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IMPACT OF ORGANIZATIONAL CULTURE OF PRIMARY HEALTH CARE CENTERS ON PERFORMANCE IN A SELECT DISTRICT OF TELANGANA STATE

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ABSTRACT

Objective: To review the evidence for a relationship between organisational culture and primary health care centers' performance in select district of Telangana state

Methods: single factor anova was used

Reviews: Ten studies met the inclusion criteria. There was considerable variation in the design, study setting, quality of reporting and aspects of culture/ performance considered. Four of the ten studies reviewed in detail claimed to have uncovered supportive evidence for the hypothesis that culture and performance are linked. All the other studies failed to link, though none provided strong evidence against the hypothesis.

Conclusions: There is some evidence to suggest that organisational culture is a relevant factor in



primary health care centers' performance, yet articulating the nature of that relationship proves difficult. Simple relationships such as 'strong culture leads to good performance' are not supported. Instead, the evidence suggests a more contingent relationship, in that those aspects of performance valued within different cultures may be enhanced within organisations that exhibit those cultural traits both 'culture' and 'performance' as variables that are conceptually and practically distinct.

KEYWORDS:organisatio

nal culture , primary health care , organizational performance.

INTRODUCTION –

The notion that organisational culture can affect primary health care centres performance rests upon certain assumptions: that primary health care centres, units or work groups have identifiable cultures; that culture is related to performance; that a culture can be altered to impact on performance; that the intervention will provide a worthwhile return on investment; and that it will outweigh any dysfunctional consequences. Thus, a link between culture-

based interventions and improved organizational performance is contingent on a chain of assumptions of uncertain strength or validity. In this area, we wanted to know if any reliable evidence could be found to suggest that aspects of primary health care centres cultures are related in significant ways to aspects of their performance.

DEFINITION OF ORGANISATIONAL CULTURE

In order to interpret evidence of a link between organizational culture and organisational performance, we need an appropriate theoretical framework. Organisational culture is an anthropological metaphor, one of many used to inform research and consultancy in organisations. It is related to – but conceptually distinct from – organisational climate (a

meteorological metaphor). Although culture and climate have much in common, and are often used with unclear delineation, culture attempts to address deeper values and assumptions rather than the surface perceptions that are the focus of climate studies. Organisational culture also emphasizes that which is shared by group members rather than the diversity of individual perceptions that can make up climate. The key methodological principle in studies of organisational culture is to investigate organisations as mini-societies. A plethora of definitions of organizational culture can be found in the literature. Most of these definitions implicitly recognise the socially constructed nature of the phenomenon, locate its generation in pervasive, normative beliefs and values, and see its expression in terms of patterns of behaviour. However, arguably what distinguishes one culture from another is the vast pool of tacit knowledge, which natives understand, but are not conscious of knowing. Culture, therefore, is not merely the observable in social life; it is also the shared cognitive and symbolic context within which a society can be understood. One cannot safely interpret any aspect of a foreign culture abstracted from that tacit knowledge, which is, therefore, the heart of the matter.

DEFINING PERFORMANCE

Defining performance presents further problems, as there exists, for any organisation, a range of possible measures. This is true especially of primary health care centres, with measures of clinical process, health outcomes, access, efficiency, productivity and employee variables all offering some potential. In addition, different channels of communication may convey different performance information. The essential ambiguity of performance arises from three main senses of the nature of 'performance': performance as enacted behaviour, relating to socio-technical processes of care; performance measured in terms of end-points or outcomes; and performance as a dramatic event. Each of these meanings tends to invoke the other two, as befits the nature of signification in general. A surgical procedure, for instance, implies both a technical performance and a desired outcome, as well as entailing aspects of dramatic production and presentation (e.g. from whose perspective is success or failure determined?). A consultant's ward round is a ceremonial vehicle for demonstrating important social and technical competencies, including diagnostic skill, communication, therapeutic knowledge and learning. Finally, performance data – whether relating to waiting times, medical errors are a series of socio-technical processes. The use of such data calls for skills in the timing and presentation to target audiences, often with the aim of persuading or otherwise influencing behaviour. Armed with this understanding of the complexity of 'performance', we approached the empirical literature with open minds, prepared to classify specific definitions of performance or revise the framework as necessary.

RELATING CULTURE AND PERFORMANCE

Much work outside primary health care has attempted to make linkages between organisational culture and subsequent organisational performance. Several populist texts of the 1980s expounded these links. For example, Peters and Waterman claimed to have uncovered the corporate cultural characteristics leading to 'excellence'. Ouchi and Wilkins sought to explain links between culture and productivity, and various authors argued for the importance of 'strong cultures' as a way of ensuring high corporate performance. This 'excellence' literature has, however, not been without its critics. These have called attention to the unsubstantiated assumption of a unitary culture that underlies such work, the lack of an operational definition of cultural 'strength' and the weak methodologies employed in the original empirical work. A review of more recent studies came to somewhat more cautious conclusions about any culture–performance relationships.

Wilderom et al. reviewed ten major quantitative studies (seemingly the major empirical/quantitative culture–performance studies to date) in an attempt to substantiate the culture–performance link. Nine of these ten studies, carried out purported to end associations between cultural characteristics and both short- and long-term performance. Yet in collating the evidence, the review's authors draw attention to the diverse methodological difficulties that preclude the drawing of strong conclusions supporting such a link as causal (not least of which are the issues noted above about the ambiguity surrounding both culture and performance).

OBJECTIVES

- 1.To examine the behavior of patients towards primary health care centres.
- 2.To examine the values of primary healthcare centre
- 3.To assess the performance of employees of primary healthcare centres.

RESEARCH METHODOLOGY

Data is collected from primary sources through structured questionnaire.

Sample :14 primary healthcare centres on random basis in Warangal distinct were selected

Sample size: The questionnaire was supplied to the staff of PHCs excluding Ayush staff. The questionnaire was based on Likert five point scale. Out of which 100 employees responded.

Statistical tool: anova single factor was used to analyse the data.

TABLE 1 THE FOLLOWING TABLE SHOWS THE BEHAVIOUR OF PATIENTS TOWARDS PRIMARY HEALTHCARE CENTRES.

	strongly disagree	disagree	moderate	agree	strongly agree	Total
work of PHCs	25	15	20	35	5	100
promptness	12	15	23	30	20	100
quality of nursing care	17	13	40	18	12	100
quality of medical care	16	11	40	13	20	100

Anova: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
strongly disagree	4	70	17.5	29.66667
disagree	4	54	13.5	3.66667
moderate	4	123	30.75	115.5833
agree	4	96	24	104.6667
strongly agree	4	57	14.25	52.25

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	852.5	4	213.125	3.484332	0.033393541	3.055568
Within Groups	917.5	15	61.16667			
Total	1770	19				

From the above table it can be understood that F value is greater than F critic value ,hence the null hypothesis is rejected. Hence we can draw the inference that there is impact of behaviour of patients on healthcare centres.

TABLE 2:THE FOLLOWING TABLE SHOWS THAT THE VALUES OF PRIMARY HEALTHCARE CENTRES INFLUENCING PRIMARY HEALTHCARE CENTRES

	Strongly Disagree	Disagree	Moderate	Agree	strongly agree
Employee commitment	15	16	18	23	28
satisfaction	35	23	27	15	0
consistency	25	32	23	5	15
resource allocation	10	20	15	45	10
adaptability	15	45	10	15	15

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Strongly Disagree	4	85	21.25	122.9167
Disagree	4	91	22.75	46.25
Moderate	4	83	20.75	28.25
Agree	4	88	22	289.3333
strongly agree	4	53	13.25	135.5833

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	237	4	59.25	0.476031	0.752823597	3.055568
Within Groups	1867	15	124.4667			
Total	2104	19				

From the above table we can draw the inference that F value is less than F critic value. Hence the null hypothesis is accepted. The values of primary healthcare centres have significant impact on performance of organizational culture

TABLE 3;THE FOLLOWING TABLE SHOWS THE IMPACT OF SUPERVISION ON PERFORMANCE OF PRIMARY HEALTHCARE CENTRES

	strongly agree	dis disagree	moderate	agree	strongly agree
Community Health Officers	5	17	25	28	25
Pharmaists	15	31	22	15	17
Health supervisors	11	39	12	11	27
Lab Technicians	13	27	10	17	33

Anova: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Column 1	4	44	11	18.6666
Column 2	4	114	28.5	7
Column 3	4	69	17.25	83.6666
Column 4	4	71	17.75	54.25
Column 5	4	102	25.5	52.9166
				7
				43.6666
				7

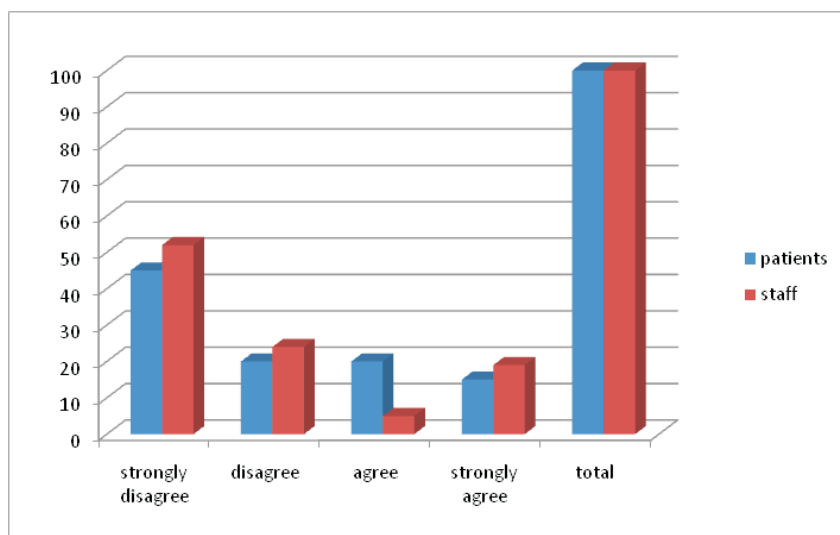
ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	784.5	4	196.125	3.87343	0.02351330	3.05556
Within Groups	759.5	15	50.6333	6	1	8
Total	1544	19	3			

From the above table we can draw the inference that F value is greater than F critical value. Hence the null hypothesis is rejected. The supervision of primary healthcare centres have significant impact on performance of organizational culture

TABLE 4: IMPACT OF PERFORMANCE OF PRIMARY HEALTHCARE CENTRES ON ORGANISATIONAL CULTURE

	strongly disagree	disagree	agree	strongly agree	Total
patients	45	20	20	15	100
staff	52	24	5	19	100



From above table we can observe that performance affects organizational culture .65% patients and 76% staff agree that performance affects organizational culture positively

CONCLUSIONS

From the above tables it can be concluded that the performance of employees of has a direct impact on the organizational culture. The impact factors are work culture of the staff of primary healthcare centres, promptness of the staff of the PHCs, quality of nursing care and medical care impact the patients to be attracted towards PHCs.

The values that impact organizational culture are employee commitment satisfaction, consistency, resource allocation, adaptability. Resource allocation has to improve as there are vacancies to be filled in order to have to maximum impact.

The supervision of the medical officers in PHCs plays a pivotal role in the development of work culture and thereby organizational culture.

Its observed that there has been a significant impact on organizational culture

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