Corporate culture as a factor of institutional development – empirical evidence from West Pomeranian healthcare

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Abstract

Strong corporate culture is a significant factor influencing the positive outcome of teamwork, and thereby the economic results of activities conducted by healthcare institutions. That is why the issues dealt with in the present article are very important from the perspective of institutional development, especially in the new-born democracies, as those in Baltic Sea Region. They are described by intensive privatisation of existent healthcare providers, emerging new non-public healthcare organizations and changing role of patients.

This paper presents a methodology for identifying and describing corporate culture in healthcare in West Pomeranian Region in Poland. The presented paper is based on preliminary research conducted on 126 healthcare providers located in West Pomeranian Region. It aims mainly at:

(1) determining the relative importance of attributes associated with corporate culture in healthcare providers both in public and private sector,
(2) identifying and describing the differences between public and private healthcare providers in respect of corporate culture,
(3) demonstrating the application of research findings in the healthcare in Baltic Sea Region.

In order to answer the above-stated inquiry, a variance analysis (ANOVA) was used, wherein the argument is the status of a (public, non-public) healthcare institution. The equality of averages was verified in distributions conditioned by the categories of the controlled factors. The conducted calculations made it possible to quantify the significant differences between public and non-public institutions for a number of factors describing organizational culture. In the paper we apply Rousseau's organizational culture subscale.

The research findings let draw the conclusion that in the newly created competitive environment in which healthcare providers now operate developing strong corporate culture is essential, not only to protect existing patient lists and

refrain quitting brilliant professionals, but also to attract prospective customers and employees. The empirical research demonstrates that the status of a healthcare institution accounts for the differences in the organizational culture in the presented types of institutions. Conditions for developing values through organizational culture are more conducive in non-public institutions. This applies to the sphere of interpersonal relations both between the subordinates and the superiors, and among the members of a therapeutic team. The paper contributes also to the discussion referring differences between public and private healthcare providers and their efficiency.

The outcome of the study creates a reliable representation of differences in organizational culture and, at the same time, challenges the widespread claims of the alleged superiority of non-public institutions stemming solely from higher salaries. Generally speaking, it can be stated that bodies representing the non-public sector –considering their attitude to employees – are better adjusted to the demands of competition in the health services market.

Keywords: institutional development, healthcare sector, corporate culture, Baltic Sea Region, ANOVA.

Reforming healthcare sectors in CEE

Health care sectors in Central and Eastern European (CEE) countries have historically been based on a variant of the Beveridge model known as the Siemaszko model (Saltman et. al. 1998, p. 5). A number of countries in this group have implemented a partial changeover to a social insurance-based systems inspired by the Bismarck model (Czech Republic, Hungary, Slovenia, Poland) A few are attempting to implement contracting between third-party payers and providers in the context of their newly established health insurance systems. Many of the issues surrounding the contractual arrangements between insurers and providers heave yet to be worked out. Countries which have implemented contracting through a purchase-provider split include, except Poland, Bulgaria, the Czech Republic, Estonia, Hungary and Romania.

Reforms in health care sector in above mentioned countries can be seen as a part of political change in the post-1989 era. The pressure of reforms escalated while the health spending as a proportion of GDP became to grow. This was obvious in the Czech Republic, where the total health expenditure as percentage of GDP rose form 4,6 per cent in 1987 to 7,8 per cent in 1994, while similar trends were observed in Hungary, Lithuania, Slovakia, Slovenia and less so in Bulgaria and Romania. Most countries in this part of the region suffered from excess capacity in terms of hospital beds and physicians per capita. The number of doctors per 1000 population in Latvia, Lithuania and Ukraine, for instance, was higher than in any EU country reaching the rate 4,3, 4,3 and 4,5 respectively in 1992 (OECD 2004, p. 253). Thus, the deep structural changes were in need.

The main topics on the reform agenda in CEE countries were as follows:

- encouraging decentralized management,
- exerting more control over the performance of health care providers,
- improving planning of health care development,
- improving management of care,
- encouraging local choice over health care.

The first issue was of particular importance for CEE countries where financial resources available to health sector depended on administrative division and central planning. The decentralized management enabled thus the bounding the providers by contractual provisions in terms of the outcomes rather than inputs for performance. Providers received

some level of autonomy to decide, within adequate rules and regulations, on the size, bed capacity and other work characteristics.

The second change refers to the fact that contracting should be based on monitoring and evaluation with special emphasis on performance indicators. This seems particular difficult to introduce in CEE countries, mainly due to lack or shortage of information systems.

The next issue could help solve the problem referring mismatch of health care objectives by previous planning systems. The rationale for using contracting as a planning tool is that, it provides a direct link between planning and resource allocation, as providers become economically motivated to follow the planning strategy embodied in contractual arrangements (Saltman, et. al. 1998, p. 26).

Improvement of management of care seemed to be very important to CEE countries. Decades of bureaucratic control over these health systems have caused substantial distortions of health care provision structure (for example, in-patient care expenditures in the Russian Federation amount to around 70 per cent of health expenditures against the OECD average of 44 per cent for hospitals and 55 per cent for hospitals plus long-term care (OECD 2004, p. 123).

The consumer sovereignty and choice in the health sector is the next important issue. The choice of hospital and physician gives individuals the ability to influence the provision of service. Introducing contracting systems to the health sectors of CEE countries encouraged competition among providers, which generates some choice for patients.

The experience of CEE countries can provide useful lessons for western European countries, since CEE countries introduced market-based reforms faster and in more radical forms. For example, the laissez-faire approach of the Czech Republic is an important experiment not too different to the situation in the US. In both cases, the operations of the competitive health insurance system become extremely expensive. This case illustrates well the crucial importance of using needs assessment as the basis of prospective financing as well as using global budgeting. After several years of health care reforms in CEE countries, the key question is about health economics in a wider sense. Policy making and its subsequent implementation is a considerably more complex issue than the transfer of paradigm applied since long time to western countries.

The health care sector in Poland – institutional approach

In the last decade Poland has re-examined the structure of governance in its health system. There are many health sector challenges that have played a significant role in triggering the current wave of reform. In addition to demographic, political and social factors, the key contextual pressure is the increased expectations of citizens and patients. Poles, parallel to citizens in all parts of Europe, are demanding a more patient-oriented approach to the delivery of health care services. Patients have strong views on the need for choice and quality in healthcare, often back up these demands with out-of-pocket payments to providers.

A number of market-style mechanisms have been introduced within different fields of the health system: in health care funding, in many sub-sets of the production of health services (e.g. hospitals, primary health care, in the allocation mechanisms). The Government's reform of health care provision in 1999 was designed to give patients a choice in the service available to them by introducing a competitive structure into health care sector. This type of publicly planned market, which has been termed as internal market, public competition or quasi-market (Saltman et. al. 1998, p. 159), involves the separation of purchaser form provider through the use of negotiated contracts. An accompanying trend reflecting the changing role of the state has been development of new methods and forms of funding and reducing the share of budgetary funds in the funding of health care (Piotrowska-Marczak, Kietlinska 2001, p. 281-293). A second accompanying trend has been decentralization of responsibility to lover levels within public sector. Finally, the growing focus on micro-level institutional activities has generated increased concern about the quality of the relations formed with patients. The rationale behind this reform and reforms prosecuted in other countries is that health care providers will have a greater incentive to satisfy their patients if a larger proportion of their income is attributable to the total number of patients on their lists (Gabbott and Hogg 1993, p. 57-64).

In the currently functioning health care system the function of the main payer has been entrusted with National Health Fund established on 1st April 2003. The Fund has replaced the health care units (kasy chorych) functioning since 1999 pursuant to the Act of 6th February 1997. the core of the project entailed institutional separation of the payer as an entity responsible for purchasing of health care form service providers that would satisfy the reported health care demand. The purchase of services is, however, one of the final stages of realization of the functions entrusted with the payer (Czepulis-Rutkowska 2002, p. 4). The National Health Fund und previous health care units, in order to make a decision as to allocation of funds coming from insurance contributions – should, along the way, fulfill the tasks related to the identification of health care demand of the insurers and inhabitants in the sixteen Polish regions. They should plan the ways of securing the demand, contract the services allowing the realization of the identification of identified demand, finance the service providers and control the execution of the concluded contracts. While executing their tasks, the managing bodies of the National Health Fund and its sixteen territorial units should get the answers to the questions what services, how much of them, with which service providers and for what price they should purchase. Monitoring of contracts realization may, on the other hand, provide information that will constitute basis for at least partial assessment of the accuracy of the decisions made, and for sure – allows for supervision over the provided services quality.

At the initial stage of the common health insurance functioning, the hope for a change in the institution was aroused by the Act on Common Health Insurance [1], that provided in the initial wording, that stating form 1 January 2002 people subjected to the common health insurance will be able to fulfill their duty not only with the public health care units (at present National Health Fund) but also other institutions for health insurance that will operate based on separate regulations as to insurance activates. However, due to the Act's update of November 2000[2], the hope has perished or at least has been deferred far in the future.

As a consequence of the above mentioned trends health care providers are under mounting pressure to increase access, lower costs, and raise quality. They have employed many tactics, form designing new services to entering alliances. But the fundamental key to institutional development of regional healthcare organizations is developing strong corporate culture.

Corporate culture defined

A large number of definitions have been proposed for the concept of culture in the organizational setting (Wilson 1997, p. 87). Some of these draw directly on definitions from anthropology and the other root disciplines. Others are specific to the corporate sector. The most common understanding of the corporate culture states that it is a learned product of group experience and is, therefore only to be found where there is a definable group with a significant history. The majority of authors (such as Wilkins, Ouchi, Tichy) believe that there are two aspects of culture: the visible level and the deeper, less visible level. The visible level relates to the physical and social environment, behaviour patterns, and the written and spoken language used by the group. The deeper, less visible aspect of culture refers to the group's values. The shared values consist of the aims and concerns that shape a group's sense of what "ought" to be (Wilson 1997, p. 88).

In the healthcare sector, special attention should be paid to such internal functions of organizational culture as satisfying the needs for safety and affiliation, determining the criteria for rewarding and disciplining, or defining group boundaries. Significance of the above is dictated by the fact that healthcare staff spends a lot of time at work and, being predominantly representatives of the medical profession, they value work ethics highly. Moreover, it can be

[1] Act of 6th February 1997 on Common Health Insurance (Journal of Laws No. 28, Item 153, Article 4a).

[2] Art. 1 Item 2 of the Act of 30th November 2000 on Amending of the Act on Common Health Insurance (Journal of Laws No. 122, Item 1311).

stated that medical professions, both in the eyes of their representatives and in the general public perception, bear the stigma of service and mission. Hence, performing such professions is to a large extent non-financially motivated. Disregarding the ever-popular public perception of the model of a good doctor (fashioned after the literary character of Dr. Judym), medical professionals are expected to assume an aid-oriented attitude toward the unwell, regardless of the degree of financial motivation involved. That is why the issues dealt with in the present article, namely those of organizational culture in healthcare institutions in the era of system reforms described mainly in terms of *"the rationalization of activities"*, are an interesting and attention-worthy subject.

Research methodology

The primary research focused on the regional (West Pomeranian) healthcare sector. In order to obtain a sample suitable for testing the effect of organizational culture, 126 healthcare units were selected to take part in the research, 50 of these were public and 76 – non-public West Pomeranian healthcare outlets. The structure of research sample is shown in table 1.

Table 1. The structure of research sample

Characteristics	Percentage of healthcare providers taking part in the research
Legal status of the provider:	
- public (SPZOZ)	44%
- non-public (NZOZ)	56%
Owner of the healthcare provider (refers only SPZOZ):	
- regional government	86%
- state government (MZ, MSWiA, MON)	11%
- Academy of Medicine	3%
Basic kind of activity:	
- general practitioners	45%
- specialists of ambulatory healthcare	35%
- hospitals	13%
- rehabilitations and sanatoriums	5%
- laboratories	2%
Location:	
- cities	36%
- towns, districts	50%
- municipalities, parishes	14%

Source: primary research.

A research instrument to measure items of corporate culture was developed following the classification of cultural subscales by D. Rousseau's (Rousseau 1990, p. 157) as follows:

1. task-related values and behaviours:
 - Clear distribution of roles and understanding thereof
- A customer orientation
2. Interpersonal values and behaviours:
- Supporting the activities of medical personnel by the management"
- Good atmosphere in the team (team spirit)
- Compatibility of management's requirements with the staff's preferences
- Personnel integration outside work
3. Individual values and behaviours:
- The sense of security at work
- Professional satisfaction
- Work commitment

The above components were attached to a six-point Likert scale on which respondents had to indicate the frequency with which certain behaviours or attitudes occurred.

The research goal was to determine the inter-group (public versus non-public healthcare units) significant differences related to organizational culture. The differences between organizations

were explored at the significance of 95 per cent level. The returns were analyzed using Statistica software.

The findings

In order to answer the above-stated inquiry, a factor analysis and a variance analysis (ANOVA) ware used, wherein the argument is the status of a (public, non-public) healthcare institution. There were five factors distinguished in the factor analysis. They had the following own values: 3,6 (factor No. 1), 0,4 (factor No. 2), 0,2 (factor No. 3), 0,15 (factor No. 4) and 0,05 (factor No. 5). According to osypisko chart (chart 1) we can assume that osypisko starts with factor No. 2. It suggests there is only one factor e.g. factor No. 1 that should be analysed. Factor No. 1 named "corporate culture" represents fast 40% of general variance described by set of nine items. Therefore, we can assume that there is one latent factor in the background of organizational culture of healthcare providers. It explains the correlations between controlled factors.

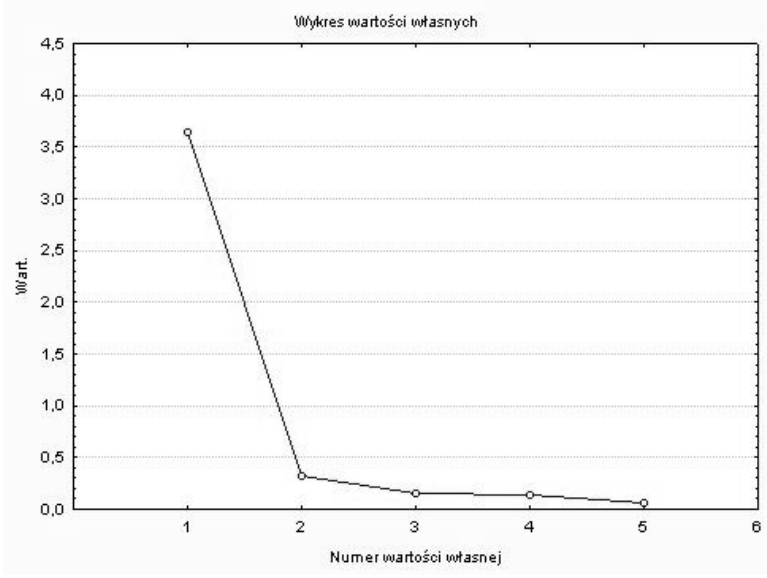

Chart 1. Osypisko chart – own values for factors No. 1-5.
Source: own study based on the printout from the *Statistica 6.0*.

Variance analysis indicates the significant variables in factor loadings dedicated to factor "corporate culture" in groups classified according to healthcare provider status ($F=13,9805$, $p=0,0002$). Correlation analysis (table 2) shows that there are negative correlations between factors and starting variables related to corporate culture level. Therefore, the higher factor loadings, the worse indications for the respective subscales od organizational culture [3].

Table 2. Factor loadings for factor number 1 and correlation coefficients (corporate culture level)

Items	Factor 1	Correlation coefficient
H	-0,590436	-0,63
I	-0,086781	-0,09
J	-0,738658	-0,78

[3] It does not refer to variable I, because there is no correlation between factor loading and level of this variable.

K	-0,777489	-0,83
L	-0,785174	-0,83
M	-0,491811	-0,52
N	-0,725664	-0,77
O	-0,760130	-0,81
P	-0,412096	-0,44
Start value	3,638835	
Cover	0,404315	

Source: own study based on the printout from the *Statistica 6.0.*

Based on above information and the chart of average ratings (chart 2) we can state that, corporate culture of non-public healthcare providers is higher than that of public ones.

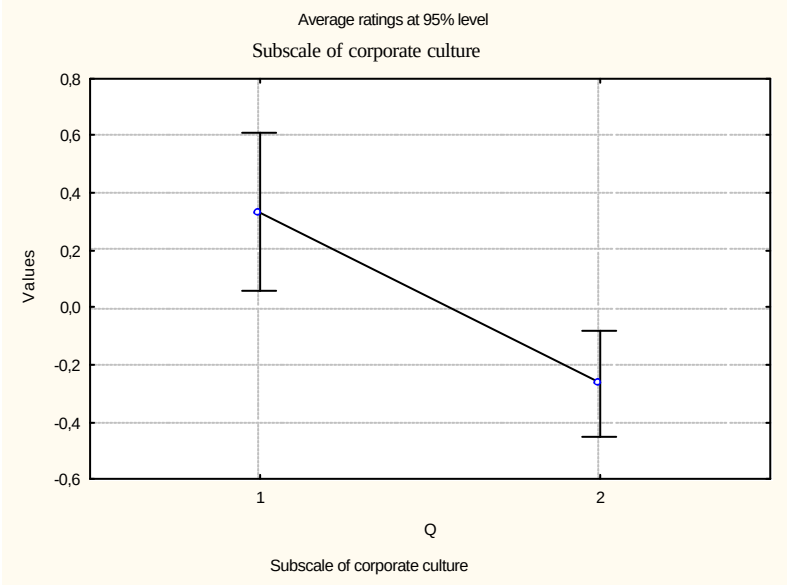

Chart 2. Average ratings of corporate culture of public and non-public healthcare providers
Source: own study based on the printout from the *Statistica 6.0.*

In the next step of the research the deeper ANOVA was conducted. The equality of averages was verified in distributions conditioned by the categories of the controlled factors. The conducted calculations made it possible to quantify the significant differences between public and non-public institutions for a number of factors describing organizational culture.

Table 3. Results of ANOVA on subscales – differences between public and non-public healthcare organizations

Subscale of corporate culture	F ratio	Significance of F	Average ratings for public units (SPZOZ) $\overline{X}_1$	Average ratings for non-public units (NZOZ) $\overline{X}_2$
H. Clear distribution of roles and understanding thereof	**4,7239**	**0,0316**	3,911	4,286
I. Patient is treated as a client (a customer orientation)	2,3668	0,1264	3,446	3,786
J. Supporting the activities of medical personnel by the management"	**14,8307**	**0,001**	3,179	4,029
K. Good atmosphere in the team	**5,8046**	**0,0174**	3,643	4,086
L. Compatibility of	**11,5822**	**0,007**	3,179	3,871

management's requirements with the staff's preferences				
M. Personnel integration outside work	**4,1104**	**0,042**	2,607	2,929
N. The sense of security at work	1,8073	0,1801	3,214	3,457
O. Professional satisfaction".	**6,9595**	**0,0094**	3,482	4,014
P. Work commitment	0,7386	0,3917	4,643	4,534

Source: own study based on the printout from the *Statistica 6.0*.

Based on table 3, it can be concluded that statistically significant inter-group differences exist for all variables (subscales of organizational culture) apart from the variables I, N and P, whereas the averages in subgroup cross-sections (SPZOZ, NZOZ) occur in each case in favour of non-public healthcare institutions. The most pronounced differences occur for the variables: "Supporting the activities of medical personnel by the management", "Compatibility of management's requirements with the staff's preferences" and "Professional satisfaction".

Discussion

Strong organizational culture – as proven in theoretical and empirical studies (Wilson 1997, s. 87-99) – is a significant factor influencing the positive outcome of teamwork, and thereby – the economic results of activities conducted by healthcare institutions. The most important spheres affected by organizational culture include improving quality standards of services provided, facilitating cooperation, inspiring patients' trust in personnel, facilitating team communication, stimulating a good atmosphere among the employees (Sierpinska and Ksykiewicz-Dorota 2001, p. 308).

Considering the system reform affecting the Polish health sector, of particular importance is the influence of organizational culture on the quality of health services and the work efficiency of medical personnel. Research into issues similar to those tackled in the present article, yet conducted on American hospitals, has shown that work efficiency in wards and understanding of high quality of care are related to the good management of team conflicts, including communication skills, problem-solving skills and providing adequate information to patients (Shortell and Kaluzny 2001, p. 417). Such an organizational culture, through the participation of staff in a team and stimulating their involvement, contributes to a value increase in the patient-healthcare employee relationship.

The application of D. Rousseau's organizational culture subscale in the research has made it possible to capture the significance of three elementary groups of values: task-oriented, interpersonal and individual.

The subscales (organizational culture signifiers) listed in table 3 are quality-oriented and relate both to work in a therapeutic team and to individual attitudes and actions of the organization's members. Their significance – as indicated in the introduction – in the healthcare sector seems particularly valuable, mainly because of the attitudes of medical staff that surpass purely financial motivations. It must be remembered that the incentive in the form of remuneration is an exogenous stimulus and as such, it is frequently not as effective as internal motivation, and moreover, it can lead to the erosion of the latter (Klich 2004, p. 16). In turn, internal incentives (variables J-P) are of a more permanent nature and bring long-term results. Although they cannot be regarded as rewards, their strength relies on the needs and preferences of the internal client, as one can undoubtedly regard employees of any organization. Recognition thereof should be the starting point of the process of internal marketing. Making it possible for the employees of healthcare institutions to articulate their preferences and then allowing for those preferences in everyday work is one way of constructing strong organizational culture. Long-term modelling of employee attitudes and behaviours aimed at achieving better results in managing the limited resources allocated to healthcare is only feasible when the employees themselves are actively involved. Contrary to external incentives which exert their influence only when a given instrument (such as a reward or punishment) is active, stimuli aimed at inspiring a sense of security at work, creating a climate of intimacy and open communication help to develop a bond with the employer. The importance of this element cannot be ignored

especially in the professional services sector, where the doctor's reputation frequently leads to a transfer of patients when a given professional changes employers.

The primary research conducted on the cross-sections of descriptive statistics (average values in subgroups SPZOZ and NZOZ) demonstrated that the conditions for developing values through organizational culture are more conducive in non-public institutions. This applies to the sphere of interpersonal relations both between the subordinates and the superiors, and among the members of a therapeutic team. In non-public institutions, the average marks concerning the relationships based on the professional hierarchy (variables: "Clear distribution of roles and understanding thereof", "Compatibility of management's requirements with the staff's preferences", "Supporting the activities of medical personnel by the management") were higher than those obtained by public institutions. Similar results – in favour of non-public institutions – were obtained when evaluating team atmosphere and the willingness for team building outside work (variables: "Good atmosphere in the team", "Personnel integration outside work"). Developing social bonds, apart from its incentive function, is an important ingredient of creating a value-oriented relationship with clients (here: patients), particularly through raising the functional value of health service processes. Numerous empirical studies (Klich, p. 18) demonstrate that such characteristics of medical personnel as: empathy towards patients, interpersonal and communication skills, friendliness, politeness, commitment, readiness to help or respect of the patient's intimacy, are the most appreciated by patients.

The presented research demonstrates unambiguously that professional satisfaction of medical staff employed in non-public healthcare institutions is higher than that experienced by the personnel of public institutions. This issue stretches far beyond the remuneration system based on an employment contract. It also involves the rewarding system, career planning, professional training, and academic development, building social relations or developing a sense of work stability. In the case of the latter, there were no statistically significant differences between the analyzed institutional subgroups. With regard to the variable "The sense of security at work", although a higher average was noted for non-public institutions, still, compared with the institutions from the public sector, it was not a noteworthy difference. Special attention should be given to the fact that the subscale of "Work commitment" – without statistically significant inter-group differences – was the only case in the entire study to demonstrate a slightly higher average for public institutions over their non-public counterparts. Therefore, it can be concluded that there is a big potential resting in medical staff which can be activated on condition that appropriate incentives are used. At the same time, it means that organizational culture and its components cannot be manipulated in a conventional manner but quite the contrary – they require pinpoint adjustment to the sub-sectoral characteristics.

Final conclusions

Taking into account the unique feature of the health sector of inducing the demand through the supply, the patient-service provider relationship is shaped overwhelmingly by the supply side. How this relationship develops in the health sector depends not only on external factors (such as the legal system, amount of public spending on health, degree of liberalization of the healthcare system), but also on the form of organizational culture in a given healthcare institution and on the incentive system motivating service providers to work effectively. Strong culture is conducive to the effective functioning of an organization through facilitating communication, a more effective decision-making process and the implementation of solutions – the employees who share certain values reach a consensus faster. Creating community bonds and instilling organizational standards and values in the employees direct and stimulate personnel activity, thereby reducing the significance of formal strategies for ensuring conformity of this activity and the organization's goals.

Secondly, strong organizational culture imbues its members with the feeling of affiliation and identification, which is conducive to developing loyalty towards the employer and, thereby, its effective operations. An adequate incentive system for medical service providers linked to the system of values created and fostered in the organization makes not just for realizing their missions, but also affects the efficiency of the health services market. This is because the level

of competitiveness among the service providers is closely linked to the degree of their motivation to act effectively. Effective operations, in turn, are a decisive factor affecting the relationship built between service providers and patients.

The empirical research demonstrates that the status of a healthcare institution accounts for the differences in the organizational culture in the presented types of institutions. Besides, it is worth highlighting that the interviews were conducted only with those employees who were employed in a given institution on their first employment contract, which basically reduced the odds of mutual "permeation" of professional experiences from the two types of institutions at the same time. The outcome of the study, therefore, creates a reliable representation of differences in organizational culture and, at the same time, challenges the widespread claims of the alleged superiority of non-public institutions stemming solely from higher salaries. Generally speaking, it can be stated that bodies representing the non-public sector –considering their attitude to employees – are better adjusted to the demands of competition in the health services market. They seem to appreciate the interdependence between patient satisfaction and employee satisfaction. Adopting this simple rule is hard to accept for the majority of the public entities involved in the study.

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