

Influence of Market Structure and Leadership on the Performance of Faith-Based Hospitals in Kenya

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Abstract:

Background: Globally, business has become very competitive where firms are trying to create their own competitive advantage to survive. However, there are common factors which affect the operating environment of an organization and they include; technology, resources, customers, economy, competition, political and social conditions. The operating environment can substantially affect the growth, current operations, and long-term sustainability of an organization even though it occurs outside the organization. Classifications and standards of quality healthcare service delivery is related to patients' contentment, allegiance and the organization efficiency and output. As a result, healthcare organizations throughout the world consider patient satisfaction as a strategic determiner of competitive orientation thus giving the firms the foresight in improving quality of healthcare services. Faith-based hospitals experience major challenges due to increased competition in health sector. The major challenge is funding since the government does not consider the faith-based hospitals in its budget as other public Hospitals, market structure, and leadership. This study examines how market structure and leadership influence the performance of faith-based hospitals in Kenya, and considers competitive orientation as a moderating variable.

Materials and Methods: The study adopted a correlation research design to describe the existing association between the independent and dependent variables in line with regression analysis. The study focused on five employees in all the mission hospitals making a total of 425 respondents. The employees involved in the study were Chief Executive Officers, Administrators, Finance Managers, Human Resource Managers, Chief Medical Officers, And Nursing Managers. A sample of 40 hospitals was selected and questionnaires were used to collect the data. SPSS version 23 was used to analyse data.

Results: The research established that market structure has a weak negative correlation ($r=-.062$) with performance, while leadership has a weak positive correlation with performance ($r=.068$). According to the regression model, there is a positive relationship between performance of faith-based hospitals and market structure and leadership ($R=0.974$). According to the hypothesis tests, there is no significant change in the performance of FBH due to market structure since the sig value is $0.88 > 0.05$. Besides, leadership does not have a significant influence on the performance of FBH since the sig value is $.825 > 0.05$.

Conclusion: Market structure and leadership have no effect on the performance of FBHs.

Key Word: Market structure, Leadership, Faith-based hospitals.

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I. Introduction

The Faith-based Hospitals mainly comprises of non-profit community hospitals that are mainly funded by charity groups, religions, and research funds. According to Raffle and Gray (2019), non-profit mission hospitals in the United States face three major challenges. Firstly, financial challenges due to increased competition in the health sector and lack of funding since they do not receive funding from the government. Secondly, poor performance due to insufficient human resources especially nurses (Raffle & Gray, 2019). Lastly, accrued unpaid since there is high number of uninsured patients visiting the hospitals who are unable to pay their bills, leading to huge debtor portfolio causing financial crisis. This has formed a ground for high competition in the health care industry and faith-based organisations with no finances must enhance their operations to remain competitive. Regionally, faith-based Hospitals (FBHS) provide 30-70% of health care in the third world countries (WHO, 2017). Research has shown that most rural facilities in many African countries lack qualified personnel and are managed by nurses and midwives as health care providers (WHO, 2017). According to Adjei et al (2019), FBHs are facing serious operational challenges due to lack of financial and technical assistance from partners, donors, and the African governments. Therefore, the FBHs should consider facing the tough competition in the health care industry by adapting the operating environment to enhance their

performance. According to Van and Adedokun (2021), Nigeria healthcare is fully controlled by three levels of government hierarchy. The private healthcare providers and herbal medicine have a great role to play in healthcare delivery. The faith-based hospital in Kenya run in the private sector funded by several religious organizations, and their management structures, regulations of the sponsor and policies. They are controlled by three main bodies namely, the Supreme Council of Kenya Muslims, Kenya Conference of Catholic Bishops, Christian Health Association of Kenya (Abuor, 2012). The hospitals are often financed by internally generated revenue, grants, and donations from well-wishers. The hospitals do not receive funding from the government and are unable to compete successfully with other hospitals in the sectors. Further, these hospitals mainly target the low-income earners in the society and are not able to huge financial muscles like other high-end private hospitals operating in the economy, which limits the ability of these hospitals to compete successfully in the market due to lack of financial resources to employ high qualified employees and the use of modern technologies (Nzuve & Mwarey, 2013).

II. Material And Methods

The study was conducted among employees in all the mission hospitals under the Muslim, Catholics, and Protestants associations between March and May, 2022. A total 425 adult subjects (both male and females) of aged ≥ 18 , years were for in this study.

Study Design: Correlation research design

Study Location: The study was conducted across 85 Faith Based Hospitals in Kenya.

Study Duration: March 2022 to May, 2022.

Sample size: 200 respondents.

Sample size calculation:

Umbrella	No. of Hospitals	$n = N/1 + N(e/2)$. sample	Total Respondents from each umbrella
Kenya Conference of Catholic Bishops (KCCB)	54	24	120
Christian Health Association of Kenya (CHAK)	24	10	50
The Supreme Council of Kenya Muslims (SUPKEM)	7	6	30
Total	85	40	200

Subjects & selection method: Purposive method to the selection of the respondents was favourable where top managers were picked from the relevant sections only these were HR Manager for competencies, Chief Medical Officer for clinical area, Nurse Services Manager for the nursing and patient care, CEOs and Administrators for the leadership, Finance Managers for the resources were used in the study to eliminate personal bias

Inclusion criteria:

1. Employees in FBHs
2. Either sex
3. Aged ≥ 18 years,

Procedure methodology

In order to identify the operating environment and competitive orientation on the performance of faith-based hospitals in Kenya, the study collected primary data through questionnaires that consisted of both open and closed ended questions. The rationale of using primary data is that, despite the fact that it may be expensive, it gives accurate results (Harrell & Bradley, 2009). Further, primary data is more reliable when compared to secondary data. Opinion data was collected using a Likert rating scale because it is the most regularly used variation of the summated rating scale. Respondents rated their answers and statements in relation to the variables studied where each response in the questionnaire was assigned an arithmetical mark to reflect its degree of attitudinal favourableness.

The rationale for using questionnaire is that it is an efficient method of data collection since its time saving, large volume of data can be obtained within a short duration, and it also helps in eliminating personal bias during data collection (Delport & Roestenburg, 2011). Secondary data was obtained from hospitals' websites, while articles, online books, and journals were used for the purposes of literature review. The rationale of using secondary sources of data was that they were cheap and free, easy to access, it allows the researcher to generate new insights from previous analysis and less time-consuming methods of collecting data (Mwathi, 2013). The respondents cut across all the faith-based hospitals in Kenya ranging from KCCB, CHAK and SUPKEM Hospitals in Kenya that operates as Faith Based to enable the researcher collect unbiased views from all participants.

Statistical analysis

Descriptive statistics were used to summarize the data collected through questionnaires and comment based on measures of the central tendency, dispersion, mean, percentages, and skewness. Inferential statistics were used in hypothesis testing and estimations of parameters to make inferences of the entire population.

SPSS version 23 was used to analyse data collected, and the study combined both qualitative and quantitative data. The qualitative data was obtained through the questionnaires and was transformed into quantitative data through coding. Data analysis combined both descriptive and inferential statistics.

A regression model of operating environment parameters was run against the performance of faith-based hospitals in Kenya. However, before running the regression model diagnostic tests were carried out to ascertain the accuracy and effectiveness of using the data to run the model for analysis.

III. Result
Descriptive Statistics

Table No 1.Shows the gender of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	93	51.7	51.7	51.7
	female	87	48.3	48.3	100.0
	Total	180	100.0	100.0	

Table no.1 shows the gender of the respondents. The study findings established that the mean of the respondents' gender was $\mu=48$. This implies that majority of respondents were male.

Table No. 2. Shows the respondent's level of education

The Level of Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Diploma	31	17.2	17.2	17.2
	Degree	85	47.2	47.2	64.4
	post graduate	64	35.6	35.6	100.0
	Total	180	100.0	100.0	

Table No. 2. Shows the respondent's level of education. The study findings implied that majority of the respondents, 47.2%, were degree holders. Besides, 35.6% had a postgraduate qualification, while 17.2% were diploma holders. This implies that middle and top-level managers in FBHs have a graduate and postgraduate qualification

Table No. 3 Shows the number of years worked in the hospital

The number of Years Worked in the Hospital

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-1 years	13	7.2	7.2	7.2
	1-3 years	38	21.1	21.1	28.3
	4-7 years	55	30.6	30.6	58.9
	8-10 years	74	41.1	41.1	100.0
	Total	180	100.0	100.0	

It was established that majority of the respondents had worked for 8-10 years, 41.1%.

Measures of Independent Variables

Market Structure

Table No. 4 shows responses on whether FBHs have a well formulated marketing structure.

FBH Have Well Formulated Marketing Structure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	117	65.0	65.0	65.0
	Disagree	43	23.9	23.9	88.9
	Undecided	3	1.7	1.7	90.6
	Agree	10	5.6	5.6	96.1
	Strongly Agree	7	3.9	3.9	100.0
	Total	180	100.0	100.0	

Table No.4 shows that majority of the respondents strongly disagreed that FBHs have a well formulated marketing structure. These findings are similar to Martin et al (2018) who established that faith-based hospitals

lack a proper marketing strategy and recommended the firms to develop strong marketing approaches. Similarly, Kinyajui et al (2015) established that FBHs have an inefficient marketing structure. Besides, Kuzma et al (2009) established that protestant-based hospitals have a weak marketing structure and recommended the firms to develop a stronger market structure. Thus, FBHs inability to cope with strong market competition could be attributed to poor marketing structure.

Table No. 5 shows responses on whether FBHs are able to cope with existing regulations.

FBH Are Able to Cope with Existing Regulations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	94	52.2	52.2	52.2
	Disagree	55	30.6	30.6	82.8
	Undecided	6	3.3	3.3	86.1
	Agree	15	8.3	8.3	94.4
	Strongly Agree	10	5.6	5.6	100.0
	Total	180	100.0	100.0	

Table No. 5 shows that majority of the respondents strongly disagreed that FBH are able to cope with existing regulations. These statistical findings imply that FBHs are unable to cope with existing regulations. These findings disagree with Kinyajui et al (2015) who established that majority of the FBHs are able to cope with existing regulations due to their strong financial capacity. Therefore, more research should be carried out to establish the FBHs ability to cope with existing regulations.

Table No. 6 shows responses on whether FBHs are able to cope with huge number of competitors.

FBH Are Able to Cope with Huge Numbers of Competitors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	96	53.3	53.3	53.3
	Disagree	53	29.4	29.4	82.8
	Undecided	2	1.1	1.1	83.9
	Agree	14	7.8	7.8	91.7
	Strongly Agree	15	8.3	8.3	100.0
	Total	180	100.0	100.0	

Table No. 6 shows that majority of the respondents strongly disagreed that FBHs are able to cope with huge number of competitors. Majority of the respondents, 53.3% strongly disagreed that FBHs are able to cope with huge number of competitors. 29.4% disagreed that FBHs are able to cope with huge number of competitors, while 7.8% and 8.3% agreed and strongly agreed respectively. These findings are in tandem with Chen and Kao (2012) who found that FBHs cannot cope with huge number of competitors and recommended them to focus on relationship and traditional marketing to improve their competitive position. Therefore, FBHs should strengthen their marketing approach to enhance their competitiveness in the market.

Table No. 7 shows responses on whether FBHs compete for the same market share and patients are sufficient.

FBH Compete for the Same Market Share and Patients are sufficient

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	96	53.3	53.3	53.3
	Disagree	52	28.9	28.9	82.2
	Undecided	1	.6	.6	82.8
	Agree	12	6.7	6.7	89.4
	Strongly Agree	19	10.6	10.6	100.0
	Total	180	100.0	100.0	

Table No. 7 shows that majority of the respondent strongly disagreed that FBH compete for the same market share and patients are sufficient. These findings imply that majority of the respondents, 53.3%, strongly disagreed that FBHs compete for the same market share and patients are sufficient, while 28.9% disagreed. Therefore, FBHs do not compete for the same market share and patients are insufficient. However, Kinyajui et al (2015) noted that majority of the FBHs compete for similar market share, but patients are insufficient. Therefore, it is essential to establish the diversities in the FBHs target markets and the degree of competitiveness in each market fragment.

Leadership

Table No. 8 shows responses on whether FBHs have well-structured leadership styles.

FBH Have Well Structured Leadership Styles

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	61	33.9	33.9	33.9
	Disagree	95	52.8	52.8	86.7
	Undecided	4	2.2	2.2	88.9
	Agree	16	8.9	8.9	97.8
	Strongly Agree	4	2.2	2.2	100.0
	Total	180	100.0	100.0	

Table No. 8 shows that majority of the respondents disagreed that FBH have a well-structured leadership style. Majority of the respondents, 52.8% disagreed that FBH have a well-structured leadership style, while 33.9% strongly disagreed that FBHs have a well-structured leadership style. Similarly, Khan (2016) established that structured leadership has a positive impact on the performance of faith-based hospitals and majority of FBHs lack a well-structured leadership style. Therefore, FBHs should strengthen the structure of their leadership styles to enhance performance and attain their vision and mission.

Table No. 9 shows responses on whether FBHs have uncomplicated bureaucracies that enhance leader's performance

FBH Have Uncomplicated Bureaucracies that Enhance Leader's Performance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	69	38.3	38.3	38.3
	Disagree	93	51.7	51.7	90.0
	Undecided	3	1.7	1.7	91.7
	Agree	6	3.3	3.3	95.0
	Strongly Agree	9	5.0	5.0	100.0
	Total	180	100.0	100.0	

Table No. 9 shows that majority of the respondents disagreed that FBHs have uncomplicated bureaucracies that enhance leader's performance. Majority of the respondents, 51.7%, disagreed that FBHs have uncomplicated bureaucracies, while 38.3% strongly disagreed that they have uncomplicated bureaucracies. This means that majority of the FBHs have complicated bureaucracies that impair their performance. Similarly, Web (2011) established that FBHs have complex bureaucracies and argued that bureaucracies create inefficiencies, but perception, attitude, and support of the leaders enhance performance. Therefore, FBHs should eliminate bureaucracies to enhance their performance.

Table No. 10 shows FBHs have well equipped leaders with skills and academic qualifications.

FBH Have Well Equipped Leaders with Skills and Academic Qualifications

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	67	37.2	37.2	37.2
	Disagree	82	45.6	45.6	82.8
	Undecided	3	1.7	1.7	84.4
	Agree	20	11.1	11.1	95.6
	Strongly Agree	8	4.4	4.4	100.0
	Total	180	100.0	100.0	

Table No. 10 shows that majority of the respondents disagreed that FBH have well equipped leaders with skills and academic qualifications. The study established that majority of the respondents, 45.6%, disagreed that FBHs have well equipped leaders with skills and academic qualifications. Besides, 37.2%, strongly agreed that FBHs have well equipped leaders with skills and academic qualifications. Only a small percentage of the respondents, 11.1% and 4.4% agreed and strongly agreed respectively that FBHs have well equipped leaders with skills and academic qualifications. Similarly, Adolf et al (2018) established that majority of FBHs have not equipped leaders with needed skills and academic qualifications to enhance performance. They observed that leaders with better academic qualifications and leadership skills improved the performance of faith-based hospitals.

Therefore, FBHs should develop incentives to equip leaders with skills and academic qualifications to enhance their performance.

Summary of the Regression Model

Table No. 11 shows summary of the regression model and coefficients

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				Durbin-Watson	
					R Square Change	F Change	df1	df2		Sig. F Change
1	.974 ^a	.949	.947	.27404	.949	43.251	6	73	.00	2.216

a. Predictors: (Constant), Competitive Orientation, market structure, Resources, interaction variable, Leadership

b. Dependent Variable: Performance

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.435	.117		29.407	.000
	Market structure	.003	.022	.003	.152	.880
	Leadership	.007	.031	.005	.222	.825

a. Dependent Variable: performance

The R-square (R=.947) shows that 94.7% of variation in performance of FBH in Kenya can be explained by market structure and leadership. Since the R² is greater than 0.5, the model is effective to determine the relationship between dependent and independent variables.

The ANOVA determines whether the model is significant enough to determine the outcome. The model's p value (p=.000, 95% confidence interval) is less than 0.05. Therefore, the result is significant. The F-ratio represents an improvement in the prediction of the variable by fitting the model after considering the inaccuracy present in the model. Since the F-ratio (F=643.251) is greater than 1, the model is efficient.

IV. Discussion

The first objective of the research was to examine the influence of market structure on the performance of faith-based hospitals in Kenya. Under this objective, the research examined whether competition and regulation affect the performance of FBHs. The descriptive statistics (means) established that faith based-hospitals have a well formulated marketing structure to match the competition level needed, faith-based hospitals are able to cope with the existing regulations, the hospitals are able to cope with the huge number of competitors in the health sector, and they are competing for the same market share and the number of the patients served are sufficient for all of them. From the regression model, the research found a positive relationship between measures of market structure (competition and regulation), which implied that competition and regulation does not have a significant effect on the performance of FBH. Nonetheless, favorable regulations and strong competition enhance FBHs innovativeness and performance. These findings are in tandem with the Michael Porter's Five Forces Theory, which states that favorable regulations and competition enhance performance of firms.

The second objective was to evaluate the influence of leadership on the performance of faith-based hospitals in Kenya. The measures of leadership were types of leadership, bureaucracies, and qualifications. Under this objective, the research examined whether leadership styles are well structured to enhance the performance of faith-based hospitals, hospitals have complicated bureaucracies that makes it very easy for the leaders to perform, and hospitals have equipped its leaders with the necessary skills and academic qualifications to support their performance. The descriptive statistics (mean of the responses) indicated that leadership styles are not well structured to enhance the performance of FBHs, FBHs have complicated bureaucracies that makes it very difficult for the leaders to perform, and FBHs have not equipped its leaders with the necessary skills and academic qualifications to support their performance. From the regression model, leadership does not have a significant influence on the performance of FBHs. This finding implies that leadership has no effect on the performance of FBHs since they have complicated bureaucracies, lack well-structured leadership styles, and leaders are not equipped with the necessary skills and academic qualifications to support their performance. Reducing complicated bureaucracies, having a well-structured leadership style, and equipping leaders with necessary skills and academic qualifications can enhance the performance of FBHs. These findings are in line

with the Upper Echelons Theory, which states that good and structured leadership style enhance the performance of an organization.

V. Conclusion

On the effects of market structure on the performance of faith-based hospitals, the research concluded that that faith based-hospitals in Kenya have a well formulated marketing structure to match the competition level needed, faith-based hospitals are able to cope with the existing regulations, the hospitals are able to cope with the huge number of competitors in the health sector, and they are competing for the same market share and the number of the patients served are sufficient for all of them.

On the effect of leadership on the performance of faith-based hospitals, the research concluded that FBHs leadership styles are not well structured to enhance their performance, FBHs have complicated bureaucracies that makes it very difficult for the leaders to perform, and FBHs have not equipped its leaders with the necessary skills and academic qualifications to support their performance.

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