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**DETERMINANTS OF HEALTH CARE SERVICE DELIVERY AS A DEVOLVED FUNCTION IN LEVEL FOUR HOSPITALS IN  
KIAMBU COUNTY, KENYA**

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**DETERMINANTS OF HEALTH CARE SERVICE DELIVERY AS A DEVOLVED FUNCTION IN LEVEL FOUR HOSPITALS  
IN KIAMBU COUNTY, KENYA**

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**ABSTRACT**

*The general objective of the research was to establish the determinants of health care service delivery as a devolved function on level four hospitals using the case of Kiambu County, Kenya. The study was guided by the two specific objectives: To find out the role of government funding on health care service delivery and to determine the role of social accountability on health care service delivery. The study reviews theories that explain governance of health care. The research design was descriptive research, the sample size comprised of 12 respondents from all Level IV hospitals in Kiambu County. Questionnaires were used for data collection for the study. The respondents were contacted and requested for their time prior to sending the actual questionnaire. The collected data was coded and analyzed using the descriptive statistics by use of Statistical Package for Social Science (SPSS). The presentation of data was in the form of tables and figures. The study findings revealed that the employed government funding and social accountability significantly affected healthcare service delivery. Based on the study findings, the study concludes that health care service delivery in Level IV Hospitals in Kiambu County, Kenya was affected by social accountability and government funding. The study recommends that public health institutions should adopt use of face-to-face, upward, horizontal and vertical communication channels. From the findings the study also recommends that the government should improve systems of funds disbursement to service delivery points in order to promote other functions that contribute to service delivery.*

**Key Words:** Government Funding, Social Accountability, Health Care Service Delivery, Level IV Hospitals, Kiambu County

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## INTRODUCTION

In the current healthcare environment, there are many forces, both internal and external, that require some physicians and hospitals to rethink their traditional leadership relationships. These hospital leaders are being both pulled and pushed together in new ways by these changes, including increased direct employment of physicians by hospitals, the development of accountable care organizations, intended to manage the quality and cost of care of defined populations of patients, new payment methodologies and financial incentives from public and private payers, and the need to deliver greater value in an increasingly competitive marketplace. Among the suggested solutions is a call for integrated physician-hospital leadership (Persily, 2014).

Only the leaders of a healthcare organization have the resources, influence, and control to provide for these factors. It is the leaders who can together establish and promulgate the organization's mission, vision, and goals. It is the leaders who can strategically plan for the provision of services, acquire and allocate resources, and set priorities for improved performance (Kramon & Posner, 2011). It is the leaders who establish the organization's culture through their words, expectations for action, and behavior—a culture that values high-quality, safe patient care, responsible use of resources, community service, and ethical behavior; or a culture in which these goals are not valued (Holland & Rohe, 2012).

While leadership's responsibility includes strategically addressing the organization's culture, planning and provision of services, acquiring and allocating resources, providing sufficient staff, and setting priorities for improvement, the organization's leaders must also actively manage each of these factors. Strategic thinking focuses on where to go, while management focuses on implementing a plan and sustaining the activities

needed to get there (Wong, 2008). In between the implementation, there is determination of how to achieve the strategic goal—a determination that requires both strategic skills and management skills (Mittulah & Kamau, 2013).

Many international hospitals do not have leading managed care contracting capabilities internally. Relative bargaining strength also tends to vary greatly with critical mass in a particular area. For example, in developed areas of the world one payor dominates the market and smaller providers have very little ability to negotiate rates or terms. In addition to outside expertise, a larger scale can also help with these negotiations. For a large number of providers, insurance reimbursement only covers a portion of the cost of providing services. Treating an insurance patient is a money losing proposition (Mishra & Mishra, 2013). As a result, commercial payor reimbursement rates become even more critical to financial success. The ultimate marker of success of all new models of care is if patients have a better experience, improved health and a lower per capita cost compared to current models (Logan, King, & Fischer-Wright, 2012). It is possible that integrated leadership would benefit patients by focusing on developing new channels for patient engagement, and delivering care in a manner that eliminates overuse, underuse and misuse of resources while increasing physician professional satisfaction, building trust relationships and financial stability for both physicians and hospitals (Rich, Singleton, & Wadhwa, 2013).

Kenya's vision for health is to provide equitable and affordable health care at the highest affordable standard to all citizens, involving (among other things) the restructuring of the health care delivery systems in order to shift the emphasis to preventive and promotive health care (Ministry of Health, 2013b). Key focal areas of access, equity, quality, capacity and institutional framework was achieved through a devolution approach that will allocate funds and responsibility for delivery of health care

to hospitals, health centers and dispensaries, thereby empowering Kenyan households and social groups to take an active role in maintaining and managing their health care (Leroy, 2013). Using guidelines set by the Ministry of Planning, National Development and Vision 2030, County governments undertook the process of developing health care plans (Mishra & Mishra, 2013). The leadership processes include several steps: review of Existing policy documents, situation assessment undertaken to determine successes and challenges for the Department of Health, and, conducting series of workshops, identifying priorities, strategies and implementation matrix of the leadership plan. Internal as well as health sector stakeholder consultations on the leadership roles are undertaken and comments incorporated into the existing leadership schemes (Marshall, 2010).

The Constitution of Kenya 2010 established one of the most revolutionary changes in the country's history with the establishment of the two tier governance system; the National government and 47 County governments. The county governments are expected to spearhead development at the County level aimed at bridging the developmental disparities that have existed in the country since independence. County governments have been tasked with major functions under the constitution; key among them is health (Giannantonio & Hurley-Hanson, 2013). Devolution and implementation of the Constitution are key policies of the government. Priority at the national level is given to provision of adequate finances to match functions allocated to counties, and capacity enhancement for policymaking and project implementation in all county governments in order to bring the full benefits of devolution to the people (Rigolosi, 2013). This will in turn ensure more accountability as government services are brought closer to the people. The Public Financial Management Act (2012) is implemented with the aim of exercising controls in public spending and improving the

quality of public expenditure through full implementation of the Integrated Public Financial Management Systems (IFMIS) at national and county levels (Veronica, 2009). Further training of public officials involved in MTEF and budgeting and expenditure at both levels of government is undertaken.

Kiambu County's Strategic Plan guides the Health Services Department and an expression of commitment and determination to give improved health services to the people. Kiambu County's strategic plan details the activities of the County health sector and other health partners in the County for five years (July 2013- June 2018). The plan is modeled along the Kenya Health Policy 2012 – 2030, the Kenya Constitution 2010, the Kenya Vision 2030, Kenya Health Strategic and Investment Plan (KHSSP), 2012 – 2017, Millennium Development goals (MDGs) and the Kiambu County Integrated Development Plan (Rosenberg & Weissman, 2013).

The Department of Health Services is well positioned to play its role that contributes towards ensuring all Kenyans enjoy a high quality of life. To achieve this, the Department endeavors to use available resources in an efficient manner so as to maximize results and receive value for money. More importantly, the leadership strategy acts as a guide for assessing performance and achievement of the results in the Department in the next five years. It provides clear strategies; objectives and outputs that guide stakeholders implement projects and programs so as to realize the health sector objectives (Morrison, 2002). Further, the plan provides the coordination mechanism for collaboration among the different stakeholders in the sector. It is my belief that all stakeholders find this plan a useful tool in collaboration and implementation of the various strategies outlined therein; enable us to use the limited resources

more efficiently as well as increase accountability (Veronica, 2009).

### **Statement of the problem**

The quality of service delivery in public health care facilities across the world has undergone major transformations due to different environmental changes. Due to the developments in the health sector, problems arise in wide contexts, for example obsolescence of working skills, insufficient resource and patient satisfaction. This directly impacts on quality service delivery and responsiveness of the Level IV Hospitals (Ndavi, Ogola, & Kizito, 2009). Distribution of human resource with specialized training remains a challenge. The health services provider-population ratio of 1.69/1000 for all cadres of health care is an indicator of the absolute shortage of workers in the sector (Rosenberg & Weissman, 2013).

In Kenya, the new constitutional dispensation has decentralized the management of health care to County Governments. This way, many counties have encountered numerous challenges in the implementation of the health care requirements (Forman, 2010). Level IV Hospitals in Kiambu County have implemented service model systems to achieve competitiveness. Some of these improvements include introduction of modern medical equipment. However, even with these improvements the Level IV Hospitals are still facing client complaints and constant default of payments to suppliers. This directly impacts on quality of service delivered by the Level IV Hospitals thus encouraging patients to turn to alternatives such as private health care facilities that tend to be more responsive (Ministry of Health, 2013a). Therefore this study sought to identify Determinants of Health Care Service Delivery as a Devolved Function in Level Four Hospitals in Kiambu County as a way to handle such issues.

### **Objectives of the Study**

The general objective of this study was to establish the determinants of health care service delivery as a devolved function in Level IV Hospitals in Kiambu County. The specific objectives were:

- To establish how government funding determines health care service delivery as a devolved function in Level IV Hospitals in Kiambu County
- To determine the role of social accountability in health care service delivery as a devolved function in Level IV Hospitals in Kiambu County

### **LITERATURE REVIEW**

This chapter reviews selected conceptual and empirical literature on the key study variables with the aim of highlighting the existing research gaps.

#### **Theoretical Framework**

The following section reviews the major frameworks for analysis of decentralization that have been used in the current literature on health care decentralization.

#### **Social Capital Theory**

The social capital approach, used by Putnam in a path-breaking work on Italy, has generated new research in the area of decentralization. This approach focuses on explaining why decentralized governments in some localities have better institutional performance than other localities. Putnam finds that it is the density of civic institutions a broad range of different, largely voluntary, organizations that create general expectations and experiences among the local population that he calls "social capital" (Sperry, 2003). It is this investment in social experience that encourages people to work together rather than as autonomous self-seeking individuals, and to develop expectations, reinforced by experience, that they can trust each other. He argues that it is

this trust that fosters behavior that makes for better performance in local institutions (Giannantonio & Hurley-Hanson, 2013).

Applied to health care, this approach suggests that those localities with long and deep histories of strongly established civic organizations will have better performing decentralized governments than localities which lack these networks of associations (Leroy, 2013). Critics do not have systematic information; anecdotal cases suggest that some regions, might have more dense social networks, which might explain why they have better performing local institutions (Cohn & Hough, 2008). The denser civic associations of democracy may vary from location to location, providing a test of these hypotheses. In addition, a cross national comparison might provide insight into the effects of social capital with a likelihood of having the most “social capital” (Johnson, 2001). The weakness of this approach is that it does not provide easy policy relevant conclusions. Areas without civic networks seem to be left out of the picture. Areas which did not develop social capital in the Middle Ages are not likely to perform well in the twentieth century. There is skeptic perception that government policy can work to create this trust (Provost & Murray, 2011).

### **Local Fiscal Choice Theory**

The local fiscal choice model was developed by economists to analyze choices made by local governments using their own resources and intergovernmental transfers from other levels of government (O'Brien, 2010). It has been applied mainly in federal systems where local governments have had a history of constitutionally defined authority and significant locally generated resources (Dye & Garman, 2006). This theory assumes that local governments are competing with each other for mobile voters/taxpayers and that government officials make choices about resource mobilization, allocation and programs in an attempt to satisfy the

preferences of the median voter (Gunderman, 2009). Studies of federal systems have tended to find that central governments are more effective for making equitable allocation decisions (especially for assisting the poor), and that local governments may be more effective in utilizing funds for efficiency and quality objectives (Harrigan, 2005). This approach to choice usually views intergovernmental transfers from higher levels of governments as simply part of the resources of the local government. One issue often stressed in this literature is the role of intergovernmental grants as substitutes for local spending, driving out local funds for health rather than stimulating local counterpart funding (Drinka & Clark, 2000).

Literature where this approach has been used to review of recent experiences in fiscal decentralization leads to a criticism of the trend of assigning state and local governments an increasing share of centrally collected revenues (Hickey & Kritek, 2012). Peterson sees this trend as a threat to macro-economic policy control (Scott, 2003). He also notes that there is little incentive for local governments to match the intergovernmental transfers, since these transfers are usually not stable and are viewed by the local government as subject to increases negotiated with the central government (Curry, 2005).

Each of these explanations focuses on factors which this model does not incorporate. This study suggests that stronger monitoring by national level regulators, effective interchange (Ritvo, Ohlsen & Holland, 2004) between central government regulators and state officials, and “set asides” which restrict local choice explained the outcome (Cohn & Hough, 2007). The local fiscal choice approach has additional weaknesses for the purpose of analyzing decentralization of health systems (Forman, 2010). As Peterson points out, in most countries, local resources are such a small portion of local expenditures, and intergovernmental transfers

come with such restrictions, that it is difficult to assume that the voter holds local authorities responsible for both the taxation, which is centralized and the programs, which are only partially decentralized (Pelote & Route, 2008).

### **Public Administration Theory**

The public administration approach was first introduced for evaluating broad processes of decentralization in developing countries (Maccoby, Norman, Norman & Richard, 2013). This approach was applied to the decentralization of health systems in a seminal World Health Organization publication on the issue. The public administration approach focuses on the distribution of authority and responsibility for health services within a national political and administrative structure (Krause & Hidley, 2008). The analysis tends to assume that the public administrative organization is highly centralized and concentrated at the Ministry of Health offices at the national level in the capital city an often realistic assumption in developing countries (Kayden, Anderson, Freitas & Platz, 2014). Therefore the analysis leads toward prescriptions about how to move responsibility and authority out from the center to the periphery of the administrative system. This approach has developed a now well known four-fold typology of different *forms* of decentralization: 1) deconcentration; 2) delegation; 3) devolution; and 4) privatization.

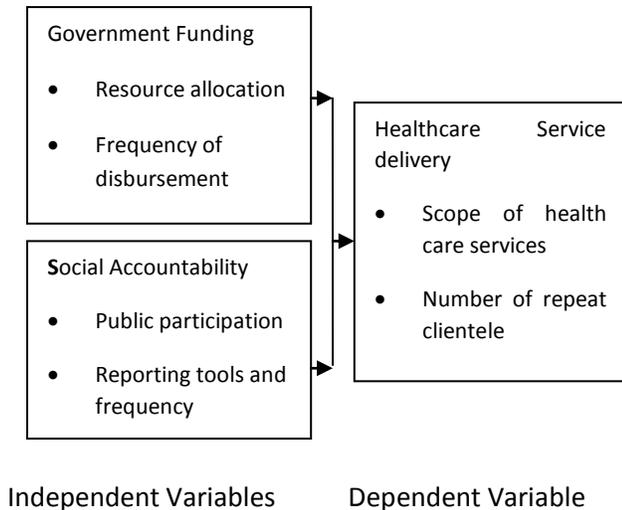
Deconcentration is defined as shifting power from the central offices to peripheral offices of the same administrative structure (i.e. Ministry of Health) (Hertz, 2010). Delegation shifts responsibility and authority to semi-autonomous agencies, usually with boards of directors representing separate corporate interests (labor, business, government) (Holland & Rohe, 2012). Devolution shifts responsibility and authority from the central offices of the Ministry of Health to separate administrative

structures still within the public administration (e.g. provinces, states, municipalities) (Gunderman, 2009). Privatization creates a contractual relationship between public entities and private providers of service. In each of these forms of decentralization significant authority and responsibility usually remains at the center (Porter-O'Grady & Malloch, 2013). In some cases this shift redefines the functional responsibilities so that the center retains policy making and monitoring roles and the periphery gains operational responsibility for day to day administration (Henwood, 2014). In others, the relationship is redefined in terms of a contract so that the center and periphery negotiate what is expected from each party to the contract (Gopee & Galloway, 2013). A central issue of the public administration approach has been to define the appropriate levels for decentralizing functions, responsibility and authority. The principal arenas are usually regions, sub-counties, and local communities, and there is usually some question about the appropriate number of levels depending on the size of the country analyzed (Wonderlich, 2007).

This approach focuses on the institutional arrangements of decentralization, but it does not provide much guidance for analyzing the functions and tasks that are transferred from one institutional entity to another, and does not identify the range of choice that is available to decision makers at each level (Gabel, 2012). There is an implicit assumption that moving from deconcentration toward privatization is likely to increase the range of choice allowed to local officials and managers; however there is no clear analysis for why this should be the case (Joint Commission Resources, Inc. 2011). Much of the empirical literature using this approach discusses the need to specify just what tasks or functions are assigned to each form or level, but as a framework it does not provide us with analytical

tools to specify and compare tasks and functions (Grabán & Swartz, 2013).

**Conceptual Framework**



**Figure 1: Conceptual Framework**

**Government Funding**

Kenya has had a history of health financing policy changes since it gained independence in 1963. User fees, or 'cost-sharing' as it commonly referred to in Kenya, was not part of the policy discussion between 1963 and 1989. The health financing system in Kenya was then supported primarily via general tax revenue (Commission on Revenue Allocation. 2014). However, in the late eighties, cost-sharing would start to attract considerable policy attention (Hess, 2012). In 1989, structural adjustment policies and severe government budgetary constraints led to the introduction of user fees for outpatient and inpatient care at government health facilities (Provost & Murray, 2011). Yet, for children under five and for specific ailments, an exemption from fees was introduced. In addition, health care at dispensaries would still be delivered free of charge (Holland & Rohe, 2012).

Health care facilities are required to balance their budgets given the current restricted funding outlook, yet more efficiency savings was needed in

order to meet demand (Sperry, 2003). However, these savings was increasingly hard to deliver following the years that such arrangements have already been in operation (Johnson, 2001). Seeking to charge service users more may be one option to help fill any funding gap (Cornelison, 2008). What seems more likely is that non-statutory services was at even greater risk than now, as will service quality levels that are deemed to be over and above the minimum necessary (World Health Organization. 2012b).

Currently, the Public Finance Management Act requires that all revenue collected in the county be submitted to the county revenue fund. Further, it states that no monies should be used at source (Commission on Revenue Allocation. 2014). This way, the hospitals are later funded from the county revenue fund account through Authority to Incur Expenditure Vouchers (Joint Commission Resources, Inc. 2011).

The fragmentation of the health financing system also creates obstacles for an integrated service provision. Ideally, patients are treated where medically most effective and economically most efficient. Fragmented financing mechanisms can create incentives working against this principle. Patients have an obvious incentive to seek care where they are covered against the costs of treatment (Nagelkerk, 2005). Where hospital treatment is covered, patients may bypass primary facilities where adequate treatment can be provided at the lowest possible costs (Hess, 2012). For example, County Facilities may refer patients to tertiary hospitals since these are not financed by the County, but by the Ministry of Health (Scott, 2003). Varying payment mechanisms may compound this issue. The more fragmented the financing system, the more difficult it is to avoid negative effects (KPMG International. 2013).. In addition, the flow of medical information is often inhibited where different funding sources are

involved in data collection (Gold, Mumford & Thorpe, 2010). This can have obvious negative impacts on health outcomes and on the governance of the health sector (O'Brien, 2010).

The bigger challenge, however, is the insufficient amount of (especially domestic) public funds in the system. Public infrastructure investments financing should continue via coordinated input-based financing from the budgets at MOH and the Counties, depending on the level of health infrastructure (Cornelison, 2008). This reflects their role as a key driver of equity of access. In order to rationalize public investments and better align public and private investments, a “Needs-based health services planning and licensing Act” is suggested, which would regulate the distribution, level and quantity of health service providers and high-cost and high-risk health technologies and activities (World Health Organization. 2012b). Licensing of private investment may require access via public financing mechanisms to ensure that universal access is provided also under private provision (Hess, 2012). At the same time, costs for private investments into licensed health infrastructure need to be refinanced via recurrent costs, i.e. public and private providers was paid the same reimbursements for recurrent costs of contracted services, but private providers will receive an “investment top-up” based on standard price lists and depreciation rules for investment items if contracted to deliver services to people enrolled in public schemes (Griffith, 1998).

### **Social Accountability**

Section 46 (1) of the Constitution of Kenya outlines the Consumer rights with respect to Health (Constitution of Kenya. 2010). Opportunities for information exchange, dialogue, and negotiation between citizens and the state can include the introduction of new tools for citizen-state interaction or reforming existing mechanisms

(Bercaw, 2013). Willingness and ability to seek government accountability among citizens and civil society can include technical capacity building as well as mobilization, coalition-building, negotiation, and advocacy (Curry, 2005). Transparency and open information sharing, attitudes, skills, and practices supporting listening and constructive engagement with citizens may utilize incentives, rewards, and sanctions to promote transparent and responsive behavior (Porter-O'Grady & Malloch, 2013). An enabling environment can include policy, laws, and a regulatory atmosphere that fosters civic engagement; type of political system, how much political freedom is granted, and a tradition of open pluralistic debate; economic basis and financial viability of different forms of civic engagements; and values, norms and social institutions present in a particular society that support or inhibit open and pluralistic debate and critical but constructive engagement (Cornelison, 2008).

A health care institution that aspires to excellence in the production of health care professionals should be granted that status not only when its graduates possess all of the competencies desirable to improve the health of citizens and society, but when they are able to use them in their professional practice (Joint Commission Resources, Inc. 2011). Although medical schools are not presently held to account for the ways in which their graduates are used, and serve, their societies, such an accounting may be required in the future (Porter-O'Grady & Malloch, 2007). Health care institutions are increasingly requested to be more explicit about their outputs of professional practitioners and the impact of their presence on social well-being. Professionals may expect policies in higher education and health care to foster such an approach, providing there is political will to improve coordination between the identification of people's health needs, health care system management and health care strategies (Porter-O'Grady & Malloch,

2010). In return, health care institutions must use their autonomy and resources to make the best use of their innovative potential to meet these challenges (Rich, Singleton, & Wadhwa, 2013).

The enabling environment is the key to implementation. In some cases, governments at various levels may not inform local officials that they should participate, so there may not be a true willingness to engage (Krause & Hidley, 2008). Lack of rights to information in the preparation phase or lack of a collaborative government partner can be an impasse. If political will is nonexistent, the process will not work; changes in health outcomes may not be possible. In the absence of some minimal level of political will, functions as a strong awareness rising program (Gopee & Galloway, 2013).

These principles relate to the understanding of the complexity of a health care system and to the capacity to find a most useful place in it (Porter-O'Grady & Malloch, 2013). The institution is likely to improve its effectiveness if it works in partnership with other stakeholders in the system, namely, policy makers, health system managers, health care professionals and civil society (Mwaniki & Dulo, 2008). In order to implement the humanistic principles outlined above, each of these stakeholders has a coordinated role to play (Pelote & Route, 2008). For instance, the policy maker should frame a long-term vision of a health care system which is coherent and integrated; the health system manager should ensure an allocation of resources that is consistent with this vision; the health care professional should acquire competences to deliver the appropriate range of services, and the citizen should assume greater responsibility in protecting his or her own health and that of the community (Porter-O'Grady & Malloch, 2013). All partners should adapt their roles and act in synergy to strengthen the system and its human resources for health. The principle of quality

seeks to provide the citizen with the best possible measures to protect, restore and promote a state of physical, mental and social wellbeing (Kayden, Anderson, Freitas & Platz, 2014). The principle of equity tries to ensure that every citizen has full access to health care services and does not face any form of discrimination. The principle of relevance seeks a response to priority health care needs and the provision of special attention to the most vulnerable individuals or groups in society (Drinka & Clark, 2000). The principle of effectiveness refers to the utilization of health care resources, both human and material, in a manner that serves the public interest in the most effective and efficient way (Joint Commission Resources, Inc. 2011).

#### **Service delivery as a devolved function**

The Government Computer Services retrieved data through printouts, resulting in printing of bulky listings which were hardly used for the intended purpose. The result was submission of payroll data by Ministries/Departments to the human resource management system using diskettes thus compromising data integrity besides not being cost effective. Before introduction of IPPD, HRM systems did not share data due to lack of appropriate network (Cornelison, 2008).

In 2009, United Nations Development Programme (UNDP) supported the Kenyan government to step up public sector reforms to focus on national transformation. Before then, it was the Government that spearheaded institutionalization of results-based management in the public service but currently the focus is on transforming public service delivery through building partnerships. These efforts were boosted after the promulgation of the new Constitution of Kenya in 2010 (Sullivan & Denis, 2011). The changes provided an ideal opportunity to tackle deep-rooted problems of inefficiency because citizens are increasingly becoming empowered to demand for better

services. This is achieved through implementing the new Constitution, attaining of the Kenya Vision 2030, transforming public service delivery and private-public dialogue to enhance good governance (Porter-O'Grady & Malloch, 2013).

Health care programs should be adjusted accordingly. It is imperative that the design, implementation and follow-up of health care program be established in a manner that ensures they are relevant to the needs of citizens and society as a whole and are closely related to the process of national health development (Cornelison, 2008). Because health policy has an influence on the spectrum of competencies that health care professionals need to possess, the institution must have an interest in such policy (Ritvo, Ohlsen & Holland, 2004). This proactive posture of the institution should be clearly enunciated in its mission statement and institutional objectives (Porter-O'Grady & Malloch, 2013). Moreover, its strategic development plan should be formulated with due regard to evolutionary trends in the health care system and the projected needs of health care personnel, in both qualitative and quantitative terms (Mwaniki & Dulo, 2008).

A fragmented health financing system can also create challenges for assuring equitable and efficient investments into services if no integrated system of investment planning and/or licensing is in place (Gabel, 2012). On the one hand, some areas in need may fall between the gaps of different funders (especially if the areas are poor and providers are motivated by profits). On the other hand, some areas may also be oversupplied with care, especially high-cost technologies. This does not only reduce available funding for investments into disadvantaged areas, but also increases recurrent costs (Joint Commission Resources, Inc. 2011). This is especially the case for diagnostic devices, where providers can induce demand while quality of care

may suffer. Fragmentation of pools is also an issue for revenue collection. Schemes collect, bank and invest their own revenue. This is administratively inefficient (Persily, 2014).

In a health care facility, leadership groups comprise the managers of the organized medical staff. Only if these three leadership groups work together, collaboratively, to exercise the organization's leadership function, can the organization reliably achieve its goals (Wonderlich, 2007). As mentioned above, this includes high-quality and safe patient care as well as financial sustainability; community service; and ethical behavior. In some organizations, the individuals who comprise these leadership groups may overlap (Logan, King, & Fischer-Wright, 2012). In small organizations, they may be the same individuals, or even one individual in the smallest organization. But the leadership function is the same, whether performed collaboratively by different or overlapping groups, or by the same group of individuals, or even by one person (Rosenberg & Weissman, 2013). In the international practices, a hospital is the most complex healthcare setting in which these three groups of leaders must collaborate in order to successfully lead the organization. For this reason, the leadership roles include among the leaders of the organization, the leaders of the medical staff (Bercaw, 2013).

### **Empirical Review**

According to Mwaniki & Dulo (2008), in the study "Migration of Health Workers in Kenya: The Impact on Health Service Delivery", training influences the capacity of health workers. High quality and accessible health services cannot be delivered without sufficient numbers of well-skilled, well-distributed and well-managed health workers. The erosion of Kenya's key health indicators – life expectancy, infant mortality and maternal mortality – during the last two decades can be traced at least in part to the deterioration of the health work

force. The acute shortage, inequitable distribution and inadequate skills of health workers have contributed to this negative trend. Staff shortages are particularly acute in hard-to-reach regions (Henwood, 2014). Currently, county governments in Kenya are in charge of the human resource management and development function from 2015.

Ndavi, Ogola, & Kizito (2009), in the study "Decentralizing Kenya's Health Management System: An Evaluation" observed that patient satisfaction is a critical component in health care service delivery. The leadership strategy is formulated using the logical framework format with participation of the County Health Team, sub-counties and stakeholders in the County. It is comprehensive and its implementation calls for integrated multi-sectoral action at all levels. The County Health Team implements the strategic plan through focusing on achieving the set targets, hence reversing the downward trends with the minimal available resources. This is only realized when concerted efforts and collaboration across all the health care actors and stakeholders in the County is enhanced (Daniels & Ramey, 2005). This collaborative approach emphasizes the growing awareness among all stakeholders that the challenges of health nationally and in Kiambu County in particular, can only be successfully addressed by working as a team. It is our strong conviction that the participation by individuals from all sectors, representing a wide range of organizations, of ensures dynamic County action that yields desirable results in health services in Kiambu County.

According to Mittulah & Kamau (2013), in the study "The Partnership of Free Speech and Good Governance in Africa", social accountability is a core determinant of public resource utilization. The Government will ensure that all pending legislations required by the Constitution are completed and

enacted. It will provide full support to the ongoing transformation of an independent judiciary by providing it with adequate resources and with political support. Under the MTP II, the government will also strengthen public service reforms, performance contracting, accountability and transparency (Bercaw, 2013).

Kramon & Posner (2011), in the study "Kenya's New Constitution" observed that government funding is an entrenchment of economic growth. Intergovernmental transfers account for over 90% of most local resources, and the central government restricts local choice over these transfers. In addition, it is difficult to assume that local authorities respond to the median voter assumptions when so many other political factors are involved in making local choices. Also, voters tend not to be single issue voters; they choose candidates for a variety of reasons, not just health care issues. Finally, the assumption of voter mobility is often unrealistic.

## **RESEARCH METHODOLOGY**

This chapter describes the methodology that was used in undertaking the study. The study adapted a cross-sectional survey research design to help in indicating trends in attitudes and behaviors and enable generalization of the findings of the research study to be done. The target population was drawn from a population frame of 180 Hospital Management Team Members (MOH, 2013a). The study's population consisted of various management staff from Level IV health care facilities namely; medical superintendents, administrative officer and other heads of departments such as accounts, supply chain office, nursing services, physiotherapy, laboratory services, mother and child health, nutrition, clinical services, public health, bio-medical engineering office and accommodation, health records, and radiology. The

study focused on the Hospital Management Team Members because they are the accounting officers of the respective institutions as stipulated in the Public Finance Management Act 2012. In this study, a sample size of 64 Hospital Management Team Members across 12 Level 4 Health Care Facilities was used. Primary data was collected through questionnaire. Suitable, usable and adequate data for the study was collected through administering questionnaires. The questionnaires were self-administered. The respondents were called and requested for their time prior to meeting physically for the actual questionnaire. Prior to disseminating the questionnaires, the researcher carried out a pilot study to try out the research techniques and methods and the questionnaire. The Cronbach's alpha coefficient was used to measure the reliability of the scale, which was also used to assess the interval consistency among the research instrument items.

#### **Data Analysis and Presentation**

Data analysis is defined as the ordering and organizing of raw data to extract useful information from it. Data was analyzed through the regression and descriptive models. The gathered data was analyzed to ascertain the factors affecting health care service delivery as a devolved function in level four public facilities. These statistics were generated with an aid of the computer software, Statistical Package for Social Sciences (SPSS version 21) which offered extensive data handling capability and numerous statistical analysis routines that can analyze small to very large data statistics. Quantitative data was edited to eliminate inconsistencies, summarized and coded for easy classification in order to facilitate tabulation and discussion. Descriptive statistics were used in describing the sample data in such a way as to portray the typical respondent and to reveal the general response pattern.

#### **RESEARCH FINDINGS AND DISCUSSION**

This chapter contains the analysis of the data collected and the discussion of the findings made in the study. In this study, out of the 64 questionnaires issued to the respondents by the researcher, 53 of them were received fully completed recording a response rate of 82.8 percent. Cronbach's alpha for each value was established by the SPSS application and gauged against each other at a cut off value of 0.7 which is acceptable according to Cooper and Schindler (2008). In this study all the values were above 0.7 which concludes that the data collection instrument was reliable. On duration of service, from the study findings, 15 percent of the respondents had worked in the organization for a period of between 1 and 2 years, 49 percent for a period of between 3 and 5 years, 28 percent for a period of between 6 and 8 years and 8 percent for a period of above 8 years .

The findings indicated that the majority (49%) had degree education level, 24% had advanced diploma education level, 8% had master's education level and 2% had PHD level of education.

#### **Social accountability**

##### **Extent of agreement of statements on stakeholder involvement that affect health care service delivery**

Based on the study findings, majority of respondents strongly disagreed to the statements that stakeholders formulate hospital care policy, implements patients' charter, monitors patients' waiting time and customer service and evaluates hospital performance. Further respondents disagreed on the statement that a range of medical services is provided by stakeholders.

##### **Indication on how important respondents consider the stakeholders to be involved in consultation on patient treatment**

The study found out that the respondents strongly agreed that the doctors and administrators are the

most important. Further respondents agreed on the statements that the following stakeholders are important in consultation on patient treatment; nursing staff, pharmacists and hospital managers. The findings agree with Logan, King & Fischer-Wright (2012) that decentralization, at least in its devolution form, implies that those who manage the health system was accountable to the local population (or local political system), who become additional principals and who may have quite different objectives from those of the principals at the national level.

#### **Indication on how desirable respondents consider the following methods of stakeholder involvement**

The study found out that the respondents view the use of stakeholder representative council as a strongly desirable method of stakeholder involvement. Further respondents view statements on the following methods of stakeholder involvement as desirable; stakeholder focus group or committee, ombudsman, anonymous interviews and regular questionnaire survey. The respondents also indicated other methods of stakeholder involvement which included the use of social media platforms like facebook and Whatsapp in dissemination of health information to the public. The findings concur with EFP (2006), communication is the most important aspect of the Service delivery as Communication with patients is vital to delivering service satisfaction because when hospital staff takes the time to answer questions of concern to patients, it can alleviate many feelings of uncertainty.

#### **Indication on how desirable respondents consider the following methods of providing information on the performance of a hospital**

The study found out that the respondents view the production of hospital annual report as a strongly desirable method of providing information on the performance of a hospital. Further respondents

view statements on the following methods of providing information on the performance of a hospital as desirable; audit report, media (e.g., newspaper), separated social audit report/statement and internet (e.g., webpage).

The findings concur with Research by Payne (2006) that communication challenges have a negative impact on: access to treatment, participation in preventive measures, ability to obtain consent, ability for health professionals to meet their ethical obligations, quality of care, including, hospital admissions, diagnostic testing, medical errors, patient follow-up, quality of mental health care and patient safety.

#### **Government Funding**

##### **Extent of agreement of statements on nature of funding that affect health care service delivery**

The study found out that the respondents strongly agreed that the conditional grants are available and sustainable; the cash-equivalents such as provision of equipment by county government are available and sustainable. Further respondents agreed on the statements that government agencies such as treasury are involved in budgeting process; communities are involved in budgeting process and that the facility's absorption rate for provisions is adequate.

The findings concur with (Brown & Du guid, 2003) financial accountability using monitoring, auditing and accounting mechanisms defined by the country legal and institutional framework is a prerequisite to ensure that allocated funds are used for the intended purposes (Oliveira-Cruz, Hanson, & Mills. 2001). In many developing countries, governments do not have the financial and technical capacity to effectively exercise such oversight and control functions, track and report on allocation, disbursement and use of financial resources (Smee, 2002).

### **Extent of agreement of statements on budgeting that affect health care service delivery**

The study found out that the respondents agreed that the budgets are approved and funded as presented and without alteration; budgets are subjected to further revision processes. Further respondents strongly disagreed on the statements that budgets are under-funded; budgetary management presents adequate resource management practices.

The findings concur with Peters, Elmendorf, Kandola & Chellaraj (2000), that political and bureaucratic leakage, fraud, abuse and corrupt practices are likely to occur at every stage of the budgeting process as a result of poorly managed expenditure systems, lack of effective auditing and supervision, organizational deficiencies and tax fiscal controls over the flow of public funds.

### **Extent of agreement of statements on financial management that affect health care service delivery**

Based on the study findings, majority of respondents strongly agreed to the statements that payment of legal obligations is delayed, increased supplier conflicts due to accumulated unpaid bills, hospital facilities can explore pre-financing options, hospital facilities can explore donations from non-governmental organizations and hospital facilities can explore Kenyan Health Sector Services Fund (HSSF). Further respondents disagreed on the statement that hospital based collections are sufficient to sustain operations and that disbursed funds are always timely. The findings concur with Adams and Colebourne (1999), that financial management, in service organizations, has been a constraint and an obstacle to other functions that contribute to service delivery. They suggest an “enlightened” approach to finance in service organizations. This consists of more participative and positive approach where far from being an

obstacle, it contributes to strategic planning, costing systems, personnel motivation, quality control, continued solvency, and keeping outsiders’ confidence in management (Arhin-Tenkorang, 2000).

## **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

This chapter discusses the summary of the key findings along the study objectives and the corresponding hypothesis. It then draws conclusions based on these findings and discussions are put forth for the recommendations of the study based on both policy and practice. Finally, the chapter presents the study limitations and recommendations for further areas of research.

### **Summary of Major Findings**

The general objective of the study was to establish the determinants of health care service delivery as a devolved function on Level IV Hospitals in Kiambu County. The study specifically determined the role social accountability and government funding on health care service delivery. The reviewed literature showed that the independent variables play an important role in health care service delivery. The key findings summarized from the two specific objectives are as follows:

### **Role of social accountability on health care service delivery as a devolved function in Level IV hospitals in Kiambu County**

The study findings showed that social accountability factors notably; stakeholder involvement, methods of stakeholder involvement and methods of provision of information on the health facility performance to a large extent influenced health care service delivery. From the findings, the researcher found out that social accountability has a significant strong positive correlation with health care service delivery.

### **Role of government funding on health care service delivery as a devolved function in Level IV hospitals in Kiambu County**

The study findings showed that government funding factors notably; schedule of government fund disbursement, nature of funding, sources of funding and financial management influenced health care service delivery to a large extent. From the findings, the researcher also found out that government funding had a significant strong negative correlation with health care service delivery. Increasing levels of government funding by a unit would decrease the levels of health care service delivery. This indicates that there exists a strong negative relationship between government funding and health care service delivery.

### **Conclusions**

Based on the study findings, the study concludes that health care service delivery in Level IV hospitals in Kiambu County, Kenya is affected by social accountability and government funding. These are the major factors that mostly affect health care service delivery in Level IV hospitals in Kiambu County, Kenya. Technology adoption in health institutions would enable the provision of high-quality medicine to patients, reduce time lags in getting lab and imaging results, ensure the resulting system meets the needs of clinicians and improve the accessibility of relevant information efficiently and effectively. Effective communication would enable the accessibility to treatment, quality of health care, efficient admissions; diagnostic testing and patient follow-up also reduce risk of hospital admission, intubation and poor prescribed medication, delayed diagnosis, misdiagnosis, and inappropriate referral.

From the findings, the study concluded that delivery of service quality health in the health sectors should be improved through effective allocation of financial resources in public health sector in order

to promote other functions that contribute to service delivery, reduce the bureaucracy in financial management and offer funds for purchase of high quality health equipment and employing of more competent staff who could offer. The financial resource allocation should be done through a strategic planning, costing systems, personnel motivation, quality control, continued solvency, and keeping outsiders' confidence in financial management, financial accountability using monitoring, auditing and accounting mechanisms to ensure that allocated funds are used for the intended purposes in order to ensure good expenditure control and maximize the effectiveness, quality, or quantity of medical care offered by hospitals.

### **Recommendations**

#### **To establish how government funding determines health care service delivery as a devolved function in Level IV Hospitals in Kiambu County**

The government should improve financial disbursement channels in service organizations in order to promote other functions that contribute to service delivery, reduce the bureaucracy in financial management and offer funds for purchase of high quality health equipment and generally influence delivery of health service quality so as to enhance patient satisfaction, patient retention, loyalty, health service guarantees and growth and development of health institution from public sectors.

#### **To determine the role of social accountability determines health care service delivery as a devolved function in Level IV Hospitals in Kiambu County**

The study recommends that public health sectors should adopt modern technology and equipment so as to facilitate service assessment, improve communication process, provide high-quality reports to patients, reduce time lags in getting lab

and imaging results, ensure the resulting system meets the needs of clinicians and improve the accessibility of relevant information efficiently and effectively. The study also recommends that public health institutions should adopt use of face-to-face, upward, horizontal and vertical communication channels as this would enable flow of information to upper level managers, improve individual participation, conveying difficult or ambiguous messages, enable the accessibility to treatment, quality of care, efficient admissions, diagnostic testing and patient follow-up also reduce risk of hospital admission, intubation and poor prescribed medication, delayed diagnosis, misdiagnosis, and inappropriate referral.

#### **Areas for further research**

The study encountered some limitations which provide avenues for further research despite the fact that it produced meaningful results. The first limitation was the selection service delivery variables in health care included in the conceptual framework which was not exhaustive. Further, the study relied on data collected mainly from the Level IV Health Care Facilities in Kiambu County. Further research could seek to address this limitation by conducting a similar study in more Counties since this would enhance the validity and generalization of the research findings.

## REFERENCES

- Barr, J., & Dowding, L. (2008). *Leadership in Health Care*. New York: SAGE.
- Barr, J., & Dowding, L. (2012). *Leadership in Health Care*. New York: SAGE.
- Bercaw, R. G. (2013). *Lean Leadership for Healthcare: Approaches to Lean Transformation*. New York: CRC Press.
- Capella University. (2009). *The Career Paths of Executive Women in Healthcare Leadership: A Phenomenological Study*. New York: Capella University.
- Cohn, K. H., & Hough, D. E. (2007). *The Business of Healthcare*. New York: Greenwood Publishing Group.
- Cohn, K. H., & Hough, D. E. (2008). *The Business of Healthcare: Leading healthcare organizations*. New York: Greenwood Publishing Group.
- Commission on Revenue Allocation. (2014). *Revenue Division among County Governments*. Nairobi, Kenya: Commission on Revenue Allocation.
- Constitution of Kenya. (2010). *Fourth Schedule*. Nairobi, Kenya: Government of Kenya.
- Cornelison, P. (2008). *Guide for Assessing Hospital Liability: A Former CEO's Perspective*. New York: Lawyers & Judges Publishing Company.
- Craigie, F. C. (2010). *Positive Spirituality in Health Care: Nine Practical Approaches to Pursuing Wholeness for Clinicians, Patients, and Health Care Organizations*. New York: Hillcrest Publishing Group.
- Curry, W. (2005). *Positive Leadership in Health Care: Building on Strengths, Managing Around Weakness*. New York: American College of Physician Executives.
- Daniels, S., & Ramey, M. (2005). *The Leader's Guide to Hospital Case Management*. New York: Jones & Bartlett Learning.
- Dickson, G., & Tholl, B. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment: A New Perspective*. New York: Springer Science & Business Media.
- Drinka, T. J. K., Clark, P. G. (2000). *Health Care Teamwork: Interdisciplinary Practice and Teaching*. New York: Greenwood Publishing Group.
- Dunham-Taylor, J., & Pinczuk, J. Z. (2006). *Health Care Financial Management for Nurse Managers: Merging the Heart with the Dollar*. New York: Jones & Bartlett Learning.
- Dye, C. F., & Garman, A. N. (2006). *Exceptional Leadership: 16 Critical Competencies for Healthcare Executives*. New York: Health Administration Press.
- Forman, H. (2010). *Nursing Leadership for Patient-centered Care: Authenticity, Presence, Intuition, Expertise*. New York: Springer Publishing Company.
- Gabel, S. (2012). *Leaders and Health Care Organizational Change: Art, Politics and Process*. New York: Springer Science & Business Media.
- Giannantonio, C. M., & Hurley-Hanson, A. E. (2013). *Extreme Leadership: Leaders, Teams and Situations Outside the Norm*. New York: Edward Elgar Publishing.
- Gilkey, R. W. (1999). *The 21st Century Health Care Leader*. New York: Wiley.
- Gold, J., Mumford, A., & Thorpe, R. (2010). *Leadership and Management Development*. New York: Chartered Institute of Personnel and Development.
- Goodwin, N. (2013). *Leadership in Health Care: A European Perspective*. New York: Routledge.
- Gopee, N., & Galloway, J. (2013). *Leadership and Management in Healthcare*. New York: SAGE Publications.
- Graban, M., & Swartz, J. E. (2013). *The Executive Guide to Healthcare Kaizen: Leadership for a Continuously Learning and Improving Organization*. New York: CRC Press.

- Griffith, J. R. (1998). *Designing 21st Century Healthcare: Leadership in Hospitals and Healthcare Systems*. New York: Health Administration Press.
- Gunderman, R. B. (2009). *Leadership in Healthcare*. New York: Springer Science & Business Media.
- Harrigan, M. (2005). *Leadership Challenges in Canadian Health Care: Exploring Exemplary Professionalism Under the Malaise of Modernity*. New York: Simon Fraser University.
- Hartley, J., & Benington, J. (2010). *Leadership for Healthcare*. New York: Policy Press.
- Henwood, S. (2014). *Practical Leadership in Nursing and Health Care: A Multi-Professional Approach*. New York: CRC Press.
- Hertz, H. S. (2010). *Health Care Criteria for Performance Excellence: Baldrige National Quality Program (2009-2010)*. New York: DIANE Publishing.
- Hess, M. J. (2012). *Shine! Healthcare Leadership Distilled: Increase your bottom-line through improved leadership*. New York: Author House.
- Hickey, M., & Kritek, P. (2012). *Change Leadership in Nursing: How Change Occurs in a Complex Hospital System*. New York: Springer Publishing Company.
- Holland, D., & Rohe, D. (2012). *Surviving and Thriving in Waves of Change: For Healthcare Leaders*. New York: Xlibris Corporation.
- Huber, D. (2013). *Leadership and Nursing Care Management*. New York: Elsevier Health Sciences.
- Johnson, L. M. (2001). *The Effect of Military Experience on Civilian and Military Healthcare Facility CEO Leadership Development, Behaviors, and Outcomes*. New York: Universal-Publishers.
- Joint Commission Resources, Inc. (2011). *From Front Office to Front Line: Essential Issues for Health Care Leaders*. New York: Joint Commission Resources,
- Kayden, S., Anderson, P. D., Freitas, R., & Platz, E. (2014). *Emergency Department Leadership and Management*. New York: Cambridge University Press.
- Kenya National Bureau of Statistics (2012): *Kenya facts and figures 2012*. [online]. –URL: [http://www.usaid.gov/sites/default/files/documents/1860/9\)%20Kenya%20facts%20and%20figures%202012.pdf](http://www.usaid.gov/sites/default/files/documents/1860/9)%20Kenya%20facts%20and%20figures%202012.pdf)
- KPMG International. (2013). *Devolution of Healthcare Services in Kenya: Lessons Learnt from Other Countries*. Accessed July 17, 2014, from <https://www.kpmg.com/Africa/en/IssuesAndInsights/Articles-Publications/Pages/Devolution-of-Healthcare-Services-in-Kenya.aspx>.
- Kramon, E., & Posner, D. N. (2011). "Kenya's New Constitution." *Journal of Democracy*22(2): 89–2013.
- Krause, T. R., & Hidley, J. (2008). *Taking the Lead in Patient Safety: How Healthcare Leaders Influence Behavior and Create Culture*. New York: John Wiley & Sons.
- Leroy, H. (2013). *Leading In Health Care Organizations: Improving Safety, Satisfaction, and Financial Performance*. New York: Emerald Group Publishing.
- Logan, D., King, J., & Fischer-Wright, H. (2012). *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization*. New York: HarperCollins.
- Maccoby, M., Norman, C., L. Norman, C., & Richard, M. J. (2013). *Transforming Health Care Leadership: A Systems Guide to Improve Patient Care, Decrease Costs, and Improve Population Health*. New York: John Wiley & Sons.
- Malloch, K., & Porter-O'Grady, T. (2010). *Introduction to Evidence-Based Practice in Nursing and Health Care*. New York: Jones & Bartlett Publishers.

- Marshall, E. (2010). *Transformational Leadership in Nursing: From Expert Clinician to Influential Leader*. New York: Springer Publishing Company.
- Mishra, A., & Mishra, K. E. (2013). *Becoming a Trustworthy Leader: Psychology and Practice*. New York: Routledge.
- Mittulah, W. & Kamau, P. (2013):“The Partnership of Free Speech and Good Governance in Africa” *Afrobarometer’s Report*. The Institute of Development Studies at the University in Nairobi. 16 October.
- MOH. (2013a). *Kenya Service Availability and Readiness Assessment Mapping (SARAM) Report*. Nairobi, Kenya: World Health Organization.
- MOH. (2013b). *Human Resources for Health and Health Infrastructure Norm and Standards*. Nairobi, Kenya: MOH.
- Morrison, I. (2002). *Health Care in the New Millennium: Vision, Values, and Leadership*. New York: Wiley.
- Mwaniki, D.L. & Dulo, C. (2008). “*Migration of Health Workers in Kenya: The Impact on Health Service Delivery.*” Regional Network for Equity in Health in East and Southern Africa. Discussion Paper no.55, March 2008.
- Nagelkerk, J. (2005). *Leadership and Nursing Care Management*. New York: Elsevier Health Sciences.
- Ndavi, P. M., S. Ogola, P. M. Kizito, K. Johnson. (2009). *Decentralizing Kenya’s Health Management System: An Evaluation*. Kenya Working Papers No. 1. Calverton, MD: Macro International Inc.
- O'Brien, M. (2010). *Servant Leadership in Nursing*. New York: Jones & Bartlett Learning.
- Pelote, V., & Route, L. (2008). *Masterpieces in Health Care Leadership*. New York: Jones & Bartlett Publishers.
- Persily, C. A. (2014). *Team Leadership and Partnering in Nursing and Health Care*. New York: Springer Publishing Company.
- Porter-O’Grady, T., & Malloch, K. (2007). *Quantum Leadership: A Resource for Health Care Innovation*. New York: Jones & Bartlett Learning.
- Porter-O’Grady, T., & Malloch, K. (2013). *Leadership in Nursing Practice: Changing the Landscape of Healthcare*. New York: Jones & Bartlett Publishers.
- Porter-O’Grady, T., Malloch, K. (2010). *Innovation Leadership: Creating the Landscape of Healthcare*. New York: Jones & Bartlett Publishers.
- Provost, L. P., & Murray, S. (2011). *The Health Care Data Guide: Learning from Data for Improvement*. New York: John Wiley & Sons.
- Rich, C. R., J. Singleton, K., & Wadhwa, S. S. (2013). *Sustainability for Healthcare Management: A Leadership Imperative*. New York: Routledge.
- Rigolosi, E. (2013). *Management and Leadership in Nursing and Health Care: An Experiential Approach*. New York: Springer Publishing Company.
- Ritvo, R. A., Ohlsen, J. D., & Holland, T. P. (2004). *Ethical Governance in Health Care: A Board Leadership Guide for Building an Ethical Culture Health Forum*. New York: University of Michigan.
- Rosenberg, G., & Weissman, A. (2013). *Social Work Leadership in Healthcare: Director’s Perspectives*. New York: Routledge.
- Scott, T. (2003). *Healthcare Performance and Organisational Culture*. New York: Radcliffe Publishing.
- Sperry, L. (2003). *Becoming an Effective Health Care Manager: The Essential Skills of Leadership Health*. New York: Professions Press.
- Sullivan, T., & Denis, J. (2011). *Building Better Health Care Leadership for Canada: Implementing Evidence*. New York: McGill-Queen's Press - MQUP.

- Veronica, B., (2009). *Leadership For Nursing And Allied Health Care Professions*. New York: McGraw-Hill Education.
- Wamai, R. (2009). The kenya health system: analysis of the situation and enduring challenges. *JMAJ*, 52(2), 134-140.
- WHO -World Health Organization (2012b). *WHO Global Health Expenditure Atlas*[online]. –URL: <http://apps.who.int/nha/atlasfinal.pdf>
- Wolf, J. A., Hanson, H., & Moir, M. J. (2011). *Organization Development in Health Care: High Impact Practices for a Complex and Changing Environment*. New York: IAP.
- Wonderlich, S. (2007). *Key Topics in Healthcare Management: Understanding the Big Picture*. New York: Radcliffe Publishing.
- Wong, C. A. (2008). *The Role of Authentic Leadership in Nursing and Healthcare*. New York: University of Alberta.
- World Health Organization. (2012a). *Global Health Report: Kenya*. Retrieved from <http://www.who.int/countries/ken/en/>