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The Rights and Wrongs, Ups and Downs, and Ins and Outs of Organisational Cultures in Australian Public Hospitals

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Introduction: Exploring Organisational Culture in Healthcare

For many scholars, organisational culture centrally involves the shared behaviours, values, and attitudes of meso and macro work groups (e.g., Schein, 2004). Over the past three decades, interest in organisational cultures in healthcare has flourished (Davies et al., 2000; Braithwaite et al., 2010c), and it is increasingly recognised as an important mediating influence on quality improvement and patient outcomes (Mannion & Davies, 2018). A recent systematic review showed that among 62 studies, 74%

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reported a consistent positive association between organisational and workplace cultures and patient outcomes (Braithwaite et al., 2017). For example, an organisational culture characterised as more supportive, trusting, and inclusive is likely to be associated with increased patient satisfaction and lower mortality rates (Braithwaite et al., 2017). Another review found evidence that hospitals with lower hospital-acquired infection rates tended to have a positive safety culture, generative leadership styles, embraced innovation, engaged and empowered staff, and enhanced collaboration and communication (van Buijtene & Foster, 2019).

These reviews broadly reflect a view of organisational culture as something a hospital *has,* but even when treated as something an organisation *does*, its important role in patient outcomes is still clear. For example, Weick and Sutcliffe's (2003) analysis of the Bristol Royal Infirmary disaster demonstrated how 'small actions can enact a social structure that keeps the organisation entrapped in cycles of behavior that preclude improvement' (p. 74), and which ultimately contributed to the deaths of multiple babies. Staff at the hospital engaged in behavioural commitment, rationalising the poor performance of the paediatric cardiac surgery unit as a result of case severity rather than any failings on their part.

There are many methods to assess organisational cultures; however, self-report surveys are by far the most common in healthcare, particularly those focusing on the assessment of safety culture as a subset of organisational culture (Jung et al., 2009; Halligan & Zecevic, 2011). Surveys have the advantage of being cost-effective, quick, and straightforward to administer at scale (Tucker et al., 1990), making them highly suited for use in large hospitals. Quantitative data obtained from surveys can be aggregated to look at the attitudes of staff or subsets of them across a whole health system, or used to compare different organisations, professional groups, or wards within a hospital, and provide insights into where differences may lie (Yauch & Steudel, 2003). In that way, survey data can give an indication of how fragmented, differentiated or integrated the culture of an organisation or system is (Davies et al., 2000; Martin, 2001; Martin, 1992). Collecting data over time also enables the tracking of improvements and measuring the effectiveness of culture change interventions (Nieva & Sorra, 2003; Morello et al., 2013). The Agency for Healthcare Research and Quality (AHRQ), as an example, developed the

Hospital Survey on Patient Safety Culture and runs a comparative database where hospitals in the United States can deposit their survey data and receive a report in return that compares their data to the entire database, providing both cross-sectional, snapshot information and trend data over time (AHRQ, 2019).

Theoretically, in attempting to understand and study organisational culture in healthcare, researchers often make a distinction between organisational *culture* and organisational *climate* (Braithwaite et al., 2010c). The latter is thought to involve peoples' *perceptions* of their organisation (i.e., its procedures, practices, and the kinds of behaviour that are tolerated or rewarded), whereas culture is considered by many scholars to operate on a deeper, more enduring level, representing the underlying, sometimes unconscious, beliefs and values enmeshed within an organisation (Flin et al., 2006). However, others in the field use the terms 'culture' and 'climate' interchangeably (Cox & Flin, 1998). Van den Berg and Wilderom (2004) argue that these variations in nomenclature reflect different research paradigms with organisational culture having more sociological, qualitative, and social constructionist origins, while climate hails from a psychological and quantitative tradition, and hence aligns more with survey research. We appreciate that using organisational *climate* provides an additional layer of extrapolation, acknowledging that methodologically surveys provide a snapshot or window into an organisation's culture at a particular time (Scott et al., 2003; Colla et al., 2005; Ginsburg et al., 2013; Mearns & Flin, 1999), while qualitative approaches (interviews, focus groups, observations, and particularly ethnography) are more suited to examining culture in richer, drawn-out detail (Laflamme et al., 2019; Nakrem, 2015; Nugus, 2019). Here, for simplicity we employ the word *culture* to acknowledge that surveys, while having limitations, attempt to examine some of the same core issues, processes, and features as methods like ethnography (Braithwaite et al., 2010b).

When governments, policymakers, or hospital leadership carry out any sort of survey of organisational cultures—something which they do frequently in countries such as the United Kingdom, Canada, and Australia (Mannion et al., 2009; Bishop & Fleming, 2014; Simpson et al., 2019)—they are (assumedly) most interested in the results of that investigation.

However, the contents of the tool(s) used to collect that data are also revealing about the cultures of that organisation, government body, health system or nation, and about the kind of things valued, prioritised, and expected of those working within it. As such, it is worth examining these instruments and the purposes for which they are used. In this chapter, we take up this task, focusing on the measurement of organisational culture across the Australian public hospital system. We first examine the context of the Australian healthcare and public sector systems, both of which require assessment of culture. We then present an analysis of the surveys most widely used to assess organisational culture in Australian public hospitals, focusing on their contents and what the data collected is used for. We conclude the chapter with a consideration of the implications of this analysis and reflections on how use of large-scale organisational culture surveys could be improved.

Organisational Surveys in the Australian Political and Policy Context

Australian Healthcare: A Complex, Federated System

Healthcare systems worldwide increasingly recognise the importance of understanding and assessing organisational cultures within their services, particularly with regard to their impact on safety (Halligan & Zecevic, 2011). Australia provides a particularly useful context for examining the large-scale assessment of organisational culture in hospitals because the country's size, geographical and demographical diversity, and mix of local, state, and federal funding and governance arrangements have contributed to a public hospital system that is complex and highly fragmented (Hall, 2015). This translates to a multitude of different stakeholder groups and levels, as well as approaches through which culture might be examined in Australian hospitals. Indeed, a brief scoping of grey and academic literature (Table 9.1) identified numerous assessments of organisational culture and safety culture using different approaches and targeted at varying organisational levels in hospital in Australia (see also

Table 9.1 Examples of organisational culture measurement in Australian hospitals and the healthcare system

Organisation	Level	Assessment tool
Department of Health and Human Services (TAS)	State	Competing Values Framework (Goodman et al., 2001; Shannon et al., 2012)
Bundaberg hospital (QLD)	Hospital	Retrospective public inquiry (Morris, 2005; Casali & Day, 2010)
Local Health districts (NSW)	Region	Hospital Survey on Patient Safety Culture (Piper et al., 2018; Sorra & Dyer, 2010)
St Vincent's hospital (VIC)	Hospital in a public/ private network	Patient Safety Culture Survey, a modified version of the Safety Attitudes Questionnaire by Sexton et al. (2006) (St Vincent's Hospital Melbourne, 2018)

Hogden et al., 2017). The purposes of these assessments (e.g., understanding), and what was ultimately done as a result of collecting this information (e.g., quality improvement, organisational change), varied and were not always clear. Similar issues have been identified in England, with recent research finding an extensive range of tools used to assess and understand cultures in National Health Service (NHS) Trusts; these included surveys specifically intended for that purpose, as well as other measures (e.g., of patient satisfaction) and indicators of safety and quality, with users having varying levels of satisfaction with these tools (Simpson et al., 2019).

The quality standards of the Australian healthcare system, which are evaluated based on accreditation methodology (Braithwaite et al., 2010a; Hinchcliff et al., 2012; Greenfield & Braithwaite, 2008), require hospitals to 'develop a culture of safety and quality improvement' (Australian Commission on Safety and Quality in Health Care, 2017, p. 6). This includes as a key task ensuring 'that systems are in place to regularly survey and report on organisational culture' (Australian Commission on Safety and Quality in Health Care, 2019a). However, there is currently no explicit guidance on how Australian hospitals should go about meeting the standards, such as what type of culture assessment to use, how regularly to collect this data, and what to do with it, although delivery of this advice is in the planning phases (Australian Commission

on Safety and Quality in Health Care, 2019b; Australian Institute of Health and Welfare, 2016).

While Australia's accreditation standards are set nationally, publicly funded health services are operated by state governments through shared funding responsibilities with the national government. Management of hospitals is largely devolved to smaller, geographically bounded regions akin to the United Kingdom's NHS Trusts (known as Local Health Districts in New South Wales (NSW), Hospital and Health Services in Queensland). At the lower levels are localised layers of management, quality improvement units, and clinical microsystems operating *within* each hospital. As Hall (2015) indicates, the result of these sorts of arrangements 'is a complex set of overlapping and fragmented responsibilities' where 'no single level of government has all the policy levers needed to ensure a cohesive health system' (p. 495).

The Public Sector Policy Landscape and Organisational Culture Surveys in Australian Hospitals

In addition to the national healthcare standards, public sector policy in Australia emphasises routine collection of data which acts as a further window into organisational cultures in hospitals. The *Public Sector Management Act 1994*, Section 21, denotes the Public Sector Commissioner's role in monitoring and assisting agencies to comply with public sector standards (Australian Capital Territory, 1994). Surveys are thereby used to monitor what goes on in Australian public organisations, including public hospitals. The stated reasons for collecting these data are to: (a) determine the extent employees' view behaviour in their organisation as consistent with good human resource practice, ethical practice, and diversity and inclusion principles; (b) assess employees' job satisfaction; and (c) examine their perceptions regarding leadership, management, and administration in their organisation (Australian Capital Territory, 1994).

While originally positioned as tools to examine non-compliance, such public sector employee surveys are increasingly used by state departments of health to measure organisational cultures (Public Sector Commission,

2018). A justification for conducting these surveys is to contribute to continually improving workplace culture including strengthening the values of collaboration, openness, respect, and empowerment (NSW Health, 2018). Australian states and territories routinely conduct their own versions of these surveys. In Victoria, the *People Matter Survey* is administered to all public sector employees (Victorian Public Sector Commission, 2019), with a similarly named survey used in the Northern Territory (Northern Territory Government , 2019) and also now in NSW (NSW Government Public Service Commission, 2019). The *NSW People Matter Employee Survey* was previously (i.e., pre-2015) termed *Your Say Workplace Culture Survey.* Other states and territories have distinguishable but broadly comparable surveys (Government of South Australia, 2019; Tasmanian Government, 2019), with variations to the names of the instruments over the years (Department of Health, 2019). As the survey names have changed, so too has the focus of some questions. That is, while core questions may be held constant, aspects of the surveys have altered over time to address new concerns and priorities in public and healthcare policy. For example, cognitive testing of the *NSW People Matter Workplace Culture Survey* led to the implementation of new questions in the 2018 survey related to physical harm, sexual harassment, and abuse (NSW Government, 2018).

We know that assessments of culture, and particularly safety culture, happen at more localised levels in the Australian healthcare system (see Table 9.1 and Hogden et al., 2017), but these surveys represent the most widely used and closest approximations of a national- or state-level consistent assessment of organisational culture within the otherwise fragmented public hospital system. Despite consistency in the use of these surveys across the different states and territories, and the fact that some states use some of the same survey items, no research has examined the propensity for overlap in the content of these tools. Nor has there been an attempt to examine and compare how the results from these surveys are used between the different states. This would highlight potential similarities, differences, and priorities in the conceptualisation and measurement of organisational cultures in healthcare across Australia. These insights will be useful to those working in other health systems such as the United Kingdom and Canada that also routinely conduct large-scale

assessments of organisational cultures using a range of tools (Mannion et al., 2009; Bishop & Fleming, 2014) and particularly annual staff surveys (Simpson et al., 2019).

Method

Organisational culture surveys used in the Australian public hospital sector were examined. These surveys were identified through searches of state government and department of health websites. Where possible, the most recent year for which the full survey form was available was used. We also examined associated public reporting of the results of these surveys, comparing between states and identifying whether and how results were used within hospitals (e.g., monitoring, quality improvement).

Survey Item Mapping

All items, excluding demographic data, were extracted from the organisational culture surveys and formatted into an Excel spreadsheet for purposes of thematic analysis. We also extracted the topic themes or headers used within each survey form to group items. These topic themes were used as the starting point for codes; we first inspected the headers and read through the items listed under them to familiarise ourselves with intended themes. By grouping together common or conceptually related topic themes from across surveys, a draft framework was derived, and codes subsequently defined. This framework was then used to code each survey item, a process that was completed independently but simultaneously by two authors (KC, LAE), who discussed the code assigned for each item and managed any discrepancies before proceeding to the next. Items were assigned to 18 different codes (see below in Results, Table 9.3).

Items that did not adequately fit under any of the codes or were coded inconsistently were reviewed a second time, leading to minor modifications (e.g., changes to the definition or title), or development of new codes to cover emergent issues (inductive coding). Two new codes were 'safety culture related' and 'initiative and autonomy'. All coded items

were then reviewed a final time to ensure they adequately fit under their assigned code.

Thematically associated codes were then organised together to highlight broader themes among the items. The starting point for this was the distinction between items that asked about individual perceptions, evaluations, and experiences, compared with those focused on more collective, interpersonal, or external factors. From there four themes were developed: (1) individual feelings and experiences at work, (2) social issues at work, (3) leadership and supervision, and (4) organisational and workplace factors.

Reporting and Using Results from Public Sector Culture Surveys in Healthcare

A scoping review of the grey literature was conducted to examine how the findings from the Australian public sector surveys, specific to healthcare, are reported and used. This included examining the websites of state departments of health and looking for reports or uses of the surveys by regional health units (e.g., local health districts in NSW) using Google Search function. The most recent reports were identified for each state (2018 or 2019) and data were extracted regarding how findings were reported and any detail on how the findings would be used (e.g., improvement). Extracted data were tabulated to enable comparison across states and territories.

Strengths and Limitations of the Method

The coding framework used to classify items was, for the most part, based on pre-existing approaches. In coding these items, though, it became clear that many constructs are closely related. For example, it was difficult to separate 'job satisfaction' from 'engagement'. Having two coders to complete this task (analyst triangulation, Patton, 1999), creating explicit coding rules and discussing codes until consensus was reached, overcame most of the difficulties and led to a more rigorous analysis.

Another limitation was that only seven surveys used in Australian public hospitals were examined, with the Australian Capital Territory (ACT) survey missing. Furthermore, it was not always possible to compare the same surveys in the same years for all states. This reflects the fragmentation in the use of these surveys by states; not all complete them annually, and not all states make survey forms available for all years.

Results

Survey Item Mapping

Seven surveys used in the public sector for six Australian states (NSW, Queensland [QLD], South Australia [SA], Tasmania [TAS], Victoria [VIC], Western Australia [WA]) and the Northern Territory (NT) were identified. These surveys are outlined in Table 9.2.

A total of 597 survey items across the seven surveys were examined. There was considerable similarity among these survey items but very few identical items; for example, among the items assessing job satisfaction there were: 'I would recommend my workplace as a good place to work' (NSW), 'I would recommend the Tasmanian State Service as a good place to work' (TAS), 'I would recommend my organisation as a good place to work' (QLD, VIC, WA), and 'I would recommend my agency as a good place to work' (SA, NT). Although it is worth noting this overlap, in the analysis each item from every survey was treated as independent.

Of the 18 codes identified (see Table 9.3), the most common were 'organisational values and behaviours' (n = 68), 'discrimination or

Table 9.2 List of organisational culture surveys

State/territory	Name of survey
NSW	2015 NSW Health your say workplace culture survey
NT	2014 People matter survey
QLD	2017 Working for Queensland
SA	2018 I WORK FOR SA—Your voice survey
TAS	2017 People matter survey
VIC	2017 People matter survey (Health edition)
WA	2019 Minister for Health engagement survey

Table 9.3 Number of items mapped to survey constructs

Theme	Construct	NSW	QLD	SA	TAS	VIC	WA	NT	Total no. of items
Individual feelings and experiences at work	Burnout, health, and wellbeing	1	4	2	1	0	1	1	10
	Job satisfaction	2	12	10	11	9	2	10	56
	Engagement	4	2	10	3	2	4	6	31
	Personal plans around employment	0	5	3	2	1	0	1	12
	Role and fitting in with the organisation	3	3	3	3	4	5	3	24
	Initiative and autonomy	5	3	4	3	1	4	1	21
Social issues at work	Discrimination or tolerance	5	9	2	5	31	2	8	62
	Bullying and sexual harassment	10	10	0	3	2	0	7	32
	Domestic and family violence	0	6	0	0	0	0	0	6
Leadership and supervision	Performance assessment and development	3	10	4	7	6	5	8	43
	Line manager	5	13	10	12	0	2	13	55
	Senior management	6	10	8	5	4	3	3	39
Organisational and workplace factors	Workgroup/team values and behaviours	5	13	6	10	8	3	3	48
	Workplace environment	1	3	3	1	1	2	0	11
	Organisational values and behaviours	10	12	5	7	13	6	15	68
	Organisational processes, policies	8	3	3	13	12	4	7	50
	Organisational change and improvement	3	3	4	2	0	1	5	18
	Safety culture related	1	0	0	1	6	3	0	11
Total		72	121	77	89	100	47	91	597

tolerance' (n = 62), 'job satisfaction' (n = 56), and 'line manager' (n = 55). The codes represented by the least number of items were 'domestic and family violence' (n = 6) and 'burnout, health and wellbeing' (n = 10). Between states, there was differential coverage of some coded constructs; for example, 'performance assessment and development' and 'senior management' items were present in every survey, but only four had 'safety culture related' items and only one state had items mapped to 'domestic and family violence'. No survey included items related to all 18 constructs.

In addition to a range of individual issues (e.g., job satisfaction, burnout), the surveys broadly assessed staff's perceptions of the shared behaviours, values, and attitudes of their work group and leadership and, in that sense, would seem to focus on aspects of organisational culture. In terms of organisational values, many items were concerned with idealistic qualities such as openness ('My organisation is open to new ideas'), inclusion ('My input is adequately sought and considered about decisions that directly affect me'), fairness ('People are treated fairly and consistently in my workplace'), justice ('If I raised a complaint, I feel confident that it would be taken seriously'), and improvement ('My manager encourages people in my workgroup to monitor and improve the quality of what we do'). Taken as a whole, these questions were somewhat superficial and arguably normative, setting a standard for how public hospital staff *should* behave and what they should value, rather than attempting to characterise what makes them tick in the first place. Few items focused on patient care or healthcare issues explicitly though (e.g., 'In my workplace patient safety is at the centre of all decision making'), likely because these surveys were developed for a general workforce of public sector employees.

Reporting and Using Results from Public Sector Culture Surveys in Healthcare

We scoped state government and department of health websites followed by searches of Google for other reports or uses for the results of the different state organisational culture surveys. These results are displayed in Table 9.4.

Table 9.4 Differences in how state surveys of organisational culture are used

State	How are staff survey results disseminated specific to health sector?	What was the data used for?
NSW	NSW Health reports at **state level** and by **department and agencies**, including by local health districts (but not individual hospitals).	Reports suggest areas for improvement but not how the data will be practically used.
NT	NT people matter survey results reported at the **state level for the whole public sector**.	The state-level report indicates areas for improvement and encourages local entities to take action by providing a worksheet. However, there were no specific ideas for how the data will be used.
QLD	Findings are reported at the **state level** and broken down by **departments, public sector offices and government entities, and health agencies**.	Reports suggest areas for improvement but not how the data will be practically used.
SA	SA survey findings reported at **state level for the whole public sector**.	State-level reports encourage local entities to take action by providing a worksheet, although no specific ideas for how the data will be used.
TAS	Survey findings from Tasmania only reported at the **state level for the whole public sector**. It is up to heads of agencies (e.g., Tasmanian Health service) to decide how their results will be made available to employees. No evidence found that Tasmanian Health service publicly releases this data.	The report identified areas that need to be improved at state level (e.g., management/leadership) but not how the data will be used for change.

(*continued*)

Table 9.4 (continued)

State	How are staff survey results disseminated specific to health sector?	What was the data used for?
VIC	High level survey results are reported publicly **at state level for the whole public sector**, with some data broken down by health. Results are apparently privately fed back to organisations. Individual reports are issued by **some regions**.	The reports suggest results will assist organisations to understand employee engagement and job satisfaction, and encourage local entities to then work out how to improve the working environment. Some regions report and provide insights into what changes they are making because of it. For example, introducing more opportunities for regular discussion and feedback, including monthly organisation-wide staff meetings (Kerang District Health, 2016)
WA	Survey results reported at the **state level**. Findings are compared across health services (e.g., Department of Health, Health support services), but not reported in detail specific to regions.	The state-level report indicates areas for improvement and encourages local entities to take action by providing a worksheet, although no specific ideas for how the data will be used.

This analysis revealed that there is inconsistency even in describing these surveys as measures of organisational cultures. For example, the *Working for Queensland Survey* was badged as a measurement of employees' perceptions of their work, manager, team, and organisation (Queensland Government, 2019). This description makes no mention of organisational culture, although some of its items made explicit reference to culture: 'My workplace has an inclusive culture where diversity is valued and respected'. Alternatively, the 2015 *NSW Health Your Say Workplace Culture Survey* was described as a workplace culture survey (NSW Government, 2019).

States and territories differed in how they publicly distributed their survey findings, or indeed whether they distributed them at all. Some states reported on the region level, while others only reported results on the state level for the whole of the public sector. QLD and NSW had public reports of their organisational culture survey findings available at

various levels (e.g., state, department, agency). States also had limited information on *how* the findings would be practically used for improvement within the hospitals involved. Where survey results were available, they supported the idea that little improvement was made based on the results of the previous years' survey findings. For example, a few of the items coded to 'Organisational change and improvement' specifically asked about the extent of changes made in one's organisation since the previous years' survey (QLD). A majority of the responses from participants at most of the healthcare organisations examined disagreed that changes had been made in light of previous findings.[1] The fact that most states did not report all their data by at least the healthcare sector, or use the same wording of items or response ranges even when questions were extremely similar, precluded comparisons between states and territories. Hence, it was not possible to aggregate organisational culture survey data to draw conclusions nationally for Australia or make comparisons by state.

The fragmentary nature of the Australian healthcare system likely contributed to the inconsistent reporting of findings and limited discussion of actions taken to improve working conditions. To the latter, reports from many states indicated that the responsibility for making improvements based on the surveys would be handled by the relevant regional authority, and some provided generic tools to help with this (e.g., SA, WA). While consideration of local context is important when trying to improve healthcare organisations (Churruca et al., 2019), in this instance it means local authorities must take ownership of the end stage of a process that they had limited control of, including in terms of the survey contents.

Discussion: What Value Do Annual Staff Surveys Have in Understanding Organisational Cultures in Hospitals?

Our examination of the annual surveys specifically or ostensibly used to assess organisational cultures in Australian public hospitals identified the most common themes and highlighted differences in the constructs

[1] Average across all health agencies in Queensland was 62.3%=NO; a further 15.8% reported having worked in the organisation for <12 months.

covered by different states. States also differed in reporting results of these surveys and made varying claims about the uses of the data.

Survey Contents

If we take these surveys as a window into the culture of hospitals, or at least the priorities when it comes to measurement of that culture, the variability among states suggests that there are overlaps but no overarching perspective on cultures in Australian hospitals. The constructs most consistently identified also bore similarity to those in the annual NHS staff survey, including morale; equality, diversity, and inclusion; health and wellbeing; and bullying and harassment; however, the NHS survey includes an explicit focus on safety culture (NHS England, 2020).

In our study, the job satisfaction items were among the most common. Although individual-focused, literature supports a strong association between culture and job satisfaction (Sempane et al., 2002). Engagement items were also common, with studies from England associating this variable with higher-quality ratings in NHS acute Trusts (Wake & Green, 2019). Other items endeavoured to assess general aspects of culture—good leadership, collaboration, and a supportive environment—that have been found to have an association with the quality and safety of patient care (Braithwaite et al., 2017; van Buijtene & Foster, 2019). However, in our study only a few items were healthcare specific or focused on safety culture, despite the priority these receive in the Australian national standards (Australian Commission on Safety and Quality in Health Care, 2017). Furthermore, no items captured the more complex aspects of healthcare delivery such as when two organisational priorities (e.g., efficiency, patient-centredness) are in conflict with one another (Hollnagel et al., 2013).

Because they are updated yearly, these surveys also responded to contemporaneous social concerns. For example, the QLD survey included items related to domestic violence, a prominent issue that has received increased national public attention over the last five years (Keane & Slessor, 2018; A. Piper & Stevenson, 2019).

Purpose and Use of Surveys

If the original purpose of these surveys, as stated in public sector policy, is not assessment of organisational cultures per se, but monitoring employee experiences and evaluations of their workplace; we find they fulfil that brief. However, questions must be asked then about what value there is in conducting them, often yearly at considerable time and expense, when there is limited evidence of change based on the data. This is perhaps because surveys are designed and analysed at one level (state), but in many instances results must be interpreted and actioned at another, lower level.

The organisational culture surveys used in the Australian public hospital sector are also curated and 'marketed' for the political climate of the time. For example, the newest iteration of a WA survey, which ran for the first time in 2019, was represented as a state election promise where the survey findings would be used to improve the WA health system, enhancing its prospect as an employer of choice (Department of Health, 2019). Findings were distributed via media statements, arguably, to boost political agendas, without providing details of how the government would improve or make changes to the health system (Government of Western Australia, 2019b). For example, an Employment Engagement Index of 62%[2] was reported in press releases, and compared favourably with the results of surveys from other Australian states (Government of Western Australia, 2019b). These media statements made no mention of the fact the response rate was only 33% (Government of Western Australia, 2019a), nor that the people most likely to fill in such a survey are also likely to be the most engaged.

All of this suggests that the use and reporting of results from these surveys may serve political purposes, while the practical applications of findings remain opaque. At the extreme, it could be argued that culture surveys—taking place at the state level on an annual basis—are mostly a bureaucratic exercise; they have vague substantive goals and do not often lead to real improvements in individual hospitals. While the federated and fragmentary nature of the Australian healthcare system may have

[2] Unclear how this index was scored, but likely based on engagement and job satisfaction items.

contributed to poor and inconsistent reporting and utilisation of results, other research suggests that the use of performance data—or lack thereof—is a widespread problem in public sector management (Moynihan & Pandey, 2010).

Implications for Hospital Managers and Policymakers

How well do these surveys do in assessing organisational culture across Australian public hospitals? In terms of consistency, there were many overlaps but few direct comparisons in the items used in the surveys across states. From these overlaps a picture begins to emerge of an idealised workplace and the employee within it: fair and equitable treatment, ability to report issues, a focus on improvement. Undoubtedly, these features play a role in the capacity for hospital staff to provide safe and high-quality care (Braithwaite et al., 2017; van Buijtene & Foster, 2019). Overall, though, items lacked the healthcare focus and nuanced complexity required to understand organisational culture at a level useful for providing insights into patient care. In terms of meeting national standards, then, some hospitals might use a survey like this as *one component* of the system 'to regularly survey and report on organisational culture' (Australian Commission on Safety and Quality in Health Care, 2019a), but it should not be the only one. However, we did not study whether the staff responsible for quality management and improvement within hospitals use these surveys for this purpose. In England, a similarly focused annual staff survey is used within some hospitals to understand their culture, and in fact receives a relatively high satisfaction score for this purpose; however, that survey has much greater coverage of safety culture than the ones we examined here (NHS England, 2020; Simpson et al., 2019).

Of course, critique of these particular surveys in many respects only echoes the criticisms levelled at all culture surveys, that in isolation they are not ideal for exploring the underlying assumptions at the heart of an organisation's culture (Schein, 2006). In Australian hospitals, the other limitation of these surveys relates to their typically poor response rates. For example, the *2018 I WORK FOR SA—Your Voice Survey*, yielded a

response rate of only 22% (Government of South Australia, 2019). Many academic studies stress the importance of achieving a high response rate (>60%) to gain a fair representation of the sample and draw inferences about culture (see Pronovost & Sexton, 2005).

Moving forward, our analysis points to the limited utility of large-scale organisational culture surveys in meaningfully understanding organisational culture within any one hospital, and particularly in relation to quality and safety. Nevertheless, hospital management may find value in the results of the surveys in pointing to areas of concern, particularly if there is a pattern of extreme responses among related items. However, in order to trust the integrity of such results, a hospital must achieve a high enough response rate in the first place. This would require not only local support for the survey by hospital management when it is rolled out, but also for employees to see some value in filling it in. And this is less likely to happen unless results are fed back, and changes or improvements made in light of the findings. For policymakers, then, rather than treating these surveys as purely an annual process of monitoring—simply because that is what the original public sector policy outlined—greater consideration to what goes into these surveys, and what substantive uses they can be put towards, is required.

Conclusion

The measurement of organisational culture can be useful in managing hospitals, influencing the delivery of healthcare, and is mandated by Australian national standards for healthcare organisations. However, policy does not provide guidance on appropriate tools, strategies for use, and analysis and results feedback. State-based public sector surveys represent the closest approximation of large-scale attempts at organisational culture measurement in hospitals in Australia. In reviewing these surveys, we identified items covering 18 different constructs. In conjunction with examining the reports on the results of these surveys, we see that these surveys are as much a window into the ideal public sector employee, and social and political context, as a hospital's culture. Indeed, despite the

extensive resources that go into running and promoting the regular roll-out of these surveys, their substantive value to healthcare organisations appears to be limited. Greater consideration of what goes into these surveys, and what should come out of them, is required for them to truly have value in hospitals.

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