverty-related diseases, such as diarrhoea and pneumonia; and an emerging epidemic of noncommunicable chronic diseases.[1] The number of service providers is often inadequate to cope with the workload. Healthcare workers are inequitably distributed. For example, doctors are found in greater numbers in urban areas, the private sector and hospitals, rather than in the communities.[2]

The district health system itself is a relatively new structure and many district-, subdistrict- and facility-level managers are still being appointed. Poor leadership and governance is one of the identified challenges that faces the new health districts.[3]

According to the Department of Health, primary healthcare workers are expected to be caring and compassionate at the coalface, and yet becoming patient-centred and improving the quality of care in this context is a challenge:[4]

"The department renders a large and complex service every day of the year, and the clinical environment is often stressful. Staff attitudes are a common source of complaints. A key issue is how greater commitment and engagement from staff can be promoted on a daily basis, moving towards a more client-centred service with a greater focus on quality improvement".[5]

Ongoing stressors for staff may manifest in a range of negative behaviour, such as despondency, anxiety, being emotional and physically unwell, as well as a general culture of demotivation.[6] In a study by Mash B et al, it was found that workers became resistant to any improvements that required additional effort or workload, and asked the organisation to be more "caring of the carers".[7]

The need for change in the organisational culture was highlighted in a recent review by Coovadia H et al of the healthcare system:

"A more efficient public sector requires the political determination … to change the culture of the public service from one that is orientated towards security of employment and reward for loyalty, to one that focuses on accountability and delivery of services to the public, in which competence and performance are both expected and rewarded".[3]

However, in a changing organisational culture, there is a need to ensure congruency between the values and behaviour expected during the consultation, or in the patient's experience of health care, and the values and behaviour experienced by staff in the organisation. Indeed, the nature of the healthcare worker-manager relationship may influence the patient-healthcare worker relationship. For example, if healthcare workers do not feel respected and are not treated with dignity, they may mirror this attitude in consultations.[8] Similarly, doctors and nurses may struggle to form effective teams because of differences in the way in which they perceive their roles and their underlying value.[9]

Vision 2020 of the Western Cape Department of Health espouses values of caring, competence, accountability, integrity, responsiveness and respect.[5] However, there may be incongruity between the actual experience of the organisational values by healthcare workers and these espoused or desired organisational values. Incongruity between personal and organisational values, as well as espoused and actual values, may manifest in personal behaviour, professional practice, organisational structures and processes that are also incongruent with one another.[10]

It is widely recognised that the success of an organisation is intimately linked to the strength of the culture. Who you are and the values by which you live are becoming the most important criteria for success.[10] The aim of this study was to evaluate how staff within the Metro District Health Services of Cape Town perceived their values and organisational culture. The objectives were to measure the current personal values of staff, the current organisational values experienced by staff, and the future organisational values desired by staff, and to evaluate incongruities and alignment between personal, current and desired organisational values.

Method

Study design

This study entailed a cultural values assessment based on a cross-sectional survey of staff at community health centres (CHCs). The cultural values assessment was based on a conceptual framework for whole system change that considers the alignment between individual and collective values with individual and collective behaviour (Table I).[10]

Table I: Four quadrants of human systems

	Internal	External
Individual	*Personality:* Individual values and beliefs	*Character:* Individual actions and behaviour
Collective	*Culture:* Collective values and beliefs	*Social structures:* Collective action, behaviour and processes

The framework suggests that enabling change that is congruent among all the four quadrants should lead to whole system change.

Three other important principles for whole system change are: [10]

- Leaders of groups have to drive the process of change.
- The vision, mission and desired organisational values should be explicitly linked to decision-making, structures, systems and processes.
- The culture should be monitored to see whether or not the values being expressed increase entropy or resilience in the organisation. Cultural entropy is the amount of energy in a group that is consumed in unproductive work and is a measure of the conflict, friction and frustration that exists within a group. Resilience implies the ability to adapt to or change in the environment.

Values can be understood as belonging to seven different levels of organisational consciousness, as shown in Table II. Organisational values can also be analysed and expressed in terms of their emphasis on key areas of organisational functioning, as shown in Figure 1.[10]

This study used the tools developed and validated by the Barrett Value Centre to evaluate the personal values of healthcare workers, their experience of current organisational values and their desire for future organisational values.[11] The aim of this evaluation was to demonstrate incongruities in these three areas and to identify key issues for the purposes of improving organisational culture and functioning.

Setting

Primary healthcare services in Cape Town (a population of 3.1 million) are divided between services offered by the Provincial Department of Health and those by the City of Cape Town. Approximately 84% of the South African population is uninsured and depends on these public sector

Table II: Seven levels of organisational consciousness

Level of consciousness	Examples of positive collective values (and limiting collective values)*
Service: Selfless service to the world	Social responsibility, future generations, long-term perspective, ethics, compassion and humility
Making a difference: To the local community or health district	Collaboration, community involvement, strategic partnerships, staff fulfilment, coaching and mentoring, and leadership development
Internal cohesion: Building internal organisational community	Shared values, vision, commitment, integrity, trust, passion, creativity, openness and transparency
Transformation: Continuous renewal and learning	Accountability, adaptability, empowerment, teamwork, goals orientation and personal growth
Self-esteem: High performance and quality of care	Systems, processes, quality, best practices and pride in performance *Bureaucracy, arrogance, image and hoarding information*
Relationships: With colleagues and patients	Loyalty, open communication, patient experience and friendship *Blame, internal competition, rivalry and manipulation*
Survival: Resources and safety	Sufficient budget, equipment, employee health and safety *Control, chaos, caution and job security*

*: Examples of potentially limiting or "negative" values are given in italics
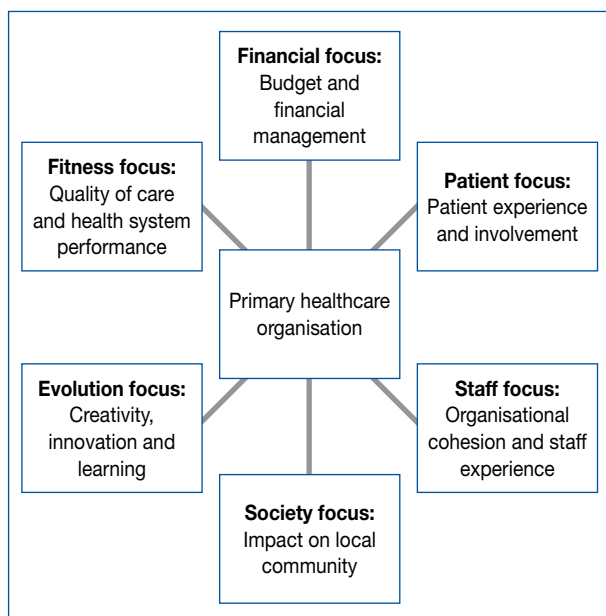
Limiting values are shown in italics

Figure 1: Organisational scorecard

services. This study was conducted in CHCs run by the Department of Health. The Metro District Health Services divides the Metropole into four substructures, which each have two subdistricts with a separate management team. Altogether, there are approximately 45 CHCs covering the population. Nine centres are open on a 24-hour basis. CHCs employ a multidisciplinary team of doctors, nurses and allied health professionals, as well as management and administrative staff. Each CHC has a facility manager, and specialist family physicians have been employed at the 24-hour facilities as the most senior clinicians with a specific responsibility for clinical governance.

Study population

Family physicians from the CHCs in the Metropole were invited to collaborate in the study. Five CHCs agreed to participate, namely Khayelitsha CHC, Retreat CHC,

Kraaifontein CHC, Hanover Park CHC and Mitchells Plain CHC. The selected CHCs included all four substructures. Staff members employed at the CHCs, together with their immediate management teams, were invited by family physicians to complete the survey.

Data collection

The questionnaire was a standardised and validated tool, developed by Barrett Value Centre. Participants were presented with a predetermined list of values, and asked to select the top 10 that best represented their personal values and experience of the existing organisational culture, as well as desired future organisational values. Demographic information on their age, sex, role and length of service was also collected. The standardised value list was modified by the research team and selected staff members to ensure that the list would make sense in the organisational context. The anonymous questionnaire was provided in English, the usual means of communication within the organisation. The questionnaire was administered in hard copy at each of the CHCs by the family physicians to their staff. Once all staff members had had an opportunity to respond, the collated questionnaires were entered on the Barrett Value Centre website by a data capturer.

Data analysis

The Barrett Value Centre analysed the data and provided the research team with the results and a report. Analysis was descriptive and provided frequencies for the selected values. Results were presented in words and figures according to the seven levels of organisational consciousness and the organisational scorecard. The principal author is a trained counsellor with the Barrett Value Centre and accredited to perform and interpret the cultural values assessment results.

The results of the survey were presented to the Division of Family Medicine and Primary Care at Stellenbosch

University, the Metro District Health Services' family physicians' forum, and to staff at the participating CHCs. Feedback was obtained from the family physicians and staff to enable more in-depth interpretation of the results.

Results

Overall, 154 staff members completed the questionnaire. They were distributed between the five CHCs as follows: Mitchells Plain (30, 19.5%), Khayelitsha (45, 29.2%), Hanover Park (9, 5.8%), Kraaifontein (31, 20.1%) and Retreat (39, 25.3%). The profile of the different staff categories in the sample is shown in Table III. One hundred and five (68.2%) were women and 49 (31.8%) were men. Seventy-nine (51.3%) regarded themselves as coloured, 37 (24%) as African, 26 (16.9%) as white and 8 (5.2%) as Indian. The average age of staff was 40.8 years, with a range from 20-63 years. The average length of service was 11.2 years, with a range from 2 weeks to 48 years. One hundred and twenty-eight (83.1%) were in permanent positions and 21 (13.6%) on contracts in temporary positions.

Table IV shows the top 10 values selected in order of predominance for the participants' personal values, current experience of the organisation and desired future experience of the organisation.

Of the personal values, seven focused on relational attributes and four on individual attributes. None of the selected personal values appeared in participants' experience of the current organisation.

Of the current organisational values, nine were defined as limiting values that potentially limited the functioning of the organisation (labelled "L"). Only three were positive values. When all of the values were analysed, 36% of those selected for the current organisation were limiting values, which suggests a high level of entropy. Of the top current organisational values, six focused on relational issues, five on organisational, and one on societal, issues.
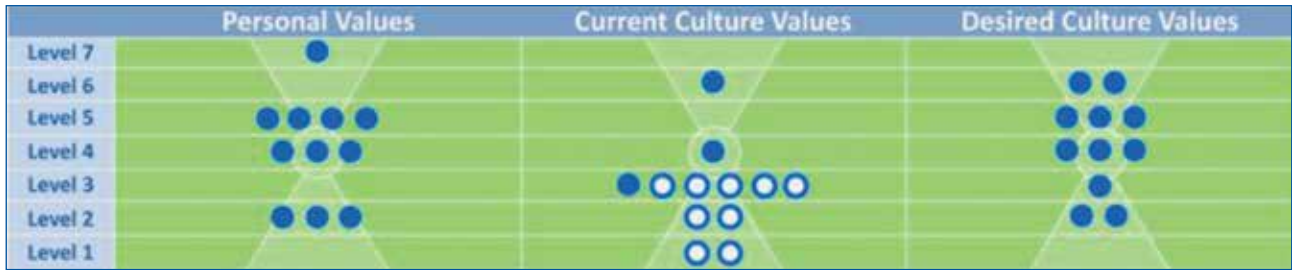
There were no limiting values selected regarding the desired organisational values. The desired culture included two values already found in the current culture, namely teamwork and community involvement. However, nine of the desired values were not experienced currently. The desired culture also included two values in the top 10 personal values, namely accountability and fairness. The desired organisational culture had only 2% entropy. Six values focused on relational issues, four on organisational, and one on societal, issues.

The implications of the top current organisational values are shown in Table V, which includes insights from the feedback by staff members.

Figure 2 shows the top values plotted according to the defined levels of organisational consciousness for personal, current and desired organisational values. Solid blue circles are positive values and white circles are limiting values. Personal values are concentrated at levels 4 and 5, representing transformation (20% of all values) and internal cohesion (32% of all values). This indicates a willingness to learn or change, the importance of personal cohesion and a search for meaning.

Table III: Different staff categories (n = 154)

Staff category	n	%
Manager	20	13
Administrator	23	14.9
Doctor	25	16.2
Nurse	53	34.4
Allied health professional	27	17.5
Support staff	4	2.6
Unknown	2	1.3

Table IV: Top ten personal values, current organisational values and desired organisational values

Personal values	n = 109 n	Current organisational values	n = 145 n	Desired organisational values	n = 149 n
Caring	73	Not sharing information (L)	49	Transparency	46
Honesty	68	Cost reduction (L)	48	Accountability	45
Commitment	67	Community involvement	45	Shared decision-making	43
Respect	67	Confusion (L)	43	Teamwork	41
Accountability	65	Control (L)	36	Community involvement	40
Compassion	45	Manipulation (L)	35	Patient satisfaction	37
Responsibility	43	Blame (L)	34	Leadership development	34
Balance	38	Power (L)	34	Staff recognition	34
Trust	35	Results orientation	32	Professionalism	33
Fairness	33	Hierarchy (L)	31	Fairness	32
Listening	33	Long hours (L)	31	Staff engagement	32
		Teamwork	31		

L: limiting values

Table V: Implications of the values in the current culture

Limiting value	Implications
Not sharing information	Information is perceived to flow only from the top downwards. There is no exchange of information that allows genuine participation in decision-making. Sometimes, information flows unevenly between facilities, or arrives too late for adequate planning. The rationale for top-level decisions or reasons for dysfunction in the system are not communicated, and yet staff members are confronted with the consequences of problems and feedback from patients. The call for transparency, shared decision-making and staff engagement in the desired culture requires a two-way flow of information, more openness in why decisions are made and why things go wrong, and a more structured approach to effective communication and staff engagement.
Cost reduction	There is recognition that the budget is finite and needs to be managed equitably and rationally. However, there is also a perception that costs are reduced in a top-down manner, without explanation, and in a way that often makes it difficult to deliver quality of care, e.g. cutting of posts and other resources. Overall, people are not concerned about the financial sustainability of the organisation, as the government funds public health services.
Community involvement	Community health centres are effectively embedded in the community and their staff members interact with community members on a daily basis. However, community involvement in the organisation is not always experienced positively. Patients' expectations are sometimes detrimental to the smooth running of the community health centre, as well as to the care of other patients. There is a sense that accountability should extend to patients, and that they should be a part of the team to make the community health centre run as equitably and effectively as possible. There is scepticism about the effect of more community involvement in governance structures. There is a call for ongoing community involvement that emphasises patients' responsibilities, as well as their rights.
Confusion	A lack of clear direction results in inefficiency and frustration and is linked to poor communication with, and within, facilities.
Control	Decisions are made at the top. Even facility-level managers feel little sense of control. Top management members hold service providers accountable for the quality of service, and yet service providers have little sense of choice in or control over their work situation. This leads to a lack of ownership, accountability, innovation and creativity among staff. Fundamentally, there is a lack of trust in the relationships among staff and management members. There is a clear call for more shared decision-making and decentralisation of power. There is recognition that managers must make decisions, but a request was made for more input in these decisions and better communication.
Manipulation	Being simultaneously over-controlled, and yet blamed for poor quality of care or inadequate use of resources, makes staff members feel that they are being manipulated. This leads to a sense of disempowerment and distrust. There is a call for fairness in the system and for staff to only be held accountable for activities over which they have some choice and control.
Blame	Poor communication in an overly controlled environment leads to staff blaming top management when things go wrong and vice versa. Staff members feel that they are made to take responsibility for other people's mistakes or problems which may not be a result of their own actions or decisions. The call for accountability extends to staff members being held accountable for their performance and consequences for poor performance, as well as good performance (staff recognition). This also requires more openness and transparency about mistakes or problems.
Power	The culture of control, blame and manipulation makes people feel powerless. There is a call for more shared power in the organisation, so that people feel consulted and have some input in decisions and ownership pertaining to the organisational vision.
Hierarchy	This is closely connected to control, power, and not sharing information. The lower down in the hierarchy, the less informed staff feel, and the less input they have in decision-making. Power and status are a focus of people's interactions. There is a call for leadership development that embodies a different style of leadership, with more transparency, openness, shared decision-making, sharing of information and recognition of staff.
Long hours	Sometimes staff members are foarced to work longer hours than those for which they are contracted, but mostly staff perceive the hours to be long because of the intensity of the working environment. There is little space for breaks and a constant sense of working under pressure, with little choice or control. This leads to emotional exhaustion and burnout, as well as friction between colleagues, and with patients. There is a desire to become more professional, especially in relation to patients and to value the patient's experience. Improving the staff experience may make a contribution to enabling this.
Teamwork	Teamwork is seen as an essential survival mechanism to get through the day and the tremendous workload. Teamwork is regarded as an ongoing necessity.

White dots: limiting values, blue dots: positive values

Figure 2: Top values, plotted according to levels of organisational consciousness
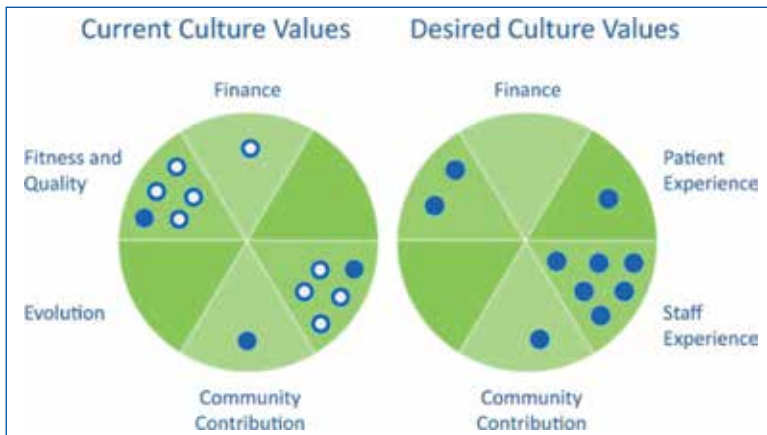
White dots: limiting values, blue dots: positive values

Figure 3: Organisational scorecard for current and desired culture

In the current organisational culture, values are concentrated at level 3: self-esteem (28% of all values), which reflects an organisational focus on performance, systems, processes, effectiveness and best practice. However, the overwhelming experience at this level is of values that limit organisational effectiveness. Values at level 1 (resources and safety, e.g. survival) as well as level 2 (relationships) are also largely limiting values.

In the desired organisational culture, values are concentrated at level 4: transformation (26% of all values) and level 5: internal cohesion (23% of all values), which reflects a desire to build internal community within the organisation and to focus more on renewal and development (see definitions in Table II). There is some alignment between the distribution of the group's personal values and the desired culture, indicating that people have the capacity to affect the changes that they are requesting. There is misalignment between both the distribution of personal values and desired culture with the current culture.

Figure 3 plots the top values according to the organisational scorecard for the current and desired organisation. In the current culture, the scorecard shows a positive focus on the organisation's community contribution, fitness and quality (results orientation), as well as staff experience (teamwork). However, this positive focus is overshadowed by negative values in the areas of fitness and quality, as well as the staff experience. In the current culture, there are no

positive values in the areas of finance, patient experience or evolution. In the desired culture, there is a concentration of positive values in the area representing the staff experience. Community contribution, fitness and quality remain important areas. There is a new focus on the patient's experience. In both the current culture and the desired culture, there are no positive values in the areas of finance or evolution.

Discussion

Strengths and weaknesses of the existing organisational culture

The strengths of the current organisation are that staff work together to make a difference to the communities served, and that they are orientated towards producing better results. The weaknesses of the current organisation are reflected in rigid and restricting internal structures. It is worrying that not sharing information is the top value, as poor flow of information increases confusion and reduces the ability of the organisation to adapt, transform and build internal cohesion. Although there is a strong emphasis on improving performance, the strategies to achieve this are experienced negatively as confusion, long hours and a management style characterised by power, hierarchy and control. Relationships in the organisation are undermined by a culture of blame and manipulation.

The Barrett Value Centre report on the survey comments that:

"Issues are impacting understanding and communication flow. People are working against one another for their own personal gain, rather than the good of the whole. They are overworked and overmanaged in an environment that emphasises short-sighted actions".

The picture that emerges is congruent with the critique of leadership and governance in the 2011 *South African Health Review:*[12]

"Together, these experiences clearly demonstrate that the organisational culture of the health system is strongly hierarchical, with decision-making dominated by command

and control approaches implemented through organisational silos (of directorates and units), in which management is traditionally seen as an administrative function, rather than a proactive process of enabling learning, and in which control is exercised in an authoritarian manner".

The scorecard reveals a lack of focus on evolution in both the current and the desired culture. Evolution refers to an organisational focus on the ability to innovate, experiment, create or evolve as an organisation. In the current culture, it may be that the command-and-control management style discourages staff from engaging with innovation at a local level, or that the long hours in service delivery leave little space for innovation. It is also worrying that staff members do not have a desire for a focus on evolution in the future.

Limitations of the study design

The study only included five CHCs from a total of 45, and these CHCs were purposefully selected depending on the willingness of family physicians to participate in the study. Although all four substructures were represented, there is a possibility of bias in the selection of CHCs. Of the five CHCs, one failed to produce an adequate sample of staff. However, results were analysed as a whole and CHCs were not compared. The sample represents a good cross-section of managerial and clinical staff. Support staff, such as the cleaners or security guards, were not well represented in the survey.

Implications for the required change of direction

There appears to be a need to continue focusing on improving performance, but to adopt a different management approach in order to achieve this. People are calling for an approach to performance built on accountability and professionalism, whereby people own their actions and strive for the highest standards and results. This requires a simultaneous change in the staff experience from an environment that is characterised by not sharing information, confusion, power, control, hierarchy, manipulation and blame, to one characterised by clear information, shared decision-making, teamwork, fairness, staff engagement and recognition. Long hours also feature as a barrier to improving the staff experience. The impact of the current organisational culture is clearly seen in a recent survey of burnout and depression among doctors at CHCs in the Metropole.[13] This survey found that 76% of doctors had high levels of burnout on the depersonalisation and emotional exhaustion scales. Also, 30% of doctors met the criteria for moderate to severe depression. Doctors reported that long hours, a heavy workload, poor working conditions and public system-related frustration were the main factors that contributed to their burnout.

A number of principles have been identified to help people build resilience in difficult circumstances.[14] These include the need to connect to the meaning in one's life, enhanced self-awareness of one's strengths and vulnerabilities, maintaining perspective and dealing with negative thoughts and feelings, developing a realistically optimistic outlook, being open-minded and flexible, and reaching out to others for support and help.

There is an expressed need, not only for a change in the organisational culture, but also for leadership development, which would presumably be required at all levels of the organisation.[15] As organisational culture is largely derived from the leadership and management, the call for leadership development is congruent with evidence for the need to transform the leadership as a perquisite for organisational change.[16]

There is also a synergy between the desire to focus more on the patient experience and the goal of Vision 2020 to be more patient-centred. The most critical aspect of improving the patient's experience is enhancing the quality of patient-provider interaction.[17] The ability to elicit and listen to the patient's problems, expectations and concerns requires qualities such as listening, trust, respect, caring and compassion. All of these qualities are evident in the personal values of the staff. The challenge is to create an organisational environment in which staff can bring these qualities to work and make them a reality. According to the Barrett Value Centre report, the top personal values of the staff were unusual in demonstrating a "deep appreciation for their connection with others". It is difficult for practitioners to manifest one set of values with patients while they experience a different set of values in the organisation.

Conclusion

The survey demonstrated that participants espouse personal values that are congruent with a move towards more patient-centred care. The majority of the top 10 organisational values were experienced as limiting, while levels of entropy suggest that more than a third of the available energy in the organisation was unproductive. Desired organisational values suggest the need for a shift towards a different organisational culture that is characterised by open communication, shared decision-making, accountability, staff recognition, leadership development and professionalism. Only teamwork and community involvement were listed among the top 10 values in both the current and the desired culture. Currently, none of the top 10 personal values were found in the top 10 current organisational values. The results support the need for transformation of the organisational culture and leadership development.

Competing interests

The authors declare that they have no competing interests.

Acknowledgements

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