THE IMPORTANCE OF ORGANIZATIONAL CULTURE IN THE PERFORMANCE OF FAMILY HEALTH UNITS – MODEL B IN THE ALGARVE REGION

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Abstract: Context and Objectives: The recent reform of Primary Health Care brought about important developments, such as the creation of the Health Care Clusters and the Family Health Units, which are innovative in terms of health care provision, with a focus on improving access to care, health and disease management, efficiency and effectiveness gains, quality of care, and user satisfaction. Increasingly considered as an essential organizational attribute for the success of organizations, knowing the organizational culture that prevails in family health units is essential for the implementation of a new work culture in Family Health Units (FHUs) with a type B management model, which is characterized as a more rigorous management model in terms of team performance, clinical governance, and teamwork. Using the Contrasting Values Model as theoretical support, this study aimed to analyze the importance of the Organizational Culture in the Performance of FHUs with a type-B management model in the Algarve region. **Methodology:** A quantitative cross-sectional study was conducted with a sample of 109 professionals from eight type-B FHUs. The Organizational Culture Assessment Instrument (OCAI) was used to identify the predominant type of organizational culture in the FHUs, and, in order to characterize the level of performance of model B FHUs, data were extracted from the Primary Health Care Identity Card. **Results:** In the model B FHUs in the Algarve region there is a predominance of the Clan type culture. Organizations with this type of culture remain cohesive due to the loyalty and tradition among their members. Knowledge of the current organizational culture in these units helps to raise awareness of their own culture, helping their leaders to develop and implement projects oriented towards high performance and productivity. Success is defined in terms of teamwork and concern for people. **Conclusion:** The study points to a predominance of the Clan culture in the analyzed FHUs, with emphasis on the existence of a productive and competitive leader.

Keywords: Organizational Culture; Primary Health Care; Family Health Units; Performance

1. Introduction

The provision of healthcare is a prime necessity. In this sense, we are compelled to be attentive to the changes occurring in this domain. In Portugal, we have witnessed a structural reform in this area, and more specifically in Primary Health Care (PHC), which was realized with the creation of Family Health Units (Baganha, Ribeiro and Pires, 2002). For these organizational changes to happen, it is important to understand the organizational culture, since it contributes to comprehending the phenomenon and the values of individuals and the group. In this sense, identifying the elements of culture assists in implementing the strategy, objectives and modus operandi of organizations (Lourenço, 2016). According to Leone, Dussault and Lapão (2014), the reform of Primary Health Care promoted the implementation of a new work culture, through closer management and incentives for clinical governance, countering anachronistic, excessively centralized and bureaucratic practices of public administration. The necessary cultural changes, with regard to healthcare provision, are condensed by Loyd (2001) into two aspects: the importance of teamwork and partnership; the need for rigorous performance management. Research in the area of organizational culture provides knowledge about its role in the success or failure of organizations, in the ability to attract and retain talent, as well as how it affects the performance, behavior, morale and well-being of an organization's workers (Chatman & O'Reilly, 2016; Warrick, Milliman, & Ferguson, 2016). Knowing the organizational culture is a key factor in understanding the capacity of individuals and groups to overcome the problems arising from the many adverse circumstances of daily life that occur in workplaces (Rocha, Gaioli, Camelo, Mininel, & Vegro, 2016). It is also a central factor in understanding how organizations function (Chatman & O'Reilly, 2016) and in comprehending all aspects of an organization's life (Alvesson, 2002). However, knowing the organizational culture (and its theory), more than teaching what to do, can help to know what not to do, and to be prepared for problems resulting from cultural clashes (Alvesson, 2002). As advocated by Cameron and Quinn (2006), knowing the central values of the organizational culture can be a useful tool for the effective management of organizational change.

In this context, the present work sought to understand and analyze the importance of Organizational Culture in the Performance of Family Health Units (model B) in the Algarve region. Given what several authors advocate (Cameron & Quinn, 2006; Schein, 2009) and the different studies conducted on the importance of culture in the performance of health organizations, one of the primary steps for introducing organizational changes is the identification of the type of organizational culture. In this sense, the diagnosis of the organizational culture from the perceptions of professionals who are part of the Family Health Units-model B, allowed the identification of the current organizational culture and assisted in recognizing the culture that these professionals consider should be developed to meet internal and external demands. The Model B Family Health Units (USF-B) are the units with a higher Global Performance Index (IDG), consisting of teams with greater organizational maturity, where teamwork in family health is an effective practice and where contracting requires higher performance than the previous model. Thus, the USF-B intend to allocate more effective services, with greater ability to achieve high levels of performance, adapted to the new demands that are imposed and at the same time achieve a high IDG. Given that the IDG is centered on the Continuous Improvement Plan, which aims to apply a set of corrective measures and promote change, it has become essential to understand whether the organizational culture that predominates in the Model B USFs meets the requirements of its management model, with a view to defining strategies that promote organizational change.

2. Literature Review

2.1. Primary Health Care

According to the Portuguese Observatory of Health Services, Primary Health Care (PHC) plays an important role in disease prevention, health promotion and reducing existing inequalities in terms of health in the Portuguese population (OPSS, 2018). These care services are provided in Health Centers (CS), whose importance is vital for the population, although they are often undervalued in relation to hospital care. PHC must meet society's expectation

that demands more from health systems at the citizen, family and community level, imposing greater equity in health, with quality services, centered on people's needs (WHO, 2008). The units most focused on personalized medical and nursing care are the USFs (family health units) and the UCSPs (personalized health care units); the USPs (public health units), which function as health observatories, being responsible for, among other things, preparing information and plans in the areas of public health, epidemiological surveillance, intervention programs in the area of prevention, promotion and protection of population health; the URAPs (shared care resource units) that integrate social workers and psychologists, physiotherapists, occupational therapists, among others, who provide care consultancy services to all other functional units; and the UCCs (community care units), created with the ACESs in article 11 of Decree-Law no. 28/2008 of February 22, these are defined as providers of health care and psychological/social support at home and in the community.

2.2. Family Health Units

The 21st Constitutional Government established the defense of the National Health Service (SNS) as a priority and, in this context, identified the need to reinforce Primary Health Care (PHC) and create more Family Health Units (USF), with the purpose of contributing to realize the centrality of the PHC network in the country's health policy and, thus, expand and improve its response capacity through all the Functional Units (UF) that constitute the Groups of Health Centers (ACES) (Order No. 1174-B/2019). One of the measures of the PHC reform consists of the creation of USFs. Family Health Units (USFs) can be defined as elementary units for the provision of individual and family health care, based on multiprofessional teams, consisting of doctors, nurses and administrative staff, and which can be organized into three development models: A, B and C. These models are distinguished by the level of autonomy, the remuneration and incentive system for professionals, as well as the form of financing and respective legal status (MS, 2007). With regard to Model A, this is based on a management model that is in a "learning and improvement phase of the family health team work", initiating the practice of internal contracting (Order nº 24101/2007, p. 30419). Model B is characterized by integrating "teams with greater organizational maturity, where work in a family health team is an effective practice", and where contracting requires greater performance than the previous model (Order nº 24101/2007, 30419). Model C is characterized by the existence of a program contract and may integrate teams from the public sector or belonging to the private, cooperative or social sector. USFs are thus subject to continuous evaluation, with the Regional Health Administration being responsible for monitoring and evaluation. USFBs are units that transitioned from model A, after applying on their own initiative. Model B is indicated for teams with greater organizational maturity, where work in a family health team is an effective practice, whose professionals are willing to accept a more demanding level of performance contracting and participation in the USF accreditation process, within a maximum period of three years. It covers public administrative sector USFs with a special remuneration regime for all professionals, including base remuneration, supplements and performance compensation (Order 24101/2007). These present better results than those of model A (Biscaia, 2014). According to the Primary Health Care Identity Card (BI CSP), in Portugal, at the end of 2020, there were 274 USFs, with 149 USFs in the Northern Regional Health Administration, 32 in the Central Regional Administration, 77 in the Lisbon and Tagus Valley Regional Administration, 8 in the Alentejo Regional Administration and 8 in the Algarve Regional Administration. In the specific case of the Algarve region, the Algarve Regional Health Administration has three ACES, namely Central, Barlavento and Sotavento.

2.3. Organizational Culture

According to Alvesson (2002), organizational culture is one of the most important themes in academic research and management practices, since cultural dimensions occupy a central place in the life of organizations. Organizational culture is an unconscious and implicit set of beliefs, traditions, values, customs, expectations and shared habits, often unspoken, that characterize a peculiar group of people (Leavitt, 1996; Sathe, 1983). Organizational values are defined as hierarchically organized principles or beliefs, relating to types of structures or

models of desirable behaviors that guide the life of the organization and serve individual, collective or mixed interests. Thus, it becomes essential to assess organizational values, since they have great relevance for organizational culture (Domenico and Teixeira, 2002). Mintzberg (2004) considers that the manager must be aware that the culture most appropriate for their organization must reflect the appropriate instruments and models to deal with the setbacks of their organization and its adaptation to the context, resizing its resources, redefining its strategy, philosophy and policy from a perspective of evolution, adaptation and survival. This is because organizational culture can modify the organizational structure of a company. Culture can thus represent a competitive advantage in organizations, especially when there is a set of common and consensual perceptions that integrate memories, values, attitudes and definitions. Managers must have the ability to identify the type of culture of the organization, the type of approaches that should be implemented to change the culture, in order to achieve different results (Ferreira, 2011).

2.4. The Competing Value Model

The Competing Values Model by Cameron and Quinn (2006) was the organizational culture assessment model chosen for this study. Considering the concepts and different perspectives on organizational culture, this theoretical model fits within the sociological and functional perspective and the possibility of diagnosing and measuring organizational culture, since the goal is to study how the structure of contrasting values manifests itself in the organization's behavior. To understand the different dimensions of organizational culture, various models have been formulated, represented in the form of a typology that groups and classifies the types of culture. Typologies assume that organizations can be characterized by a set of common characteristics or dimensions, enabling comparison between organizations (Bilhim, 2004). In addition to this advantage, using typologies to conceptualize organizational culture makes it possible to express the contrasts and paradoxes that organizations deal with and must reconcile, while also allowing for the development of monitorable intervention plans in terms of diagnosis, intervention, and control. Cameron and Quinn (2006) present a theoretical model called the Competing Values Framework, based on an empirical study conducted in various organizations. An instrument was developed - the Organizational Culture Assessment Instrument (OCAI) - which allows for diagnosing the current organizational culture and assisting in recognizing the culture that members of the organization consider should be developed to meet internal and external demands. The same authors state that each culture is composed of a unique language of symbols, rules, and ethnocentric feelings, which are represented in four types of cultures, namely: Clan Culture; Adhocracy Culture; Hierarchical Culture; and Market Culture. These four cultures are identified by means of six key dimensions of organizational culture: Dominant Characteristics; Organizational Leader; Management Styles; Organizational Principle; Organizational Climate; and Criteria for Success. These six dimensions, in turn, portray how the organization operates and the values that characterize it. The "Clan Culture" is characterized by considering workers as partners and the organization being concerned with developing a healthy work environment. It encourages teamwork, and leaders play a role in encouraging employee participation. The "Adhocracy Culture" is represented by the concepts of entrepreneurship and dynamism. Companies of this type are dynamic, and leaders stimulate creativity and innovation. The "Hierarchical Culture" is characterized by stability, control, and efficiency. The work environment is formal and structured, and the organization is concerned with the long-term future. Leaders play a role in coordinating and monitoring the organization. The "Market Culture" is oriented toward achieving goals. The organization is geared toward competitiveness and productivity with an emphasis on results. Leaders are focused on achieving results, preferably translated into profits (Cameron and Quinn, 2006).

2.5. Organizational Culture and Performance

To build a successful organizational culture, it is necessary not only to have committed and united leaders at all levels of the organization, but also that the culture must be defined and aligned with the organization's strategy and must be put into practice. Thus, the actions to be taken must be carefully designed and maintained over time (Warrick et al., 2016). The

success of an organizational culture change effort largely depends on whether the organization is able or not to gain the support of all employees (Gover et al., 2015). In order to assess whether the organizational culture perceived by employees is associated with the organization's performance, Zhou et al. (2011) conducted surveys in 87 public hospitals in China. The study carried out by Hann, Bower, Campbell, Marshall and Reeves (2007) analyzed 38 primary care units in England, in which they sought to verify the existence of a relationship between the quality of care and organizational culture. Another study on the relationship between organizational culture and performance, with a sample of ten military health units in Mexico, Revilla-Macías, Santana-Mondragón, and Rentería-López (2015) found evidence of the relationship between the type of organizational culture and performance.

3. Research Methodology

The present research work aimed to identify the predominant organizational culture in the USF-model B units in the Algarve region, based on the perceptions of professionals, with the purpose of understanding the importance of organizational culture in the performance of these units. This research followed a quantitative, cross-sectional approach.

3.1. Sample

With the aim of analyzing the importance of organizational culture in the performance of USF model B units in the Algarve region, the present study used a non-probabilistic and convenience sampling process. Within the non-probabilistic sample, the rational choice sample was chosen, since it involves constituting a sample of individuals based on a characteristic trait (extreme, deviant, typical or distinct cases), represented by the professionals of the USF model B units existing in the Algarve region. The professionals involved in the study were selected because they well represented the phenomenon under study and helped to understand it (Fortin, Côté & Filon, 2009: 322). In order to capture the diversity of perspectives regarding organizational culture, all professionals from the three represented categories were involved in the study. The target population of the study was thus constituted by all the professionals from the eight USF-model B units of the ARS Algarve, corresponding to a total of 145 professionals distributed across the three ACES, the eight USFs and the three professional categories. After the distribution of the questionnaires, which took place in April, May, August and September 2021, 109 valid responses were obtained, which corresponds to an overall response rate of 75%. Table 1 aggregates the absolute and relative data of the responses to the questionnaire considered valid, distributed by USF and ACES.

Table 1 - Distribution of Participants' Responses by ACES/USFB (N/%)

ACES	USF	Frequency (N)	Percentage (%)	Total
Central	Albufeira	11	10,1	
	Faro - Ria Formosa	13	11,9	67
	Loulé – Lauroé	12	11,0	
	Olhão – Âncora	17	15,6	
	Olhão – Mirante	14	12,8	
Sotavento	VRSA - Levante	13	11,9	
	Tavira – Balsa	17	15,6	30
Barlavento	Lagos - Descobrimentos	12	11,0	12
	TOTAL	109	100%	

Source: Own elaboration

3.2. Procedures and Instruments

The Data Sources focused on the questionnaire survey and the Primary Health Care Identity Card database (BI-CSP). The data collected from the questionnaires allowed us to analyze the perception of professionals from the Algarve region's Family Health Units model B (USF-model B) regarding the organizational culture - Clan Culture (A), Adhocracy Culture (B), Hierarchical Culture (C) and Market Culture (D).

The questionnaires were sent via email, with the support of one professional per unit for their dissemination. The distribution of the questionnaires took place in April and May 2021, with a second one being sent three months after the first, in August and September, in order to obtain a higher response rate.

From a search made on the BI-CSP platform, the Overall Performance Indices of the Algarve region's Family Health Units model B were extracted for the months of April, May, August and September 2021 (Table 2), in order to characterize the performance of the units. The selected months correspond to the period of data collection through the questionnaire surveys.

Table 2 - Global Performance Indices for April, May, August and September 2021

USF/ Months	Descobrimentos	Balsa	Levante	Albufeira	Lauroé	Ria Formosa	Âncora	Mirante
Abril	67,00	70,00	74,00	67,00	81,00	71,60	62,30	68,80
May	66,70	71,00	71,30	67,50	80,90	69,20	59,50	71,30
August	64,30	75,30	73,50	69,10	83,20	71,70	60,00	65,40
September	60,00	73,60	71,10	60,00	81,00	69,40	60,40	63,20

Source: Own elaboration

Regarding the format of the questionnaire survey, it was decided to add eight questions, with the purpose of learning about the profile of the professionals from each Family Health Unit (FHU), with respect to gender, age, workplace, qualifications, professional experience, length of practice, and professional category. Thus, the first group of questions refers to the sociodemographic and professional characterization of the professionals, and the second group relates to the Organizational Culture Assessment Instrument (OCAI) developed by Cameron & Quinn (2006), with 48 closed-response questions. This latter group is organized into two parts, with the first seeking to identify the current culture and the second the ideal culture, having been evaluated across six key dimensions: Dominant Characteristics (DC); Organizational Leadership (OL); Management Style (MS); Organizational Climate (OC); Organizational Principles (OP); Criteria for Success (CS). As an alternative to the original Ipsative scale of the OCAI (with weightings that can vary between 0 and 100 points), a Likert-type agreement scale was used, where the response options ranged from 1 (strongly disagree) to 5 (strongly agree). The OCAI showed good psychometric qualities, both in reliability and validity (Cameron & Quinn, 2006), and the Cronbach's Alpha test was applied. It was found that, for the overall responses, the obtained Cronbach's Alpha values were above 0.8, which means the presence of good internal consistency (Hair, Black, Babin, & Anderson, 2014).

For data processing and analysis, descriptive statistical analysis was carried out using the Statistical Package for Social Science (SPSS) V26 software and Excel software for creating tables and graphs. Through descriptive data analysis, the types of current and ideal organizational culture were compared, in order to identify the cultural characteristics represented by the Ministry of Health's Vision for Clinical Primary Care with the performance evaluated by the Clinical Primary Care Identity Card (BI-CSP).

The legal questions inherent to the applicability of the questionnaire were safeguarded by requesting authorization from the ethics committee of the Algarve Regional Health Administration to apply the questionnaire. Ethical issues were also safeguarded by guaranteeing the confidentiality of the respondents' data."

4. Results

4.1. Sociodemographic Characterisation of the Participants

Regarding the sociodemographic characteristics of the participants, it was found that 23 individuals are male and 86 are female, translating to 78.9% female and 21.1% male. In terms of the age group of the professionals, workers aged between 40 and 49 years predominated (45%). As for academic qualifications, the majority of professionals hold a bachelor's degree (57.8%), about 30.3% have completed between the 10th and 12th grades, and 11.9% hold a master's degree. Regarding professional category, it was found that most professionals are nurses with 37.6% (nurses 28.4% and specialist nurses 9.2%), followed by doctors with

32.1% and technical assistants with 30.3%. Concerning the number of years working in the health sector, of the total professionals surveyed (109), 46.8% responded that they have been working for more than 10 years, 44% have more than 6 years of service in the unit, and only 2.8% have been working for less than 5 years.

4.2. Organisational Culture Profile

To describe the organisational culture profile of the eight USFBs that comprise the three ACES of ARS Algarve, an analysis of the participants' perceptions was carried out, considering for this purpose the values based on the relative weighting of the dimensions of each cultural typology. Based on the results obtained from the present study, it was found that the Albufeira unit perceives the six dimensions DC (73%), OL (82%), MS (82%), OC (73%), OP (73%), and CS (73%) as belonging to Type A Culture – Clan Culture. The OL dimension (82%) is shared with Type B – Adhocracy Culture, and the MS dimension (82%) with Type D – Market Culture. When asked about their preferred culture, the unit maintains DC (82%), OL (82%), MS (82%), OC (82%), OP (91%), and CS (82%) as Type A Culture – Clan Culture. The DC dimension (82%) is shared with Type C – Hierarchical Culture.

The **Âncora unit** perceives the dimensions OL (41%), MS (71%), OC (41%), and CS (59%) as being part of Culture Type A – Clan Culture. The dimension DC (59%) is perceived as Type C – Hierarchical Culture, and the dimension OP (71%) as Type D – Market Culture. The OL dimension (41%) is shared with Type D – Market Culture, and the OC dimension (41%) is shared with Type D and B – Market and Adhocratic Cultures. When asked about their preferred culture, the unit maintains the dimensions MS (76%), OC (71%), and OP (76%) as part of Culture Type A – Clan Culture. The DC dimension (82%) remains as Type C – Hierarchical Culture, and the OL (76%) and CS (71%) dimensions as Type D – Market Culture. The OC dimension (76%) is shared between Clan Culture and Type D – Market Culture.

The **Mirante unit** perceives the dimensions DC (64%), OL (57%), and MS (50%) as Type C - Hierarchical Culture. The dimensions OC (64%) and CS (50%) are seen as Type D - Market Culture, and OP (64%) as Type B - Adhocracy Culture. The DC (64%) is equally divided with the same percentage into Type D - Market Culture, MS (50%) with Type A - Clan Culture, and CS (50%) with Type A - Clan Culture. When asked about their preferred culture, the Mirante unit favours DC (79%), OL (71%), and CS (57%) in Type C - Hierarchical Culture; dimensions MS (57%), OC (64%), OP (57%), and CS (57%) in Type A - Clan Culture. The dimensions MS (57%) and OC (64%) are also divided with Type D - Market Culture, and OP (57%) with Type B - Adhocracy Culture.

The **Ria Formosa unit** perceives five dimensions, DC (85%), OL (85%), OC (92%), OP (85%), and CS (85%), as Type A - Clan Culture. The EG dimension (85%) is centred on Type C - Hierarchical Culture. The OP (85%) and CS (85%) dimensions are divided with Type D - Market Culture. When asked about their preferred culture, the Ria Formosa unit favours DC (92%), MS (100%), and OC (77%) in Type A - Clan Culture. The dimensions OL (85%) and OP (85%) are seen as Type B - Adhocracy Culture, and the dimensions OL (85%) and CS (92%) as Type D - Market Culture.

The **Lauroé** unit perceives the dimensions DC (92%), MS (100%), OC (100%), OP (100%), and CS (100%) as Type A - Clan Culture. The dimensions OL (82%) and DC (92%) are perceived as Type B - Adhocracy Culture, and the CS dimension (100%) with the same percentage in Type D - Market Culture. When asked about the ideal culture, the professionals in the Lauroé unit would like to see characteristics of Type A - Clan Culture developed in the dimensions DC (92%), OC (92%), and CS (92%). For the dimensions OL (100%) and OP (83%), they prefer Type B - Adhocracy Culture, and for the dimension MS (100%), they prefer Type D - Market Culture.

The **Descobrimentos unit** perceives all six dimensions DC (92%), OL (92%), MS (100%), OC (100%), OP (83%), and CS (100%) as Type A - Clan Culture. When asked about their preferred culture, the unit maintains DC (83%), MS (100%), OC (92%), OP (92%), and CS (100%) in Type A - Clan Culture, and the OL dimension (92%) in Type D - Market Culture.

The **Balsa unit** perceives all six dimensions DC (94%), OL (82%), MS (88%), OC (88%), OP (94%), and CS (100%) as Type A - Clan Culture. The OL dimension (82%) is also aligned with Type B - Adhocracy Culture. When asked about their preferred culture, the unit maintains the dimensions DC (71%), MS (82%), OC (88%), OP (82%), and CS (82%) in Type A - Clan Culture, and the OL dimension (100%) in Type B - Adhocracy Culture.

The **Levante unit** perceives the dimensions OL (62%), OC (85%), and CS (85%) as Type A - Clan Culture, the dimensions DC (92%), OL (62%), and OP (85%) as Type B - Adhocracy Culture, and MS (77%) as Type D - Market Culture. When asked about their ideal culture, the unit prefers the dimensions DC (85%), MS (85%), OC (85%), OP (92%), and CS (100%) as Type A - Clan Culture. The MS (85%) is also aligned with Type D - Market Culture, and the OL (77%) with Type B - Adhocracy Culture.

5. Discussion

From the analysis of the IDG in the USFs of model B, it was possible to verify that there were no significant fluctuations across different months. In April, May, and August 2021, the USFB that achieved the highest IDG was Lauroé (81%, 80.9%, and 83.2% respectively), while the one with the lowest IDG was Âncora (62.3%, 59.5%, and 60% respectively). In September 2021, the USFB that reached the highest IDG was again Lauroé (81%), and the one with the lowest IDG was Descobrimentos (60%) and Âncora with 60.4%. All USFs have Clan Culture as the dominant organisational culture type. The study results showed that the cultural profile of the highest-performing USFs, namely Lauroé, Levante, and Balsa, is Clan Culture in all dimensions, while also displaying characteristics of Adhocratic and Market cultures, particularly in the dimensions of Dominant Characteristics, Organisational Leader, Management Style, Organisational Principle, and Success Criteria. These results suggest that USFs with lower IDG should enhance Adhocratic and Market cultures, especially in terms of Leadership and Success Criteria, to achieve better IDG scores. The USFs with the lowest IDG are Descobrimentos and Âncora. In these USFs, the predominant organisational culture profile is also Clan Culture. Comparing these with the units with higher IDG, differences in Organisational Leadership are noted, as leaders in Descobrimentos and Âncora are not perceived as entrepreneurial, innovative, or challenge-accepting. Professionals in USFs with better IDG wish to perpetuate Clan Culture while increasing Adhocratic and Market Cultures, particularly focusing on Organisational Leadership. This cultural profile could also be leveraged as a competitive advantage to improve their performance indicators. Leone and Lapão (2014) mention that a leader with Adhocratic typology possesses better characteristics to adapt and take risks in the face of change in an organisation where Clan Culture dominates. To validate the current and desired culture, strategic actions are needed to identify necessary changes and develop an action plan to improve performance indicators. In this context, and based on the results, some recommendations for this change are presented in Table 3.

Table 3 - Recommendations for Cultural Change Management Actions

Encourage employee participation in all aspects of organisational life (Cameron & Quinn, 2006).
Promote teamwork and partnerships while maintaining rigorous performance management styles (Loyd, 2001). Healthcare professionals should develop teamwork skills to create a sense of belonging to a specific group (Leone et al., 2014).
Foster management styles that reflect the Clan culture type, with approaches aimed at enhancing a supportive culture (Ferreira, 2011).
Adapt the management style to the culture of each organisational unit using appropriate tools to address organisational challenges and adapt to the context, resizing resources, redefining strategy, philosophy, and policy from an evolution, adaptation, and survival perspective (Mintzberg, 2004).
Encourage a spirit of mutual assistance, group cohesion, and a healthy and pleasant environment (Cameron & Quinn, 2006). Culture can thus represent a competitive advantage in organisations, especially when there is a set of common and consensual perceptions that integrate memories, values, attitudes, and definitions (Ferreira, 2011).
Promote the affirmation of values, mission, and vision to effectively guide the work (Monteiro & Valente, 2007).
Improve socialisation through relationships among team members and by organising activities (Schein, 2010).
Promote shared values, beliefs, and principles, as well as a strategic vision (Monteiro & Valente, 2006, 2007).
Develop a culture where empathy and close relationships between healthcare professionals and patients are important (Gregory et al., 2009).
Encourage the effective sharing of values within units, as only when cultural values are genuinely shared can strategic alignment be achieved, particularly in organisations characterised by teamwork and greater autonomy for professionals (Robbins, 2009).

Source: Own elaboration

6. Conclusion

The execution of this study allowed, in the first phase, to characterise the sociodemographic profiles of professionals in the USFB, finding that technical assistants, nurses, and doctors have a great similarity concerning the predominant culture. The three professional groups recognise Clan Culture as currently predominant in their units. This culture is characterised by teamwork, a healthy environment, human resource development, and concern with evolution and change. However, ideally, they acknowledge that the organisation should adopt a more competitive posture oriented towards production and performance. Clan Culture is typical of organisations that are very familiar places to work, where people share much of themselves, which could explain the predominance of this type of culture in the USFB. The fact that Market Culture was the second-highest cultural profile could be due to the philosophy of professionals being oriented towards high performance and productivity underlying the creation of these units (Cruz and Ferreira, 2012). Hierarchical Culture had the lowest average, as the USFB represent a new organisational model that opposes the traditional hierarchy and bureaucracy of vertical power and decision-making. The study results showed that the highest-performing USFs were Lauroé, Levante, and Balsa, which have Clan Culture characteristics in all dimensions, although they also exhibit features of other cultural types, particularly Adhocratic and Market cultures. These results indicate that no organisation reflects a single cultural type but rather a combination of them (Santos, 2000). The USFs with the lowest IDG are Descobrimentos and Âncora. In these USFs, Clan Culture is also predominant, but the organisational leader is not perceived as entrepreneurial, innovative, or challenge-accepting. A leader with Adhocratic characteristics is better suited to adapt and face risks in a changing organisation dominated by Clan Culture (Leone and Lapão, 2014), traits observed in the USFs with the highest IDG.

6.1. Limitations

Among the main limitations of this study is the fact that it was conducted during the Covid-19 pandemic, which resulted in an overload for healthcare professionals on care teams, making data collection more difficult. Another limitation was the use of the OCAI questionnaire on a Likert scale, where responses are given on a scale based on the degree of agreement, disagreement, and neutrality regarding different statements. This led to many neutral responses. The choice of an Ipsative scale would have been more appropriate, as respondents would have to allocate 100 points among the alternatives, giving more points to those most similar to their organisation.

7. References

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