EFFECT OF ORGANIZATIONAL CULTURE ON PERFORMANCE OF LARGE PRIVATE HEALTH FACILITIES IN KENYA

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ABSTRACT

Although strategy implementation is a key factor in organizational performance, other factors too enter into play. The main objective of this study was to establish the influence of organizational culture on performance of large private health facilities. By use of a cross-sectional descriptive survey, data from 58 large private health facilities were gathered using a structured questionnaire. It was further analyzed using descriptive statistics and multiple linear regressions statistical methods. The results revealed that organizational culture has not statistically significant effects on the performance of the facilities. The findings contribute to the general body of knowledge and provide a backdrop for further advancement of theory and research. The study informs the policy makers on the need to set mechanisms that support culture. The study limitations included the limited generalizability and a wide geographical spread of the facilities. Based on the limitations of the study, areas for further research have been suggested to address other contexts. Besides, different other methodologies and conceptualizations may be used.

Keywords: Organizational Culture, Organizational Performance, Efficiency, Effectiveness, Relevance, Financial viability

INTRODUCTION

Organizational performance is recognized in the extant literature as a critical aspect of businesses due to the pertinent position it occupies in shaping the success and survival of an organization in a given market place (Aosa, 1992). Performance is a multifaceted concept, thus it is affected by a variety of variables. Generally, an organization is an institution that is deliberately designed to meet a certain goal and objectives (Odhiambo, 2014). To do that meaningfully, management develops a road map that guides not only the activities but also resource allocation. That which is perceived as the road map is what an organizational strategy is according to Bourgeois (1980). Organizational culture is an internal factor that influences how an organization interacts with employees and external stakeholders. Beliefs and attitudes are some of the strongest components of organizational culture. The core element of culture is the people, their interactions and how these factors translate into a unique behaviour. Abu-Jarad et al., (2010) underscore that culture represents a potential source of competitive vantage point, which facilitates securing of enhanced performance.

The unit of this study is Large private health facilities, which occupy a prime part in propelling the realization of Universal Health Care (UHC) across Kenya. As far as Kenya is concerned, UHC has always been of utmost priority and it is not a wonder, that it tops the current government regime's newfound development initiative of the Big Four Agenda (Ministry of Health, 2017). The bigger part of the health workforce in Kenya operates in the non-government health sector. This implies that the medical doctors who form 75% and clinical officers and nurses who form 66% render their services in private health facilities (Kenya Healthcare Federation- KHF) (2016).

Unlike in public health sector, private health facilities face fewer matters that lead to overworking by staff, a factor that may lead to stress, strikes by workers and other consequences. Besides, the private facilities in most of the times offer more attractive salaries as well as general motivation to the employees. Notwithstanding these factors, medical specialists in the country are so few that they do not match the so needed services. Therefore, the few medical specialists that there are in Kenya are left with a high bargaining capacity. Therefore, the doctors practicing in private health facilities enjoy higher salaries and other morale-boosting incentives out of the fear of expertise loss (KHF, 2016) than their counter parts operating in public sector.

As a result of this distinct style of operation or culture, the costs of healthcare in private health facilities are usually higher compared to those in public health facilities. This implies that to maintain effective performance, the private health facilities must adopt strategies that match their unique organizational cultures. Further, the strategies must align to the changing times currently being experienced in the Kenyan healthcare sector, such as the aspect of Kenya growing into a middle class economy, stiff competition as well as increasing demand for quality accessible health services (KHF, 2016). Large private health facilities are operational in every part of the country, that is, in rural and urban areas alike; and they serve all categories of people. Their upward trend in performance would enable them open new centers and satellites even in the poorest zones of the country, hence make services available at the grassroot to the poor people. This would go a long way into even creating jobs for so many young people that are jobless today.

Given the current trend in global competition arising from business globalization and technological advancements, large private health facilities are compelled not only to build on available resources, but also focus on long-term customer relationships. They often find themselves in competitive situations where the external environment on which they depend and to which their services are rendered is ever changing. Therefore, shedding light on how culture influences performance of the health facilities in private sector, could serve as a basis for which these organizations can institute appropriate strategic actions and policies that suit their internal and external circumstances. In the previous studies undertaken in the Kenyan health sector, the researcher had not come across one that had tested this relationship. The past studies evidence

that they had addressed either different units of study, industries or diverse other contextualization. This research was thus inspired by a strong desire to fill this gap.

Research Problem

The concepts of culture and performance have been found to interact in a manner that reflects the performance of structure-conduct framework of industrial organization economics. The underlying principle of this interaction is that the organization operates in an environment (market structure) that shapes its strategic behaviour (conduct), which in turn determines its performance. Empirical studies of this linkage have adduced evidence to support the view that organizations which are able to appropriately and adequately react to turbulence in the environment by way of instituting appropriate strategies report positive performance (Venkatraman and Prescott, 1990). Additionally, as organizations purpose to keep pace with the demands of the external environment, they must consider how their strategic focus align with organizational cultures because such strategic fit has a great bearing on their effort to be successful (Moore, Kizer & Jeon, 2011; Armarjeev, 2018; and Kaul, 2019). The environment in which large private health facilities in Kenya operate is characterized by complexity and turbulence. Complexity arises even from the high level of regulations by the Ministry of health. Further, there are various stakeholders that the private hospitals must deal with, such as the potential patients, medical suppliers and insurance companies.

There exists evidence in the past literature pertaining studies done on the predictor variables in this study in relation to performance, in most cases, the variables have been studied in isolation or in some combinations. For instance, Zhao, Teng and Wu (2018) found a negative link between organizational culture and the performance of Chinese companies. Literature demonstrates that studies pertaining to performance and what may buffer or impinge its outcomes have been studied in different contexts. For instance, Khoshtaria (2018) focused on US-based manufacturing companies; Zhao et al. (2018) on Chinese companies; Noh et al. (2011) on Korean nursing facilities; Khan and Huda (2016) on Pakistani tertiary hospitals and Omari et al. (2016) on private hospitals in Kisii County. While a substantial amount of studies have been carried out in organizations operating in diverse geographical contexts such as USA, China, Korea and Pakistan, the findings and conclusions may not be extended to large private health facilities operating in the Kenyan context because of its unique manifestations in terms of literacy and poverty levels, economic, demography and even political aspects among others. Further, the scholar did not identify a similar work in the literature, focusing on the unit and variables that are addressed in the current study.

Following the evidence presented by literature reviewed, there are still matters that need some resolution along the conceptual and contextual realms in the interactive relationship among the variables in this work. The study advanced a conceptualization that focused on organizational culture as a predictor variable. The organizational criterion performance variable served as the

dependent variable. Consequently, the task of the study is to provide answers to the gaps established by answering to One main question: What is the effective of organizational culture on organizational performance?

Research Objectives

The objective of the study was to establish the effect of culture on organizational performance

LITERATURE REVIEW

Theoretical Foundations of the Study

The study was anchored on Cultural Dimensions Model postulated by Hofstede (1980). He defines culture as the common mind-set that differentiates members of one group of people or an organization from others. His cultural dimensions' model is widely used in literature. In a classic study of ten organizations in the Netherlands and Denmark, Hofstede (1980) identified six dimensions along which cultures of different companies can be compared. These six dimensions measure employees' perceptions regarding the degree to which they enact the different orientations of the various dimensions in their practices.

The first dimension describes whether a given workplace is more concerned with processes (process-oriented) or with outcomes (results-oriented). The second dimension measures whether an organization focuses predominantly on its staff. The third dimension refers to different sources of members' identity: parochial implies those employees whose identity is mostly drown from the organization they work for, while professional denotes employees that are known by the tasks they perform. The fourth category distinguishes between open and closed systems regarding communication habits in a company. The fifth dimension captures the amount of control mechanisms and internal structures in place. The sixth dimension measures an organization's orientation towards its customers. Different dimensions shape not only the thinking and behaviour of people, but also how decisions are made. They also define different ways of dealing with different aspects of organizational functions and processes.

As such, the six cultural attributes proposed by Hostede are very key to this study. As far as the model is concerned, the concept of culture is not only applicable in reference to ethnic groups and tribes but also in national, zonal, regional, organizational as well as professional domains among others (Hofstede, 2011). It therefore fits in a study of health facilities. According to Douglas (1982), culture is firmly rooted in human interactions.

The work of Hofstede (1980) has faced criticism from different scholars. For instance, Schwartz (1999) alluded that the survey method utilized by Hofstede was not appropriate for determining

and assessing cultural differences. Another criticism was put forward by Redpath (1997), who asserted that the model assumes domestic population as being characterized by cultural homogeneity. In the same light, Olie (1995) argued that the model assumed that information about one company could possibly be extrapolated to represent the cultural system of a country. The model plays a pivotal role in shedding light on the culture-performance linkages. It shows that organizational culture (internal factor) is key in determining the output of an organization. It is because of the significance of Cultural dimensions model that organizational culture ought to be considered in any effort toward strategic planning. Therefore, the model highlights the importance of internal attributes of an organization in improving performance.

Organizational Culture and Performance

Culture within an organizational scenario implies the routine of operations and practices that ultimately contribute to distinct characteristics (Hofstede, 2011). Buku et al., (2015) argue that culture determines the overall strength of an organization. The scholars theorize that there are several core elements that constitute the fundamental nature of culture, all of which affect performance. When culture is co-aligned with strategy, performance results may be of superior character. It is theorized that organizational culture positively contributes to the long-term effectiveness on performance (Urbius & Alas, 2009). Culture is constitutive of organizational actions, which are attuned to the interests of the stakeholders in an organization (Swedlow, 1994). Cultural dimensions model enables management to approach employees' behaviour from various perspectives (Hofstede, 2011).

Various scholars have scrutinized the linkage between culture and performance outcomes of organizations. For instance, a time-series-based study was carried out by Jacob et al., (2013) in the effort of exploring the potential link found in the interaction of cultural phenomena and performance outcomes of emergency in England-based hospitals. Using data of over three-time periods between 2001/2002 and 2007/2008, the scholars adopted ordered probit and multinomial logit analytical models to explore the connection between different organizational types (clan, hierarchical, developmental and rational) and performance outcomes of the selected health facilities. The results produced by the models demonstrated that the effects of culture on performance indicators of the facilities were positive. The study made a significant contribution to the evidence pointing to how culture affects the overall performance of businesses. However, it was not clear whether the findings based on the England acute hospitals could be generalized to the large private health facilities in Kenya.

In another study, Zhao, Teng and Wu (2018) examined how organizational culture of selected Chinese companies shaped their performance outcomes. The culture of the selected companies was proxied by the Chief Executive Officer's (CEO) speech, culture page, workers' routine activities, social responsibility, awards won, in-house capacity-building programs, company

news and medical exposure. Longitudinal data were garnered from 1,044 quoted companies. Results produced from the analysis of the data showed that culture had a negative link with the market value of the companies, but a positive interaction with the innovative capacity. While the scholars contributed to expansion of the knowledge-base, their study was context-specific. In particular, their study was carried out in China. Besides, they focused on a sector different from the one targeted by the current study.

In a similar study, Zhou et al., (2011) labored on assessing the ramifications of culture on outcomes of performance in Chinese-based hospitals. In the whole work, culture was viewed as a manifestation of four dimensions: orientation, consistency, involvement and adaptability. In a sample of 8,276 patients and 3,437 employees from 87 hospitals in China, the study found mixed results. This is as per implications of culture on the overall performance outcomes of the institutions. A fundamental limitation of this study was that the findings were limited to the context of Chinese hospitals. Therefore, extrapolating the findings to the Kenyan context or other parts of the world would be problematic. Though the industry was similar, the sector and unit are different from that of the current study.

Acar and Acar (2014) carried out a study with the intent of establishing the effects of culture on the overall outcomes of public health facilities in Turkey. The scholars conceptualized culture as a multidimensional construct, involving adhocractic, clan-based, hierarchical and market-oriented cultures. Using a sample of 512 executives from 99 hospitals (private and public) in Turkey, the scholars concluded that there was an affirmative association results drawn from the two variables in the health units. An obvious limitation of the study is that it focused exclusively on the case of Turkish hospitals. As such, the findings are not capable of depicting the interplay between culture and performance across national contexts.

However, as it stands, the impact culture has received in research is insignificant as evidenced by the review of studies presented in this section. Therefore, in addition to addressing the debate surrounding the ramifications of specific variables in this work, the study advanced the conceptualization that the overall culture could create situation which might positively impact on performance.

Conceptual Framework

Conceptual framework is an analytical tool used to organize idea and plan to ease the process of the study. It shows how study variables are related as shown below.

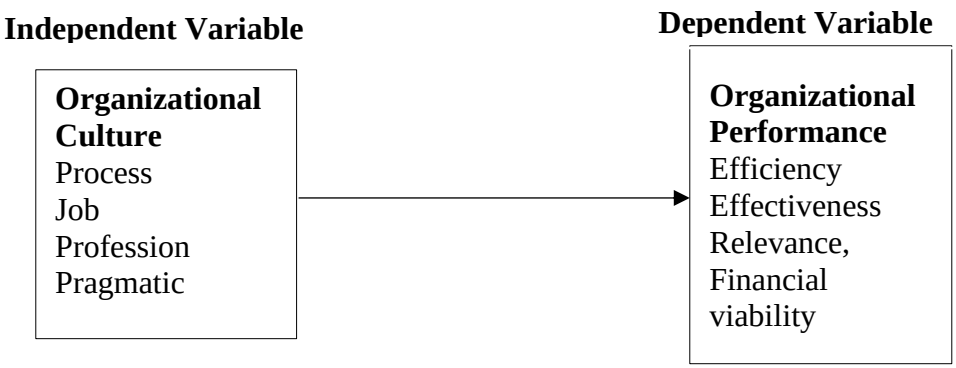

Figure 1: Conceptual Model

MATERIALS AND METHODS

Research Philosophy

This study was guided by positivistic philosophy. To the positivism philosophy was added the notion of pragmatism. This emphasizes on what is functional as pertains to research questions under investigation (Tashakkori & Teddlie, 2003). Pragmatism allowed for collection of verbatim responses springing from respondents' experiences. The objective of the current study was to establish correlations among the variables of interest. Therefore, scientific principles reflected through the use of statistical techniques such as regression and canonical correlation analyses had to be invoked. These scientific principles underpin the positivistic philosophical view utilizes in this work.

Research Design

In this study, descriptive cross-sectional survey design was employed. Cross-sectional design allowed for the utilization of the mixed-method in the work, where the findings were based upon two separate forms of information: quantitative and qualitative. Therefore, the mixed methods design allowed for the seamless integration of statistical and thematic data analytical techniques of the overall data collected.

Population of the Study

A study population is the total collection of elements in a study (Nachmias & Nachmias, 1996). The sum-total of all private health facilities registered at the time of study (2018) was Three thousand and Ninety Five (3095), as indicated and evidenced by MPDBK (2018). Categorization of the size of the facilities as large is based on One hundred (100) and above bed capacity (MOH, 2017). As of September 2018, when the study was undertaken, the sum-total of all

operational Large Private Health Facilities in Kenya stood at Sixty One (61) and this formed the study population. Therefore, a census survey was employed as there was no need for sampling.

Data Collection

A questionnaire was employed to collect primary data that was used in this study. A total of Sixty-One (61) survey questionnaire tools were administered to the research respondents, either in form of a mail or by means of persons well-trained for the job.

Reliability and Validity Tests

The Cronbach's alpha statistic is used for evaluating the reliability of such instruments. This study employed the cut-off coefficient point of 0.7 as recommend by (Alexandridis, 2018). A pilot test of the questionnaire was administered in 10 large private health facilities before the actual study commenced. Below is portrayed the results of the reliability assessment.

Table 1: Reliability Test Result

Scale	Number of Items	Cronbach's Alpha	Interpretation
Organizational culture	21	0.89	Reliable
Organizational Performance	31	0.91	Reliable

The reliability of the 21-question "Organizational culture" measure was high, as determined by a coefficient value of 0.89. The values for all the items stood greater than 0.8, hence fell within the acceptable range of values between 0.7 and 0.95 recommended by Alexandridis (2018).

In this study, validity types scrutinized are of three modes. The first one is content or logical validity, which ensured adequate coverage of all-important aspects. The second one is face validity, which ascertained that the questionnaire appeared to be measuring the constructs involved. The third one is predictive, also known as criterion validity. The scholar sought for opinions of experts in the relevant field of study, particularly the faculty members in university. This was in a bid to determine whether the questionnaire was valid or not. The expert opinion was incorporated in the research instrument design process, resulting in a valid questionnaire.

Data Analysis

The first step in the process of analyzing collected data involved editing of the same. At this stage, the returned questionnaire items were carefully scrutinized to identify incompleteness and information gaps and effort was made to minimize errors as much as possible. This ensured that collected data were of good quality, that is, free from inconsistencies and incompleteness. The objective was assessed by means of Multiple linear regression analysis. The outcome variable was organizational performance. This was operationalized into operational effectiveness,

efficiency, organizational relevance and financial viability. The predictor variable was organizational culture, which was operationalized into four constructs, namely: process, job, profession and pragmatic orientations.

The four organizational culture constructs were regressed on each performance indicator using multiple linear regression analysis. This resulted into four regression models. For each model, the following pertinent statistics were extracted: multiple r, $R^{2,}$ and *F*-value. The multiple r coefficients demonstrated the direction as well as the strength of association between the organizational culture constructs and each performance indicator. The R^2 represented the variance proportion in each criterion indicator substantiated by the combined aspect of the organizational culture constructs.

The function of *F*-value was to indicate the overall statistical significance of each model, whose assessment was hinged on 95% level of confidence (p=0.05). A model was considered statistically significant in a case where the *p*-value that has association with the *F*-value was less than *p=0.05*. The decision-making in view of rejecting the null hypothesis was thus made at values of F-values in a case where *p*-value was less than 0.05 for all the four regression models. If at least one of the models had a *p*-value greater than 0.05, then the decision would be made not to reject the null hypothesis.

PRELIMINARY FINDINGS

Response Rate

The interplay between the variables of interest was explored by drawing on data from large private health facilities in Kenya. It was thus necessary to establish the response rate in the survey so as to determine whether or not data collected met the minimum threshold of linear regressions, in order to proceed with statistical analyses. A response rate stands for the ratio of respondents who actually respond to a research tool and questions to eligible respondents in a survey expressed as a percentage (Vannette & Krosnick, 2013). Below is an exposition of the rate response.

Table 2: Response Rate

	Frequency	**Percentage**
Filled and Returned questionnaire items	58	95.00
Unreturned questionnaire items	3	5.00
Total Questionnaire pieces distributed	**61**	**100**

Organizational Culture

The current inquiry set off to assess the implications of organizational culture on the performance of facilities in question. In this regard, participants were requested to indicate the range by which they felt that organizational culture impacted the performance of their facilities.

It was operationalized into Twenty-One (21) items grouped into four constructs, namely: process, job, profession and pragmatic orientations. The respondents were presented with questions and the results produced from the analysis of the responses are displayed in here below.

Table 3: Organizational Culture

Statement	**N**	**Mean score**	**CV %**	***t*-value**	**Sig. (2-tailed)**
A. PROCESS ORIENTATION					
We have clear assignment of responsibilities that support strategy implementation	58	4.22	0.17	12.83	0.00
We have work processes that are highly automated	58	3.78	0.20	7.88	0.00
We have decision making process that is highly decentralized	52	4.02	0.23	8.01	0.00
The systems used to manage the facility have always been adopted to support strategy implementation goals	58	4.09	0.17	11.69	0.00
We perceive our practices differently at different levels of strategy implementation to ensure appropriate results	58	3.98	0.22	8.43	0.00
B. JOB ORIENTATION					
We are mostly concerned with employee performance	57	4.18	0.19	11.03	0.00
We measure employee performance and reward it accordingly	58	3.90	0.18	9.51	0.00
We have established effective systems, guidelines and policies	57	4.12	0.19	10.86	0..00
We avoid risks in our business practices	58	3.83	0.20	8.13	0.00
We often do capacity building to the employees as needs arise	55	4.02	0.27	6.88	0.00

The input of every employee is considered in management decisions to ensure that job is well done	57	4.07	0.21	9.36	0.00
C. PROFESSION ORIENTATION					
We have the ability to analyze and predict the behavior of competitors	58	3.67	0.23	6.06	0.00
We have highly charged, motivated and loyal employees	57	3.95	0.22	8.18	0.00
We have rare, valuable and imperfectly imitable facility culture	57	3.61	0.30	4.35	0.00
We have high level of client service quality	58	4.14	0.17	12.17	0.00
We provide enough resources to all units to enable quality strategy implementation	57	4.02	0.21	9.21	0.00
We have professional knowledge embedded in the facility culture	57	4.23	0.19	11.25	0.0
D. PRAGMATIC ORIENTATION					
We are often flexible in dealing with the client	57	4.35	0.18	13.29	0.00
We make decisions according to the situation at hand	57	4.18	0.20	10.74	0.00
We have the client satisfaction as the driving force in our facility	57	4.36	0.17	14.18	0.00
We rarely follow rules and procedures to the letter in our operations and processes	57	2.47	0.56	-2.86	.006
Overall Mean Score		**3.96**			

As indicated above, the overall average score for all the items in the “Organizational culture” was 3.96. This finding implies that participants concurred and agreed to a large extent with the organizational cultural practices conducted in their health facilities.

Organizational Performance

Organizational performance featured as the study outcome variable. Performance of the health facilities was operationalized into four constructs. This section exposes results as generated from the analysis of the responses from respondents pertaining to the four constructs. Table 4 depicts the results.

Table 4: Aligning Strategic Behaviour with Cultural Development on Facility Performance

	Frequency	**Percentage**
Yes	53	91.3
No	5	8.7
Total	**58**	**100**

Table 4 depicts that majority of respondents (91.3%) perceived aligning strategic behaviour and cultural developments as crucial to performance of their health facilities. About 8.7% of the respondents indicated that interacted with cultural developments, strategic behaviour did not necessarily influence organizational performance. These results reveled that for most large private health facilities, it was perceived that aligning strategic behaviour with organizational culture led to better firm performance.

Operational Efficiency

Further insight was sought on various organizational performance dimensions. This section focuses on operational efficiency, one of the performance dimensions. It was assessed by the extent to which various operations and systems in place at the private health facilities ensured that there was consistent provision of high-quality services. The respondents were provided with a set of statements descriptive of operational efficiency. They were asked to pinpoint the range at which the issue was relevant to their health facilities. Below is displayed the analytical results obtained.

Table 5: Operational Efficiency

Statement	**N**	**Mean Score**	**CV %**	***t*-value**	**Sig. (2-tailed)**
High-quality administrative systems are in place (financial, human resources, program, strategy, etc) to support the efficiency of the organization”	53	4.21	0.24	8.57	0.000
Optimal use of financial resources in the facility is made”	55	3.93	0.27	6.43	0.000

Frequency of system breakdown is very high	57	2.7	0.48	-1.72	0.090
Optimal use of physical facilities (buildings, equipment) is made	57	4.28	0.18	12.89	0.000
Timeliness of service delivery is ensured	58	4.26	0.16	13.89	0.000
There is high client inflow as depicted by registration files	58	4.31	0.15	15.25	0.000
Costs per client served is established to ensure efficiency	55	4.29	0.14	15.995	0.000
Our service quality has improved in the last five years	58	4.52	0.13	19.28	0.000
"Our market share has been improving in the last five years as evidenced by registration files"	58	4.36	0.15	16.19	0.000
We are keen on operations and processes that can reduce costs	56	4.48	0.14	27.54	0.000
Clients' complaints are responded to within 24 hours	56	4.14	0.19	10.74	0.000
Overall Mean Score		**4.13**			

As depicted above, the overall mean score for the items assessing operational efficiency in large private health facilities was 5. This average score falls slightly above the "large extent" rating scale. This mean score was an indication that operations and systems in the unit of study are efficient to a large extent. These results imply that the differences between the respondents who agreed and those who disagreed with the statement were not statistically significant. In other words, the differences occurred by chance. For the rest of the items that recorded significant results, the implication was that the differences between the respondents who agreed and those who disagreed with the statements were statistically significant, hence did not happen by chance.

Operational Effectiveness

Organizational performance was also assessed through operational effectiveness. Effectiveness was explained in view of 6 items. Accordingly, the necessary participants were requested to report the range by which these items applied to their facilities on a 5-point Likert scale. Below is displayed results produced from the analysis of the responses.

Table 6: Operational Effectiveness

Statement	N	Mean Score	CV %	*t*-value	Sig. (2-tailed)
"The mission statement and other documents provide the reason for the existence of the organization"	57	4.58	0.14	18.25	0.000
"The mission is operationalized through our c current training program goals, objectives, and activities"	58	4.43	0.13	18.30	0.000
"Quantitative and qualitative indicators are used to capture the essence of the mission"	58	4.24	0.18	12.50	0.000
"A system is in place to assess effectiveness of the organization"	55	4.29	0.21	10.45	0.000
"The organization monitors effectiveness"	58	4.50	0.16	15.62	0.000
"The organization uses feedback from stakeholders and clients to improve itself"	58	4.59	0.14	29.41	0.000
Overall Mean Score		**4.44**			

As is evidently shown above, the overall mean score for the items was 4.44. Based on the scale, this score was fairly above the "large extent" range. This signified that operations, processes and systems in large private health facilities in Kenya were effective to a large extent. A *t*-test was performed and statistically significant differences were observed for all the items assessing effectiveness in operations. This brought out the fact that there were considerable differences among the private health facilities regarding the extent to which they ensured that operational effectiveness was achieved. This was an indication that the differences did not happen by chance. These variations were caused by factors that could be accounted for.

Organizational Relevance

The study also considered organizational relevance as a key performance indicator. Organizational relevance denotes the link between the business value of a firm and its strategic goal. In this study, organizational relevance was defined into 6 items. The concerned respondents were requested to report on the level at which each of the six organizational relevance aspects was applicable to their health facilities. The responses were then analyzed and the results are as illustrated here under.

Table 7: Organizational Relevance

Statement	N	Mean Score	CV %	*t*-value	Sig. (2-tailed)
The strategy is undergoing review now and then"	58	4.16	0.20	10.83	0.000
Regular program revisions reflect changing environment and capacities of the facility"	58	4.16	0.17	12.21	0.000
Our facility regularly reviews the environment to adapt its strategy accordingly"	58	4.19	0.16	13.70	0.000
The organization regularly reviews the environment to adapt its strategy accordingly"	56	4.29	0.20	11.09	0.000
Innovation is encouraged all the time"	57	4.4	0.18	13.66	0.000
The organization monitors its reputation frequently"	58	4.4	0.15	15.79	0.000
Overall Mean Score		**4.27**			

As demonstrated above, the mean score for all the organizational relevance aspects was 4.27. The score suggests that large private health facilities in Kenya focus on organizational relevance elements as a key indicator of performance to a large degree. The *t*-test results revealed significant differences that were statistically sound for all the items used to evaluate organizational relevance. As seen in Table 7, the *p*-values for all the statements fell below the alpha value of 0.05. This provided evidence that despite the considerable differences among the private health facilities regarding the extent to which they ensured that operational relevance was met, the differences were caused by explainable factors rather than chance.

Financial Viability

In this study, financial viability was used as one of the measures for assessing organizational performance. Financial performance was considered because despite the fact that some large private health facilities are charity-oriented, they still need and use money in operations and processes. The concept of financial viability revolves around the notion that financial inflows of an organization should be greater than the outflows. Financial viability was operationalized into Seven (7) items. The necessary participants were directed to mark the range at which they perceived their facilities as having been financially viable or sustainable based on the items. The responses were well captured. The summarized results of the responses from the respondents are shown below.

Table 8: Financial Viability

Statement	N	Mean Score	CV %	*t*-value	Sig. (2-tailed)
Existing funding sources offer sustained support to the facility"	55	4.24	0.18	12.32	0.000
Our facility monitors finances on a regular basis to enable decision- making"	58	4.36	0.19	12.81	0.000
The facility consistently has more revenue than expenses"	58	3.74	0.30	5.06	0.000
Our financial performance has made assets to be greater than liabilities in the last few years"	58	4.05	0.22	8.84	0.000
To what extent is positive financial index realized as shown by the ratio of total assets to total liabilities?"	58	3.98	0.20	9.29	0.000
Our facility uses the ratio of current assets to current liabilities to gauge its performance and enable decision-making"	58	3.97	0.20	9.26	0.000
In our facility, there is growth in terms of amount of resources mobilized, assets, capital and revenues within the last 5 years"	58	4.34	0.16	14.33	0.000
Overall Mean Score		**4.27**			

As demonstrated above, results portray mean score for all the elements linked to financial viability of the health units as 4.27. As pertains the scale range, the overall mean score fell above the "Large extent" rating. A look at the p-value column above shows that the p-value for each entity was less than the alpha value of 0.05. This was an indication that although there were noteworthy differences among the private health facilities regarding the metrics used for evaluating financial viability, the variations did not happen by chance. Rather, it was due to explicable factors.

TEST OF HYPOTHESES

The objective of this study sought to investigate the influence of culture on performance. The following hypothesis was formulated in relation to this objective:

H: Organizational culture has no significant influence on performance

The dependent variable corresponding to this hypothesis was performance. As previously described, organizational performance variable was operationalized into four constructs. A mean score for each construct was computed to obtain the construct composite indices. The predictor variable in this hypothesis was culture, which was operationalized into four constructs. The responses to each of these constructs were averaged into a composite index. This construct index for culture was regressed on each of the performance constructs. The analyses generated are as seen in Appendix V. The decision point to reject the null hypothesis was at F-values that had *p*-values which fell within the significance threshold of $p < 0.05$. Below is shows the summary of the results obtained.

Table 9: Effect of Organizational Culture on Performance

Model	**Multiple r**	**R^2**	**F-value**	**Sig.**
Efficiency=f (process, job, profession, pragmatic)	0.437	0.191	3.130	0.022
Effectiveness= f (process, job, profession, pragmatic)	0.528	0.279	5.124	0.001
Relevance= f (process, job, profession, pragmatic)	0.550	0.302	5.744	0.001
Financial viability= f (process, job, profession, pragmatic)	0.390	0.152	2.380	0.063

The multiple r-values ranged from 0.390 to 0.550, suggesting a weak to moderately strong association between organizational culture (process, job, profession and pragmatic orientations) and performance. The R^2 values ranged from 19.1% to 30.2%. This means that generally, organizational culture explained less than 50% of variation in various performance indicators.

The F-values for the four models ranged from 2.380 to 5.744 (See Appendix V for full ANOVA table). The p-values associated with these F- values reached the conventional threshold of significance ($p < 0.05$), except for financial viability ($p = 0.063$). In consideration of performance as a multidimensional construct, the results have the implication that organizational culture did not exhibit an influence that is significant on the total outcomes of the health facilities. Therefore, this evidence justified the proposed hypothesis. Moreover, it could also be inferred from these results that financial viability aspect drags down the overall performance of the health facilities in a Kenya scenario.

Next, the study assessed the independent effect of culture on efficiency, effectiveness, relevance and financial viability.

Table 10: Independent Effect of Culture on Efficiency

Model Summary					
R	*R Squared*	*Adjusted R Squared*	*Std. Error of the Estimate*		
0.379	0.144	0.129	0.363		
ANOVA					
Model	*SS*	*df*	*MS*	*F*	*Sig.*
Regression	1.24	1	1.24	9.41	0.003
Residual	7.36	56	0.132		
Total	8.60	57			
Coefficients					
Model	*B*	*Std. Error*	*Beta*	*t*	*Sig.*
(Constant)	2.92	0.398		7.33	0.000
Culture	0.31	0.100	0.379	3.07	0.003

The value of R^2 was 0.144, an indication that culture accounted for a variation of 14.4 %. A scrutiny of analysis of variance revealed that organizational culture was a significant predictor in efficiency of facilities. Below is presented the results of the independent effect of culture on operational effectiveness.

Table 11: Independent Effect of Culture on Effectiveness

Model Summary					
R	*R Squared*	*Adjusted R Squared*	*Std. Error of the Estimate*		
0.442	0.196	0.81	0.500		
ANOVA					
Model	*SS*	*df*	*MS*	*F*	*Sig.*
Regression	3.41	1	3.41	13.63	0.001
Residual	14.01	56	0.25		
Total	17.42	57			
Coefficients					

Model	*B*	*Std. Error*	*Beta*	*T*	*Sig.*
(Constant)	2.35	0.548		4.286	0.000
Culture	0.51	0.138	0.442	3.691	0.001

The value of R^2 was 0.196, an indication that the effect of organizational culture explained a variation 19.6%. A check on variance analysis revealed that culture significantly predicted the effectiveness of the facilities. Below is presented the results highlighting the independent effect of organizational culture on organizational relevance.

Table 12: Independent Effect of Culture on Organizational Relevance

Model Summary			
R	*R Squared*	*Adjusted R Squared*	*Std. Error of the Estimate*
0.415	0.172	0.157	0.55

ANOVA					
Model	*SS*	*df*	*MS*	*F*	*Sig.*
Regression	3.56	1	3.56	11.62	0.001
Residual	17.17	56	0.31		
Total	20.73	57			

Coefficients					
Model	*B*	*Std. Error*	*Beta*	*t*	*Sig.*
(Constant)	2.43	0.61		3.695	0.000
Culture	0.52	0.152	0.415	3.41	0.001

The value of R^2 was 0.172, thus portraying that 17.2% of variance in the health facilities' relevance was attributable to organizational culture. The ANOVA results (F=(1, 56)=11.62, p <0.05) also illustrated culture as a significant predictor of the facilities' relevance. A change in a unit culture would impact on relevance by a factor of 0.52. Below is displayed the results showing the independent effect of culture on financial viability.

Table 13: Independent Effect of Culture on Financial Viability

Model Summary			
R	*R Squared*	*Adjusted R Squared*	*Std. Error of the Estimate*
0.386	0.149	0.134	.56

ANOVA					
Model	*SS*	*df*	*MS*	*F*	*Sig.*
Regression	3.06	1	3.06	9.79	0.003
Residual	17.53	56	0.31		
Total	20.59	57			
Coefficients					
Model	*B*	*Std. Error*	*Beta*	*t*	*Sig.*
(Constant)	2.197	0.61		3.58	0.000
Culture	0.48	0.152	0.386	3.13	0.003

Table 12 indicates that the value of R^2 was 0.149, denoting that the effect of organizational culture accounted for a variation amounting to 14.9%. A check on variance analysis reveals that culture had a significant predictive value for financial viability.

DISCUSSION OF FINDINGS

The linkage between organizational culture and performance variables was investigated using four pertinent aspects of culture. These elements are: organizational process, job, profession and pragmatic orientations. The descriptive statistics revealed that the addressed facilities focus on adopting a pragmatic-oriented organizational culture, with traits geared towards satisfaction of their clients to an extent that is large.

Such a finding is not surprising because health facilities are typically envisaged to have a mission culture of improving the lives of patients. Organizations that embark on clear visions and set strategic goals and objectives that are shared with the employees to facilitate a common understanding ultimately stand at a fitting position to achieve high customer satisfaction. Therefore, the finding suggests that the addressed units take cognizance of the value of initiating a corporate culture inclined to addressing their clients' needs.

The results generated from regression analysis further revealed that the cultural impacts did not significantly improve the outcomes of the units studied. While culture demonstrated positive linkages with the outcome indicators such as efficiency, effectiveness and relevance, a contrary finding was reported with respect to financial viability. In particular, culture was not significantly related to financial viability. These findings are inconsistent with Hofstede's cultural dimensions model, which predicts that different sub-cultures in an organization as well as the overall organizational culture contribute significantly to performance. This inconsistency may be due to the fact that the context of this study may have been a unique one.

The study finding contrasts the evidence by Zakari et al. (2013), which had revealed that corporate culture positively impacted the outcomes of Ghanaian banks. Further, it contradicts the study by Acar and Acar (2014) who found that organizational culture enhanced the performance outcomes of Turkish hospitals. The finding is also non-supportive of Zhou et al. (2011) who established an affirmative link on Chinese hospitals.

This finding corroborates the evidence by Rathert et al., (2012), who established that a health facility's culture that is patient and family-centered has a positive influence on patient's satisfaction. In another study, Salanova et al., (2011) found that a cohesive culture triggers employees' motivation and their commitment to better their performance, which in turn positively predicts customer loyalty and satisfaction. Additionally, this finding reflects the recommendations put forward by the Institute for Patient and Family-Centered Care (2013), that a patient-focused model of care by a health facility guarantees a beneficial symbiotic linkage among the health-care givers, patients and their families. The results generated from regression analysis further revealed a non- statistically significant link between the variables in question.

While culture was found to have significant linkages with performance indicators such as efficiency, effectiveness and relevance, a contrary finding was reported with respect to financial viability. In particular, culture was not significantly related to financial viability. The finding contradicts those by Makhlouk and Shevchuk (2008), who found that organizational culture and smooth cultural integration process enhance performance outcomes. The finding is also non-supportive of the argument put forward by Buku et al., (2015), that culture shapes the overall strength of an institution. Moreover, the finding is incongruous with Carmeli and Tisher (2004), who found that performance is governed by a variety of firm-level factors. These include corporate culture, human capital and governance practices.

From the foregoing discussion, it can be inferred that the results yielded in connection to the culture-performance link do not conform to the findings established by many scholars that an element such as organizational culture could help a firm safeguard its performance and gain competitive advantage. These contradictions, however, could be attributed to contextual differences, which result in pertinent factors within organizational culture (Venkatraman & Prescott, 1990). They may as well be attributed to variable operationalization differences. As some of the previous studies were done in firms operating in various contexts such as different fields and countries, their findings and conclusions may not apply to the current unit of study.

CONCLUSION AND RECOMMENDATIONS

Conclusion

These findings do not tie well with Hofstede's cultural dimensions model, which predicts that different sub-cultures in an organization and overall organizational culture in extension contribute to its performance. Moreover, the findings contradict the work by Zakari et al. (2013);

Makhlouk and Shevchuk (2008); and Carmeli and Tisher (2004) that culture had positive impact in organizational performance. Results further demonstrated that organizational culture had effects that were statistically significant on effectiveness, efficiency and relevance dimensions but not so with financial viability. Based on these findings, it was resolved that organizational culture did not have implications that were statistically significant on performance as a whole.

Limitations of the Study

In terms of context, the study outcomes are unique in nature as they involve a particular unit, that is, large private health facilities within Kenyan. The findings may not fit the context of small and medium facilities or even public health sector. As per the findings therefore, the study is limited in terms of generalizability.

From a methodological perspective, the study adopted a descriptive cross-sectional survey design. The design was the most appropriate method available, given the time and financial constraints. The study limitations did not compromise the spirit and quality of the results. Rather they paved the way for future research.

This study was cross-sectional in nature. It would be useful to replicate the study using a longitudinal research design, a factor that would help to provide in-depth evidence on the relationship between organizational culture and performance over time.

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