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The Protestant Ethic and the Spirit of Capitalism and Healthcare Entrepreneurship in Mission Hospitals in Ghana

Henry Asante Antwi[1], Zhou Lulin[1], Ethel Yiranbon[1], Barffour Adusei Maxwell[2], Awuni Joseph Agebase[1,3], Naminse Eric Yaw[1], Tevita Tangaroa Vakalalabure[1],

[1]School of Management, Jiangsu University, 301 Xuefu Road, Zhenjiang, Jiangsu, P.R. China

[2]School of Public Health, Department of International Health, John Hopkins University Bloomberg, Baltimore, USA

[3]Faculty of Agribusiness & Communication Science, University for Development Studies, Tamale, Ghana

Corresponding Author: Zhou Lulin (ZLL62@126.com)

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Abstract

The current global healthcare market requires hospitals to fundamentally and constantly transform the way they function and identify new foundations or avenues to gain or consolidate any competitive advantage. We investigated whether hospitals managed by Protestants (Presbyterian or Calvinist) in Ghana exhibit entrepreneurial capabilities and competencies than hospitals managed by Catholics and Muslims due to the perceived inherent spirit of capitalism in Protestantism (Calvinism).

Seventy five religious (mission) health facilities located across Ghana were evaluated for their entrepreneurial orientation with respect to autonomy, innovativeness, risk taking and competitive aggressiveness. The findings established that hospitals in Ghana which are managed by Protestant Churches (Presbyterian) do not differ in the adoption, application and use of entrepreneurial values and practices from those managed by Catholics and Ahmadiyya Muslims. The research contributes to the existing literature that puts the generalizability of Max Weber's Protestant Ethic notion into dispute. Its novelty lies in the extension of Max Weber's Protestant Ethic theory to analysing entrepreneurial culture in managing healthcare institutions in a "religious centric" Sub-Saharan African society"

Keywords: Max Weber, Protestant Ethic, Spirit of Capitalism, Entrepreneurial Culture, Presbyterians, Catholics, Muslims, Hospital Administration, Ghana

Introduction

The current healthcare market requires hospitals to fundamentally and constantly transform the way they function and identify new foundations or avenues to gain or consolidate any competitive advantage. Hospitals must constantly develop internal capacities to enhance

continuous innovation of their products, services, organizational processes, technologies and markets (Bodunkova and Chernaya, 2012)

Kwizera (2011) explains that it is not only profit seeking organisations that need to intensify entrepreneurial competencies but also non-profit seeking ones such as mission hospitals since their ability to break-even is premised on their entrepreneurial intensity which is stimulated by employees' motivation and the existence of entrepreneurial organizational culture. Hospitals as organisations (whether for profit or not) are subject to the same processes of sustainability and strategic management, partly as objects and victims but also as beneficiaries of entrepreneurial culture. The role of the hospital is locked within the national systems to supply the healthy human resources needed for sustainable socio-economic development (Akinci, 2012).

The history of Mission hospitals in Ghana suggest that most of them began as humanitarian institutions and even alms-houses for the poor, hostels for pilgrims and others hence survived on the generosity of churches, NGOs, the State and other benevolent individuals and institutions (Akinci, 2012). But today, that notion has changed and the survival and long term prosperity of healthcare organisations (whether for profit or not) in Ghana and all over the world is inescapably bound up with the emergence of a knowledge society, where customers are being oriented to make consumption choices (choice of hospital to attend) by evaluating its functional value, social value, epistemic value, aesthetic value, conditional value and emotional evaluation of health service brands (Sheth et al, 2001;Vitell and Singh, 2005)

This requires hospitals in Ghana to rise up to the challenge and meet the needs of the different categories of consumers by demonstrating greater competitive ability or stimulating capitalist approaches to manage their hospitals. This implies the introduction of all forms of hospital fees or its increase, retention of unpaid up patients, cash and carry policies for diseases and drugs not covered by health insurance, commercialization of mortuaries and laboratories, attracting private donations, signing contracts with nursing and medical institutions and entrepreneurial or business training for personnel, etc. This has led to what can be called entrepreneurial hospitals as specific healthcare market structures and active agents of this policy (Wildshchut and Mgqolozana, 2010).

However Bodunkova and Chernaya (2012) also explain that entrepreneurship development is related to organisational culture. There are organisations that have cultures that are more conducive for entrepreneurial development than others since each organisation has different heritages and philosophies, doctrines and practices imbedded in its orientation, thus influencing individuals and the organisations to alter organisational processes, improve commitment and loyalty, reduce bureaucracy and cost and then increase performance. Gibb (2000) appropriately offers a useful framework to measure entrepreneurial activities in an organisation including seemingly non-profit making organisations such as hospitals.

Research Problem

In Ghana specifically, approximately 42% of total health services in the country are provided by religious organisations such as the Catholic Church, the Presbyterian Church, the Anglican Church, the Methodist, and the Ahmadiyya Muslim Mission who collectively own more than 200 hospitals, clinics and health centres mostly in very rural areas of the country (Ghana Health Directory, 2012). The humanitarian notion of hospitals as presented by the colonial masters have existed for several centuries with mission hospitals depending on government support, Church contribution and other donor funding for their survival. However, healthcare

entrepreneurship has been stimulated in these institutions due to the inability of the mother churches and the state to meet all of their needs.

Subject to many rapid changes, some stakeholders are now questioning the sustainability of free or subsidised healthcare.. In 1980 for example, the missionary hospitals in Ghana condemned the cash and carry system introduced by the government to replace the free healthcare policy introduced by Ghana's first president Dr. Kwame Nkrumah. However, by year 2000, the mission hospitals had embraced the cash and carry system in order to guarantee the survival of the hospitals due to lack of funds from its sponsors (both home and abroad) (Weissand Lonnquist, 2012).

Despite the need to build entrepreneurial capabilities by mission hospitals in Ghana, there is a growing perception that entrepreneurial competency and capability among the various mission hospitals is not the same. Adams et al's (2012) evaluation of mission hospitals in Ghana reveals that the Presbyterian Health Service has already initiated a number of economic structures to provide resources that could be suitably adapted to meet the challenges of its hospitals both for the present and the future needs. It has established a financially self-sustaining eye clinic at the Agogo Hospital in the Ashanti Region of Ghana as a model healthcare facility being piloted for subsequent adoption by the various hospitals under the Presbyterian Health Service.

Even though the Catholic Health Services is the largest faith based health service provider and together with the Ahmadiyya Muslim Mission were among the first missionaries to propose the self-reliant concept and policies for its hospitals, documented evidence of implementation of related policies (introduction of new income generation activities, new self-sustainable hospital billing system, retention of unpaid up patients, commercialization of mortuaries and laboratories, signing contracts with private business organisations, entrepreneurial or business training for hospital personnel etc) are largely non -existing (Van den Boom, 2004, Adams et al's, 2012).

This has generally reignited the debate on the extent to which the capitalist versus socialist orientations of Protestants (Calvinist/Presbyterians) on one hand and Catholics and Muslims on another hand is applicable to specific national or cultural and industry context. Specifically in this research, the view that protestants are more likely to exhibit entrepreneurial capabilities than Catholics due to their capitalist religious orientation is being extended to the management of Protestant hospitals (hospitals set up and managed by Presbyterians) and Catholic hospitals (hospitals set up and managed by Catholics) and Muslim hospitals (hospitals set up and managed by Ahmadiyya Muslim Mission) in Ghana.

The interest is to compare the degree to which each of these institutions differ in their adoption, application and use of entrepreneurial values and practices in the management of hospitals in Ghana based on existing entrepreneurial culture models and scales.

Scholarly interest and framework used in this work (in the development of entrepreneurial culture and its role in managing institutions) is traced to Max Weber's classical work and ground-breaking essay on "The Protestant Ethic and the Spirit of Capitalism". Since that time, Weber's ideas on the Protestant work ethic continue to inform and influence studies of the contemporary work ethic, which is thought to have become secularised (Woehr et al, 2007).

Over the years, the Protestant Ethic thesis has attracted a lot of academic and social interest yet various authors have subjected the work to varying debates, analysis and criticisms. Philbrick (1976) shares in this view when he states that: "Every behavioural scientist is familiar with Max Weber's notion that capitalism in the western world was fostered by the impact of the Protestant Ethic. He further asserts that while the notion may remain in dispute, the

acceptance of the parameters of the Protestant Ethic, its purposes and principles have been widespread (Philbrick, 1976).

Apart from the study of Knaus (2007) and Barro et al (2003) who applied Weber's thesis to study the Anatolian Muslim entrepreneurs in Turkey, more recent studies that justifies the continuous importance of Max Webers' over century old thesis in contemporary society include Crowell (2006), Sanderson, et al (2011) etc who have applied the thesis to different fields.

In Ghana some studies have tested the protestant ethic thesis among Ghanaian business community as by Assimeng (2005) and Yiranbon (2009) but it is yet to be tested within the context of managing hospitals in Ghana.

The closest attempt to test the protestant ethic thesis in a hospital setting in a sub-Saharan African context is in a study by Kwizera (2011) that attempted to examine the quality of work and work life of healthcare professionals in South Africa with specific intention to understand the work ethic of medical professionals in selected hospitals in the Eastern Cape Province of South Africa. Our research rather seeks to explore in more detail and specifically in respect of entrepreneurial culture and competencies among the administrators in hospitals as some of whom may or may not be medical officers.

Based on the above introduction, the research seeks to achieve the following objectives: to validate the extent to which the protestant ethics theory can be applied to the management of hospitals that is, to find out if protestant hospitals are more entrepreneurial than Catholic and Muslim hospitals, investigate any peculiar traditions, values or practices of Catholics and Protestants that encourages them to be business minded in the management of hospitals and establish peculiar factors, developments and practices in Ghana that moderate differences in entrepreneurial capabilities of both Catholics and Protestants in the management of hospitals

Religion, Culture and Entrepreneurship

Culture is usually thought to influence economic outcomes by affecting personal traits such as honesty and work ethic and religion is one important dimension of culture. Just over one hundred years ago, Max Weber developed a causal model linking religion to economic development and entrepreneurship, thus Weber's (1904) protestant ethic thesis suggest that religious practices and beliefs have important consequences for economic development. Nevertheless economists have rarely included religion or other measures of culture as determinants of economic growth (Barro et al 2003). Various authors seem to be referring to culture as the pipe through which religion brings about economic transformation.

Perhaps different authors only express it differently: Landes (cited in Knaus; 2007) for instance talks about religion bringing about a personality type; Barro et al (2003) say religious beliefs influence individual traits that enhance economic performance. Also in the case of the Islamic Calvinists, the story is not too different; there is a description of an evolving milieu of the coexistence of Islam and modernity in Turkey, gradually giving way to the growth of businesses and enterprise among a hitherto socialist culture (Knaus, 2007).

Weber's work opens with a statement that makes his popular argument evident. He attributes economic growth and the rise of capitalism to Protestantism. For him this was evident in the occupational statistics of the time that showed that business leaders, owners of capital, higher grades of skilled labour and higher technically and commercially trained personnel of modern enterprise, were overwhelmingly protestant (Weber, 1960:35). According to him, the capitalistic nature of the Protestants was not only evident in the fact

that they occupied key positions in business and high grades of skilled labor, but could be clearly noticed in the kind of natural resources they possessed and the high level of economic development that was peculiar to their part of the old empire (Weber, 1960).
Weber categorize Catholics as that group of people that preferred to be at the background despite the subordination they experienced; which in Weber's view should naturally compel a people to aspire to satisfy their desire for recognition. Perhaps a more precise description of Catholics is in his concept of traditionalism (p.40). where a man by nature does not desire to earn more and more money but simply wishes to live as he is accustomed to and earn as much as is necessary for that purpose(p.59-60). Again, Weber argues that the kind of education and careers that Catholics chose fell short of that of the Protestants (Weber 1904). Catholics were less interested in inherited wealth. Catholic students less preferred technical, commercial and business career studies but were more content with classic-based grammar style schools which were not intended to equip them with the drive to find an occupation that led to capital gain.
Weber thought imbedded in the religious beliefs of these two, must have been some peculiar characteristics that resulted in these differences and not only in their temporal eternal historic-political situations. In the Ghanaian situation, it is worth looking out for these differences in any peculiar practices, teachings or doctrines in the two denominations, which could be responsible for any differences. (Ethan Crowell, 2006)
Aspects of the study by Barro et al (2003) supports Weber's Protestant Ethic thesis and throw more light on the relationship between religion and economic growth. Barro et al (2003) portray how religion directly influences or leads to capitalism by describing religion as key to the development of capitalism. Their work confirms Weber's position that though a religious ethic does not mechanically determine social action, it can give social action impetus by shaping people's perceptions, beliefs, values, attitudes, meanings, notions of time, spatial relations, concepts of the universe, material objects and define their interest (Zanden & Kroehler, 2002)
The point of departure for the two studies is in the fact that whereas Weber's study is limited to just a group of people and culture, Barro et al (2003) targeted about 59 countries including both developed and under developed countries. The other difference has to do with the fact that Weber employs a purely qualitative approach while the latter uses a purely quantitative approach.

The Islamic Calvinists

Another piece of work that brings out an outstanding revelation is Gerald Knaus' article on "Islamic Calvinists". This work opens with some interesting questions that need to be reiterated for further analysis: "can Islamic states foster an entrepreneurial ethic" Do certain religious attitudes promote economic development? Or is it the other way round: does development lead people to embrace interpretations of their faith that make it compatible with their enrichment?"(Knaus, 2007).
The work by Barro et al (2003) sought to identify the determinants of economic growth. The result reveals that growth responds positively to religious beliefs and influence individual traits that enhance economic performance. Lewis (cited by Knaus, 2007) suggested that, Islam was being practiced in a way that is inimical to development, encouraging fatalism and suppressing innovation. Secularists are reported to have said "successful development requires the retreat of Islam" (Knaus, 2007).

It is therefore quite unusual to find the appearance of the discussion of a topic such as "Islamic Calvinists change and conservatism in central Anatolia" According to Knaus (2007), the most outstanding revelation is the fact that the Anatolian entrepreneurs had begun to see business in the way the Calvinist did; they considered opening a factory, a kind of prayer. This is an indication that the kind of 'ethic' that Weber identified among the Protestants was not limited to Protestants or Christians only, but even among Muslims (as in the case in Turkey). What is happening in Turkey could be described as a functional equivalence of Weber's Protestant Ethic Thesis in Germany and other parts of Europe.

Mission Hospitals in Management

The Ghana Statistical Service, (2010 Population and Housing Census) puts the population at a little short of 25.5 million people but there were only 1,439 health care facilities in 2008 (IRIN, 2008). Another research conducted by van den Boom et al (2012) notes that access to healthcare facilities in Ghana remains a problem because medical facilities are not evenly distributed across the country, with most rural areas lacking basic facilities such as hospitals and clinics as well as doctors and nurses.

Van den Boom et al (2012) further observed that on average Ghanaians live within a distance of about 16 km from a healthcare facility with a qualified doctor. However, about half of the population cannot consult a doctor within 5 km, which corresponds to about 1 hour walking distance. Again, about a quarter of Ghanaians live more than 615 km from a healthcare facility where a doctor can be consulted" (Van den Boom et al, 2012).

Currently, the Western Region has 10% (1,924,577) of the population but has only 99 doctors and there are 91 doctors living in the Volta Region for a population of 1,635,421 and 33 in the Northern Region for a population of 1,820,806), compared to 1238 public and private medical and dental practitioners in the Great Accra Region (2,905,726). Out of this figure the Christian Health Association has a total of 200 of them with the Ahmadiyya Muscle mission having up to 35 of them (Ghana Health Service, 2011). Furthermore, the numbers of private sector healthcare providers are about 500, however these are small in size and hardly accommodates more than 5% of the population. It is estimated that the mission hospitals provide services to about 40% of the population while the remainder is provided for by the state and the traditional health attendants. Figure 1.0 shows the structure of healthcare delivery in Ghana (Abor et al, 2008).

The Government of Ghana embarked on a health sector reform in the early 1990s to improve the accessibility and quality of services. However, "the health situation in Ghana is still far from satisfactory." Hence many people in the country still rely on self-medication (van den Boom et al., October 2004).

Apart from the primary responsibility of the church in winning souls for the kingdom of God, its involvement in healthcare delivery in Ghana dates back to colonial days. The church's concern is that humankind must develop towards that "wholeness which he is called to by God" (Ghana National Catholic Secretariat-Department of Health, 2011). In this direction, it has been the responsibility of the church to improve upon the conditions of man's social, economic and spiritual life. Historical accounts of the Churches' intervention in healthcare in Ghana credits the Presbyterian for being the first to set up the Kom (Aburi) Presbyterian hospital in 1885 (Presbyterian Health Services, 2011). Although this facility developed well for some years, with the onset of the First World War, and the consequent deportation of the Basel Missionaries and lack of funding it collapsed. The construction of a new Presbyterian Hospital at Agogo in the Asante Akyem area started in 1929, and was completed in 1930. This

feat was replicated by the Catholic Church who today owns more than 80 health care facilities as against about 30 by the Presbyterians and 30 by the Ahmadiyya Muslim Mission mostly located in the rural areas of Ghana (Ghana Health Services, 2011).
According to The Christian Health Association of Ghana (2012) the Church's contribution can be described as supportive or contributory of the Governments' mandated duty to provide health care facilities. This explains why mission hospitals have over the years depended on the state and the mother churches for financial sustainability until pressure from Briton wood institutions whose Structural Adjustment Programs, Economic Recovery Program, Medium Term Expenditure Framework etc (Ministry of Finance and Economic Planning, 2000) have led many states including Ghana to reduce subsidies for hospitals especially for those which are not directly under the control of the state. Because of this most mission hospitals have been challenges to adopt marketing strategies and financial management approach in order to be financially sustained (Ghana National Catholic Secretariat-Department of Health, 2011).
Despite the fact that the proportion of Catholic Hospitals are far more than the Presbyterian hospitals, it is the Presbyterian Hospitals which have ones again blazed the trail by establishing a financially sustainable Eye Clinic at the Agogo Hospital in Ghana as a model healthcare facility being piloted for subsequent adoption by the various hospitals under the Presbyterian Health units towards a self-reliant hospital. These are some of the entrepreneurial variations which have been observed between Catholic hospitals and Presbyterian hospitals that elicit some further research. The gap in existing literature that the research will seeks to fill and which justifies the need to test Weber's work is the shifting frontiers of entrepreneurship or the spirit of capitalism in the healthcare market in Ghana. To a large extent the nature and challenges of the competitive work place which Weber saw was far from the complexity of modern society. The type of entrepreneurs, business leaders and the owners of capital, skilled higher strata of the labour force and high technical or commercially trained staff of enterprises that Weber was talking about lived in a context of less globalisation. His world largely consisted of small farmers, artisans, local merchants and preindustrial manufacturers and mechanics and businessmen and women who today will struggle to qualify as business moguls or tycoons (Banerjee, 2007). In addition, while Weber looks at entrepreneurship or a spirit of capitalism within the context of hard work, thrift and savings, industry, education, fertility, innovation, consumption type, contemporary measures of entrepreneurship have expanded profusely .
Today a spirit of capitalism or entrepreneurial dexterity includes, attitude and competence in having a well-designed business plan, corporate governance, gender balance in administration, standardization, power sharing, negotiations, income generation activities, short organizational structure, speed of decisions making, cost consciousness, revenue maximization and quality control (Abor et al, 2006). The others are change management and innovation adoption, wages and salaries administration, workplace safety management, employee motivation, branding and promotion of organisations or business, emphasis on **strong work ethic,** customer service skills, conflict-resolution abilities and investment in sustainable enterprise activities (Acheampong and Kuma, 2013). The complexity of the hospital administration therefore makes it appropriate to be used to test the extent to which this perception can be upheld.

Materials and Methods

Our evaluation of measures of entrepreneurial orientation at both individual and group level revealed that entrepreneurial orientation is a multi-dimensional construct and can be

evaluated from different perspectives. For example Miller's (1983) entrepreneurial orientation (EO) construct defines entrepreneurial orientation in terms of being innovative, risk-taking and being proactive. Later, Cornwall and Perlman's (1990) entrepreneurial orientation construct defined entrepreneurial orientation to include Risk, Earned respect, Ethics of integrity, trust, credibility, People, Emotional commitment, Work is fun, Empowered leadership throughout firm, Value wins, Relentless attention to detail, people, structure and process, Effectiveness and efficiency.

On another hand Peters's (1997) entrepreneurial orientation construct defined entrepreneurial orientation to include Listening, Embracing change, Customer focus, Total integrity, Excellence, Involve everyone in everything, Experimentation, Fast-paced innovation, Small starts and fast failure, Visible management and Measurement / accountability. Timmons (1999) on the other hand explains entrepreneurial orientation as including, Clarity, being well-organized, High standards, pressure for excellence, Commitment, Responsibility, Recognition, Esprit de corps.

We opted for the Lumpkin and Dess's (1996) Entrepreneurial Orientation construct which they explained to include Autonomy, Innovativeness, Risk taking and Competitive aggressiveness. The choice of this construct is because its questions have been tested in several empirical studies both at the intra-country and inter-country level (Muchsin, et al, 2011). Following Lumpkin and Dess (2001), we define each entrepreneurial orientation construct as follows:

Autonomy: Autonomy is important for entrepreneurs because it stimulates the independency and capacity of the team or the individuals to develop business visions (income generating activities) and implement it from the beginning to the end successfully. When the organisational culture endorses independence and innovation and encourage team members to be opportunities seekers, they develop autonomy better and faster.

Innovativeness: A culture that encourages innovativeness is a culture that supports individuals and teams to be creative and develop new ideas and methods, seek novelty, quick adoption and use of technology, investment into research and development and encourages experimentation to develop new processes. These are very important attributes of an entrepreneurial culture.

Risk taking: Risk taking in this context means the individuals or teams willingness to accept and cope with changes and uncertainties, seize market place opportunities and commit resources in new ventures in anticipation of higher returns. These are basic demands for being an entrepreneur in modern organisations.

Competitive aggressiveness: Within the context of this research, is being competitively aggressive means the tendency of the organisation to directly and intensely compete with its rivals/competitors. This is a factor which indicates the extent to which the culture enforces or encourages achievement oriented. This dimension is becoming an important component of entrepreneurial orientation because without competitive aggressiveness, firm would not be able to survive and succeed in starting up a new venture.

In our conceptual model, there were two substantive variables. The independent variable is the religious organisation's culture. We distilled and defined the scale of measurement based on Weber's analysis of the Catholic and Protestant/Calvinists cultural orientations i.e. (Catholic hospital managers with Catholic orientation and Presbyterian hospital managers with Calvinist orientation). On the other hand, we directly applied Knaus' (2007) application of the Weberian theory to the Islamic culture (The Turkey example) to evaluate the levels of

entrepreneurship among hospital managers with Muslim or Islamic orientation. The dependent variable is the entrepreneurial orientation. We directly applied the Lumpkin and Dess's (1996) dimensions of entrepreneurial orientation i.e., autonomy, innovativeness, risk taking and competitive aggressiveness.

Design of Instrument

We adapted but modified items or indicators of autonomy, innovativeness, risk taking and competitive aggressiveness of culture from previous empirical attempts at establishing a relationship between organizational culture and entrepreneurial orientation (Muchsin et al, 2012). We measured all construct items on a five-point Likert-type scale (1-disagree strongly,5-agree strongly). The questionnaire collected data about the background, religion and questions on the four dimensions of entrepreneurial orientation based on practices in the management of the hospitals. We tested for validity of content of the questionnaires by rigorously pre-testing on appropriate sample (within the population but outside the final sample) to refine the wordings.

We distributed the final questionnaires as follows:

a. Presbyterian healthcare facilities (4 hospitals, 13 clinics, 8 health centres)
b. Catholic healthcare facilities (10 hospitals, 10 clinics, 5 health centres)
c. Ahmadiyya Muslim Mission healthcare facilities (8 hospitals, 10 clinics, 7 health centres)

In all 75 heath facilities out of the 200 mission hospitals in Ghana participated in the research. These were scattered across the 10 regions of Ghana We shortlisted and distributed the questionnaires to two key informants in the survey based on their role in the hospital's administration. These were administrators of the hospitals who had the day to day administrative responsibility of the hospitals and the chairpersons of the hospitals' board who were charged with designing the long term vision of the hospital. Each of these belonged to the Church. However considering that there were some Presbyterian, Catholic and Muslim hospitals that had managers who did not belong to the same church and orientation, we excluded them from the analysis.

A typical example is the Agogo Presbyterian Hospital in the Ashanti Region which is headed by a Catholic health administrator, the Ahmadiyya Muslim Mission Hospital in Daboase in the Western Region and the Kaleo Ahmadiyya Muslim Hospital in the Upper West Region which are headed by a Catholic and an Adventist respectively. The St Martins Catholic Hospital in Agroyesum in the Obuasi Diocese of the Catholic Church (Amansie West District of the Ashanti Region) was also excluded because at the time of the research it was headed by an interim administrator who was not a Catholic.

Accessibility to the above people was facilitated by personnel from the Christian Health Association of Ghana (CHAG) which is the umbrella body of Christian hospitals in Ghana and the Ahmadiyya Muslim Mission in Ghana. The data collection was done by the 7 researchers and 38 personnel and associates of the Christian Health Association of Ghana (CHAG). The total numbers of valid questionnaires used for the analysis were 142 from 150 respondents.

Analysis of Data

We performed a two staged statistical analysis to obtain the results. Firstly, we performed factor analysis to investigate the dimensions of entrepreneurial orientation after which we imposed

a linear regression model to examine the effect of hospital administrators and board chairpersons' religious orientation on adopting entrepreneurial practices in the management of their respective hospitals. We thoroughly verified the basic assumptions i.e. the constant variance and normality and these did not affect the results.
We determined the appropriateness of the data for factor analysis by employing Kaiser–Meyer-Olkin measure of sampling adequacy (KMO-MSA) and Bartlett's Test of Sphericity. We recorded a KMO value of more than 0.60 and a significant value for the Bartlett's Test of Sphericity. We performed Varimax rotation and principle components analysis for factor analysis. We eliminated all the factors that had factor loadings lower than 0.50 after which we conducted the Cronbach's alpha reliability analysis. We ensured that all measure of sampling adequacy exceeded the Cronbach's alpha reliability value threshold level of 0.60 and large and significant Bartlett's Test of Sphericity. We eliminated 5 items of the initial 33 on the 4 dimensions of entrepreneurial orientation (autonomy, competitive aggressiveness, risk taking and innovativeness) since they had a factor loading lower than 0.50. The exploratory factor analysis and reliability statistics measures of the accepted 28 variables are shown in table 1.0.

Regression Analysis
Before the linear regression was performed, we did a product moment correlational analysis of the two set of variables (religion and entrepreneurial orientation) and noted the non-existence of multicollinearity between the variables in religion and entrepreneurial orientation. Our regression model designated the dummy value "1" if the board chairman or hospital administrator was Presbyterian, "2" if he or she was a Catholic and "3" if he or she was a Muslim.
We constructed a univariate and multivariate linear regression model, examining the unadjusted and adjusted association between religious affiliation and each of the four dimensions of entrepreneurial orientation. For each specific dimension of entrepreneurial orientation, we created a composited score by summing up all the scores for the set of questions under the dimension for each respondent. The composite scores were then used as dependent variables in the linear regression models. In separate multivariate regression models, we treated each dimension as the outcomes of interest, and the three other dimensions as covariates. Religious affiliation was treated as the primary exposure variable in all the multivariate models. All analyses were carried out in STATA version 11.

Table 1.1
Univariate regression models showing the association between each of four dimensions of entrepreneurial orientation and religious affiliation

Outcome of interest	B_0	Regression coefficient	P-value
Innovativeness	35.55846	.0060049	0.959
competition	35.58722	-.0366966	0.823
autonomy	19.84143	-.0017051	0.988
Risk	15.68285	-.0034102	0.974

Table 1.1 shows the regression analysis for dimension of innovativeness, competitive aggressiveness, autonomy, and risk taking of the healthcare orientation. The analysis, shows that there is no significant differences between attitude to innovative activities of

Presbyterian hospitals, Catholic hospitals and Muslim hospitals in Ghana (Sig. value 0.959> 0.05 significant level) The same results were also arrived at in respect of differences between the attitude of Presbyterian hospitals Catholic hospitals and Muslim hospitals in Ghana to competitive aggressive (Sig. value 0.823> 0.05 significant level), risk (Sig. value 0.988> 0.05 significant level) and autonomy (Sig. value 0.974> 0.05 significant level). Detailed regression tables for each variable are included as appendix 1.

Discussion and Implications

In the literature it was explained that the demand for greater competitive ability is stimulating the adoption of capitalist approaches to managing hospitals in Ghana. This is opposed to the humanitarian institution (with huge bad debts and dependent on church collection) that used to exist about two decades ago hence the emergence of entrepreneurial hospitals as specific healthcare market structures (Wildshchut and Mgqolozana, 2010). The individuals responsible for policy formulation and implementation in all the three categories of hospitals under examination have confirmed the fact that they are developing autonomous, competitive aggressive, risk taking and innovative institutions in order to make the hospitals self-sustaining in a self-reliant church environment. They encourage openness as in encouraging employees to express their ideas, identify business opportunities, remove communication barriers, reward and motivational packages, branding and promotion, investment in sustainable enterprise activities, well-designed business plan, customer service skills and developing sales strategy to win the competition etc. In essence within the context of the management of mission hospitals in Ghana, the research findings are unable to validate Weber's view that Catholics are less entrepreneurial than Protestants. It is possible that within the context of the Ghanaian society, there are peculiar socio-cultural and economic factors that moderate differences between Catholics and Protestants and even Muslims when it comes to the development of a spirit of capitalism. It is also not possible to rule out the fact that the Catholic Church and its orientation has been significantly impacted upon by the Protestant Church in Ghana where they are in the minority (The emergence and sustenance of the Catholic Charismatic Renewal in Ghana is an ample testimony of this impact).

While Weber's Protestant Ethic and the Spirit of Capitalism was published in 1904/1905 when the Catholic orientation was regulated by the first Vatican Council, it is possible to suggest that the open door policies of the Second Vatican Council considered by many Catholics as the "liberating Council" may be a strong factor in altering traditional Catholic orientation to accommodate contemporary challenges. Chapter 3 of the Vatican II Council documents says that: …, there is an expansion and growth in human needs hence the Church must encourage technical progress and build a spirit of enterprise, help in creating and improving new enterprises, and promote adaptation of the means of production and all serious efforts (everything) which contributes to economic progress.

Finally, there is paucity of documentation of entrepreneurial practices in both Catholic and Muslim hospitals hence heightening public and academic doubt about their commitment to entrepreneurial culture. Possibly, weak documentation may be an identified weakness in building a culture of entrepreneurship in Catholic and Muslim hospitals compared with the Presbyterian hospitals but these are areas which can be studied further in the future. Further research can also look at investigating entrepreneurial culture and alacrity in inter protestant administered hospitals and those of different Islamic branches such as the Ahamadiyah, Sunni & Shites

Limitations

This research is limited because only 75 out of the over 200 hospitals, Clinics and health centres owned by religious organisations have been included in the study. It is possible that the respondents might have represented what actually takes place in their hospitals under research conditions. Finally the research is entirely based on the management of hospitals in Ghana hence cannot be generalised to other areas of Protestants and Catholic relationship

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Appendix

Table 1.1

Exploratory Factor Analysis and Reliability Statistics for Measures

EO Dimension	**Item**	**Factor**	**Cronbach α**	**KMO-MSA**
Innovativeness	• Willingness to identify income generating opportunities • Capacity to identify income generating opportunities • Active interest in improvements and innovations at the hospital • Creating new and cost effective method of operation • Developing new services or product to cover more customer needs • Measures to control quality and encourage standardization in service delivery • Encouragement of originality among staff and employee • Rate of technology adoption and use • Management adoption and use of technology • Investment in financial instruments	.643 .608 .603 .810 .650 .776 .639 .748 .742 .648 .699 .619	.832	KMO .813 Bartlett 1239.822 Significance .0 00
Competitive Aggressiveness	• Our hospital is intensively competitive • In general, our hospital takes a bold or aggressive approach when competing • Negotiations competence • Attitude to Cost control • Employee motivation packages • Branding and promotion of services • Customer Service Skills • Well-designed business plan • Liquidity management	.672 .821 .721 .789 .651 .663 .719 .753 .811	.747	
Autonomy	• Freedom to design own programs including income generating activities	.629	.647	

	• Freedom to recruit employees • Control of income • Short corporate governance structure • Flatness of organisational structure	.921 .655 .612		
Risk	• Risk Appraisal and Management Interest • Willingness to start new projects to earn income • Workplace safety management • Conflict-Resolution Abilities	.722 .645 .693 .832	.877	

```
1 . corr
(obs=142)

             | religion    innov    compe     auto     risk
-------------+---------------------------------------------
    religion |   1.0000
       innov |   0.0043   1.0000
       compe |  -0.0189  -0.2126   1.0000
        auto |  -0.0013  -0.2633   0.2312   1.0000
        risk |  -0.0027   0.1046   0.3691   0.0168   1.0000
```

```
3 . regress  innov religion compe auto risk

      Source |       SS       df       MS              Number of obs =     142
-------------+------------------------------           F(  4,   137) =    4.95
       Model |  23.3405297     4  5.83513242           Prob > F      =  0.0009
    Residual |  161.455245   137  1.17850544           R-squared     =  0.1263
-------------+------------------------------           Adj R-squared =  0.1008
       Total |  184.795775   141  1.31060833           Root MSE      =  1.0856

------------------------------------------------------------------------------
       innov |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
    religion |   .0001432   .1114051     0.00   0.999    -.2201527     .220439
       compe |  -.1693733   .0636884    -2.66   0.009    -.2953128   -.0434339
        auto |   -.229865   .0892325    -2.58   0.011    -.4063162   -.0534139
        risk |   .2186464   .0965894     2.26   0.025     .0276475    .4096452
       _cons |   42.71783   2.551212    16.74   0.000     37.67299    47.76268
------------------------------------------------------------------------------
```

```
4 . regress  innov religion

      Source |       SS       df       MS              Number of obs =     142
-------------+------------------------------           F(  1,   140) =    0.00
       Model |  .003425326     1  .003425326           Prob > F      =  0.9594
    Residual |  184.792349   140  1.31994535           R-squared     =  0.0000
-------------+------------------------------           Adj R-squared = -0.0071
       Total |  184.795775   141  1.31060833           Root MSE      =  1.1489

------------------------------------------------------------------------------
       innov |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
    religion |   .0060049   .1178779     0.05   0.959     -.227046    .2390558
       _cons |   35.55846   .2539398   140.03   0.000      35.0564    36.06051
------------------------------------------------------------------------------
```

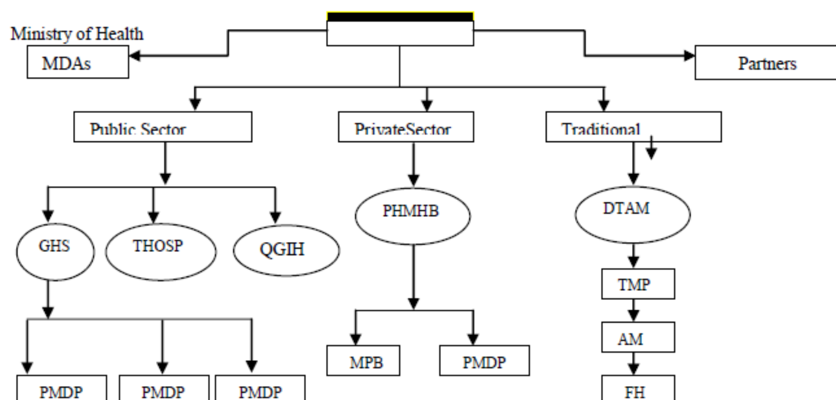
```
5 . regress  compe religion

      Source |       SS       df       MS              Number of obs =     142
-------------+------------------------------           F(  1,   140) =    0.05
       Model |  .127921133     1  .127921133           Prob > F      =  0.8232
    Residual |   357.34391   140   2.5524565           R-squared     =  0.0004
-------------+------------------------------           Adj R-squared = -0.0068
       Total |  357.471831   141  2.53526121           Root MSE      =  1.5976

------------------------------------------------------------------------------
       compe |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
    religion |  -.0366966   .1639206    -0.22   0.823    -.3607764    .2873832
       _cons |   35.58722   .3531279   100.78   0.000     34.88907    36.28537
------------------------------------------------------------------------------
```

```
6 . regress   auto religion

      Source |       SS       df       MS              Number of obs =     142
-------------+------------------------------           F(  1,   140) =    0.00
       Model |  .000276177     1  .000276177           Prob > F      =  0.9875
    Residual |  157.274372   140  1.12338837           R-squared     =  0.0000
-------------+------------------------------           Adj R-squared = -0.0071
       Total |  157.274648   141  1.11542303           Root MSE      =  1.0599

------------------------------------------------------------------------------
        auto |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
    religion |  -.0017051   .1087475    -0.02   0.988    -.2167047    .2132945
       _cons |   19.84143   .2342706    84.69   0.000     19.37826    20.30459
------------------------------------------------------------------------------
```

```
7 . regress   risk religion

      Source |       SS       df       MS              Number of obs =     142
-------------+------------------------------           F(  1,   140) =    0.00
       Model |  .001104708     1  .001104708           Prob > F      =  0.9742
    Residual |  147.097487   140  1.05069633           R-squared     =  0.0000
-------------+------------------------------           Adj R-squared = -0.0071
       Total |  147.098592   141  1.04325242           Root MSE      =   1.025

------------------------------------------------------------------------------
        risk |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
    religion |  -.0034102   .1051702    -0.03   0.974    -.2113374     .204517
       _cons |   15.68285   .2265643    69.22   0.000     15.23492    16.13078
------------------------------------------------------------------------------
```

```
8 . xi:regress innov religion

      Source |       SS       df       MS              Number of obs =     142
-------------+------------------------------           F(  1,   140) =    0.00
       Model |  .003425326     1  .003425326           Prob > F      =  0.9594
    Residual |  184.792349   140  1.31994535           R-squared     =  0.0000
-------------+------------------------------           Adj R-squared = -0.0071
       Total |  184.795775   141  1.31060833           Root MSE      =  1.1489

------------------------------------------------------------------------------
       innov |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
    religion |   .0060049   .1178779     0.05   0.959     -.227046    .2390558
       _cons |   35.55846   .2539398   140.03   0.000      35.0564    36.06051
------------------------------------------------------------------------------
```

Structure of the Health Sector of Ghana



Legend
MDA.s – Ministries Departments and Agencies
GHS- Ghana Health Service
T HOSP- Teaching Hospitals
Q GIH- Quasi Government Institution Hospitals
PHMHB- Private Hospitals and Maternity Homes Board
DTAM- Department of Traditional and Alternate Medicine
GHSP- Government Hospitals
PC- Poly-Clinics
HC- Health Centres
MBP- Mission-Based Providers
PMDP-Private Medical and Dental Practitioners
TMP- Traditional Medical Providers
AM-Alternative Medicine
FH- Faith Healers

Source: Abor, P.A; Abekah -Nkrumah, G;Abor,J: An Examination of Hospital Governance in Ghana. In: Leadership in Health Services Vol. 21. Issue 1, 2008, p.3