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Abstract

Purpose: The devolution of Governance in Kenya granted counties the authority to mobilize revenues from hospital to enhance public health care delivery. However, persistent disparities in health outcomes among Level 5 public hospitals raise concerns about the role of governance of hospital-generated revenue in health service delivery. This study investigated the influence of governance of internally generated revenue on delivery of health services in Kenya's Level 5 public hospitals, and examined the moderating effect of leadership principles on this relationship.

Materials and Methods: A descriptive cross-sectional design employing quantitative data was used to collect data from 252 healthcare personnel across 13 Level 5 public hospitals in 10 counties in Kenya. Respondents included nurse practitioners, pharmacists, doctors, physical therapists, medical technologists, and administrators. Qualitative data was also collected from patients and key informants to corroborate the quantitative findings. Descriptive statistics and regression analyses were employed for quantitative data analysis.

Findings: The findings revealed a statistically significant but modest positive correlation between governance of hospital-generated revenue and healthcare service delivery, and a strong positive correlation between leadership principles and service delivery. Governance quality explained 25.3% of the variation in health service delivery outcomes when controlling for other factors. Critically, leadership principles significantly moderated this relationship, with strong leadership amplifying the positive effect of governance on service delivery, while weak leadership rendered governance efforts counterproductive. At mean leadership levels, governance showed no significant effect. Nonetheless, the study showed that challenges including operational inefficiencies, transparency deficits, and inequitable revenue allocation persist.

Unique Contribution to Theory, Practice, and Policy: The study concludes that effective governance of hospital-generated revenue, when coupled with strong leadership principles and equitable resource allocation, is essential for strengthening healthcare infrastructure, sustaining services, and ensuring efficient, high-quality care. The study recommends strengthening transparency mechanisms, implementing tiered leadership development, adopting equity-weighted budgeting, and reforming revenue retention frameworks to optimise local revenue mobilisation and service delivery outcomes.

Keywords: Governance of Hospital-Generated Revenue, Health Service Delivery, Devolution, Public Health Financing, Leadership Principles, Level 5 Hospitals, Kenya

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1.0 INTRODUCTION

1.1 Background of the Study

The health sector in Kenya has undergone significant transformation following the promulgation of the 2010 Constitution, which introduced devolution as the core principle of governance. This framework transferred the responsibility for primary health service delivery from the national government to 47 county governments, a shift intended to enhance equity, accountability, and responsiveness (Tsofa et al., 2017). Consequently, the county governments are now responsible for managing the bulk of health sector financing, particularly for public hospitals, encompassing critical functions such as planning, budgeting, and resource distribution. However, the mere presence of these devolved structures and responsibilities does not guarantee improved outcomes. Effective service delivery ultimately depends on how well these functions are executed. That is, the quality of governance practices, which serve as mechanisms to mobilize leadership, resources, and institutional capacity for effective and efficient financial allocations directed to enhancing service provision (Kabau, 2016; Gatithu, 2016). In this way, the link between governance and service delivery becomes even more critical when examining how public hospitals generate and utilize additional revenue streams, considering that in many decentralized health systems, public hospitals generate own revenue through private wards and diagnostic services as a strategy intended to cross-subsidize care for poorer populations. However, the governance of these funds, specifically, how they are controlled, allocated, and accounted for determines whether they fulfill this purpose or introduce new distortions.

The governance of hospital-generated revenue has attracted scholarly attention across diverse health system contexts, with studies consistently demonstrating that how funds are managed matters as much as how they are raised. Globally, evidence from India's devolved health care systems shows that even though internally generated revenue is frequently reinvested in infrastructure, equipment, and emergency supplies, restrictive financial controls and the absence of clear policy guidelines on management of these internally generated revenue limits their effective utilization and outcomes (Sriram et al., 2021). This finding underscores that revenue-generating strategies must be paired with robust governance frameworks and managerial capacity. Without such foundations, efforts to enhance financial sustainability may fail to translate into improved service delivery outcomes or, worse, may create parallel systems that undermine equitable access. In Germany, patient co-payments and insurance reimbursements for local hospitals constitute significant revenue streams that facilitate investments in technology and workforce development. However, Ndayishimiye et al. (2022) posits that the gains associated with these reimbursements lies in governance quality of the institutions.

Further afield, studies from Asia and the America reinforce the centrality of governance in determining whether revenue translates into equitable service improvements. García-Subirats et al. (2020) found that decentralized financing in Colombia improved equity only where governance capacity was strong with weak governance, by contrast, leading to widened disparities. In China, Zhang et al. (2019) observed that transparency reforms reduced informal payments but disproportionately benefited urban hospitals with larger revenue bases, highlighting how governance gains can be unevenly distributed. Kaplan et al. (2021) in the United States demonstrated that hospitals with advanced revenue governance structures were more effective at reinvesting funds to improve service quality, yet these benefits were concentrated in wealthier regions. Across both low- and middle-income countries (LMICs) and high-income settings, these

studies collectively underscore that autonomy, revenue generation, and transparency alone do not guarantee equitable health outcomes. Rather, effective hospital revenue governance is essential for balancing operational efficiency, service quality, and equity, ensuring that financial resources translate into tangible improvements for patients across all socioeconomic strata.

In the African context where decentralisation and health financing reforms have gained prominence, empirical evidence highlights both the promise and pitfalls of granting fiscal autonomy to health facilities and local governments. McIntyre et al. (2018) examined whether retention of fiscal autonomy within provincial health systems translated into improved service delivery. Employing a comparative case-study methodology across multiple provinces in South Africa, the study found that hospitals became more responsive to local needs when granted greater autonomy. However, uneven managerial capacity, weak financial reporting, and rigid provincial regulations limited effective revenue use. Critically, equity was compromised where wealthier hospitals in urban centers generated more revenue, widening service quality disparities between provinces. The study concluded that strong intergovernmental fiscal frameworks and equity-oriented allocation formulas are necessary to prevent autonomy from exacerbating inequality.

In Tanzania, recent reforms provide instructive lessons for hospital revenue governance. Mwaisengela et al. (2025) examined the effect of Direct Health Facility Financing (DHFF) on financial transparency and quality compliance across primary health facilities. The DHFF model places internally generated revenue and government funds directly into facility accounts, mirroring the financing autonomy frameworks applicable to hospitals. The study found that direct financial flows improved transparency and accountability in resource use. However, the study's cross-sectional design limited its ability to capture long-term trends or facility-level heterogeneity. Complementing this work, qualitative research by Tani et al. (2025) revealed that governance challenges counterbalanced the transparency gains, including inadequate financial skills, inconsistent supervision, and limited community oversight, factors equally critical to hospital-level revenue governance. Further Tanzanian evidence from Ruhago et al. (2023) demonstrated that direct financing facilitated health facilities to reinvest flexibly. A notable gap, however, was the study's failure to examine hospitals separately from primary care facilities, leaving a significant gap in understanding hospital-specific reinvestment behaviours. These studies emphasized the need to complement financial autonomy with capacity-building to avoid governance failures.

In Kenya, hospital-generated revenue has emerged as a critical component of health financing, particularly as public resources remain insufficient to meet the healthcare demands of a growing population, necessitating donor support to bridge funding gaps. Scholars have explored the mechanisms through which hospitals generate revenue, its impact on service delivery, and the governance challenges associated with its utilisation. For instance, Barasa, Mbau, and Gilson (2022) examined facility-level financial autonomy following devolution, focusing on public hospitals' ability to generate, retain, and manage own-source revenue. The findings revealed that while hospitals generated substantial internal revenue, public financial management practices at the county level often required all revenue to be centralized in county revenue funds. This centralization undermined transparency and led to delays in reinvestment. The study identified a misalignment between legal frameworks granting autonomy and county-level administrative restrictive practices as a major governance gap. It concluded that effective governance requires harmonizing national autonomy policies, strengthening county-level financial controls, and guaranteeing predictable access to internally generated revenue. This operational tension reflects

a fundamental legal conflict between two key statutes. The Kenya Health Act (2017), which promotes facility-level financial autonomy to enhance responsiveness, and the Public Financial Management (PFM) Act, 2012, which mandates centralization of all county revenues into the County Revenue Fund. While the Health Act envisions hospitals retaining and utilising internally generated funds to address facility-specific priorities, the PFM Act requires these resources to be consolidated under county treasury control, effectively stripping facilities of timely access. This legislative dissonance creates a governance gap where hospitals are fiscally responsible for generating revenue but fiscally constrained in utilising it, contributing directly to the stock-outs, procurement delays, and infrastructure deficits documented in the literature. Hospitals thus face significant challenges accessing their own revenue, which, when compounded by delayed disbursements from the national level, resulted in stock-outs, delayed procurement, and deterioration of health service delivery.

Further Kenyan evidence by Tsofa et al. (2023) illustrated the political and administrative barriers to revenue governance under devolution. Their qualitative systems analysis, employing ethnographic and interview-based methods, revealed that opacity in county-level decision-making and inconsistent financial reporting weakened transparency and undermined hospitals' ability to plan and reinvest revenue. The methodology was particularly suited to uncovering political-economy influences often absent in quantitative financial analyses. The study's key conclusion was that unless counties embed participatory oversight structures and transparent reporting mechanisms, devolved financing may weaken rather than strengthen hospital governance.

In summary, across global, African, and Kenyan contexts, a consistent theme emerges. The governance of hospital-generated revenue, encompassing transparency, managerial capacity, predictable access, and equitable allocation determines whether financial autonomy translates into improved service delivery. While international evidence demonstrates the potential of revenue generation to enhance hospital performance, it also reveals persistent risks of inequity and inefficiency when governance frameworks are weak. In Kenya, despite constitutional provisions for devolution and facility and county-level autonomy, empirical studies document significant governance challenges, including revenue centralization, delayed access to funds, weak managerial capacity, and political interference. These challenges disproportionately affect hospitals in poorer counties, exacerbating rather than reducing health inequities. What remains underexplored is how governance structures specifically influence of the utilisation of hospital-generated revenue in Level 5 public hospitals in Kenya, and how these dynamics shape service delivery outcomes. A gap this study seeks to address.

1.2 Statement of the Problem

Despite significant increases in health financing and the expansion of fiscal decentralisation in Kenya, Level 5 public hospitals continue to exhibit persistent deficiencies in the delivery of consistent, high-quality healthcare services. This paradox whereby increased financial resources fail to translate into corresponding improvements in service outcomes raises critical concerns about the effectiveness of financial governance, resource allocation mechanisms, and institutional capacity in managing hospital-generated revenue. Empirical evidence underscores the scale of this disconnect. Data from the World Bank (2022) indicate that Kenya's health budget more than doubled from KSh 96 billion in FY 2014/15 to KSh 228 billion in FY 2019/20, resources explicitly intended to modernise Level 5 hospitals through upgrading diagnostic and treatment equipment, expanding specialist services, recruiting and retaining skilled personnel, and upgrading critical

infrastructure. However, despite these substantial financial inflows, service delivery indicators paint a troubling picture. Counties operate with only 51–54% of essential medical supplies despite notable increases in health resource allocation.

Moreover, by the end of 2024, counties had accumulated over KES 3 billion in unpaid debts to their primary supplier, KEMSA (MoH, 2024). While this debt crisis reflects broader county financial stress, it is directly aggravated by poor governance of internally generated revenue. When hospital-generated funds are centralized under county treasury control (as mandated by the PFM Act), this often result in delays, diversion, or redirection of funds to non-priority areas. Consequently, hospitals cannot settle KEMSA obligations, forcing facilities to accumulate arrears. This link between internally generated revenue governance failures and mounting supplier debt underscores a systemic inability to convert increased funding into tangible service improvements. Additionally, Level 5 facilities continue to operate with outdated medical technology, endure persistent staff shortages, and contend with deteriorating ward infrastructure. This gap between resource availability and service outcomes underscores a systemic failure to convert increased funding into tangible improvements in service quality, accessibility, or capacity at Kenya's highest-level referral centres.

Although several studies have examined the governance of fiscal resources in Kenya, three critical research gaps persist. First, existing studies have examined health financing at macro or county levels (Barasa et al., 2017; KPMG, 2016; Barasa et al., 2020), but few provide empirical insight into how internally generated hospital revenue specifically influences service delivery at the facility level. Second, while scholars have documented governance challenges such as revenue centralization and delayed access to funds (McCollum et al., 2018; Barasa, Mbau, & Gilson, 2022), they have not quantified how these challenges translate into measurable service indicators like staffing adequacy, medicine availability, or infrastructure development. Third, and most critically, no known Kenyan study has examined whether leadership principles moderate the relationship between internally generated revenue governance and service outcomes, leaving the interaction between leadership and financial governance underexplored.

1.3 Objectives

1. To determine the influence of governance of internally generated revenue on the delivery of health services in Level 5 public hospitals in Kenya.
2. To establish the moderating effect of leadership principles on the relationship between governance of internally generated revenue and delivery of health services in Level 5 public hospitals in Kenya.

2.0 THEORETICAL FRAMEWORK

The study is anchored on Proactive leadership theory and stewardship theory. Proactive Leadership Theory, as conceptualised by Bateman and Crant (1993), describes a stable disposition that drives individuals to initiate change. Proactive individuals seek opportunities, take decisive actions, and persist until meaningful transformation is achieved, whereas reactive individuals adapt to circumstances rather than shaping them (Crant, 2000). In this way, proactive leaders seek to identify systemic inefficiencies, mobilise resources, and implement sustainable solutions within their organisations (Frese, Fay, Hilburger, Leng, & Tag, 1997). They challenge the status quo, champion reforms, strengthen internal controls, and engage stakeholders to enhance organisational

accountability and performance (Seibert, Crant, & Kraimer, 2001; McKay et al., 2008). The major drawback of the theory is its overemphasis on individual disposition while underestimating structural constraints such as bureaucracy, political interference, and resource limitations that may hinder delivery of proactive leadership in public institutions. It also assumes proactivity universally yields positive outcomes, yet misdirected initiative without accountability can produce unintended consequences. Furthermore, it offers limited guidance on how proactive leadership interacts with financial governance structures to influence service delivery.

Stewardship Theory on the other hand addresses limitations of proactive theory by providing a complementary lens. Stewardship theory posits that leaders, as stewards of public resources, are intrinsically motivated to act in the best interest of the organization and the communities they serve (Davis, Schoorman, & Donaldson, 1997). Rather than pursuing personal gain, stewards prioritize collective welfare, long-term sustainability, and responsible management of resources (Jordaan & Fourie, 2013). In public sector contexts, stewardship emphasizes the careful and responsible management of resources for population well-being, linking governance functions to improved organizational performance through structures that empower managers with autonomy built on trust (BMJ Global Health, 2025). This orientation ensures that proactive initiatives are consistently aligned with public interest rather than individual ambition.

Together, these theories provide a robust analytical framework for this study. Proactive Leadership Theory explains how individual leaders drive governance reforms, identify inefficiencies, and champion accountability in revenue utilization. Stewardship Theory explains why leaders, as stewards of public resources, remain committed to transparency, equitable allocation, and strategic reinvestment even when facing structural constraints or political pressure. The integration of both theories addresses the individual disposition gap of Proactive Leadership Theory by embedding proactive action within a framework of collective responsibility and long-term organizational integrity.

Concerning governance, proactive leaders strengthen the governance of internally generated revenue by instituting transparent budgeting systems, enforcing accountability, and ensuring strategic reinvestment in service priorities such as equipment, staffing, and supplies. Stewardship orientation reinforces these actions by ensuring leaders prioritize collective welfare over personal or political interests. Furthermore, both theories position leadership as a moderating variable that conditions the relationship between revenue governance and service outcomes. Proactive leaders amplify this link by anticipating fiscal challenges, mitigating revenue leakages, and navigating bureaucratic constraints, while stewardship-oriented leaders ensure these actions are consistently aligned with public interest. In their absence, even well-designed governance structures may fail to translate into improved service delivery, underscoring leadership's critical moderating role.

2.2 Conceptual Framework

The conceptual frame guiding this study defines the mediated relationship between governance of internally generated revenue and service delivery in level 5 public hospitals. The construct of governance of hospital generate revenue is measured through three indicators of transparency, reinvestment and equitable distribution resource. Service delivery is measured by the extent of

citizen satisfaction, level of citizen access to health care services and availability of critical services, while leadership principles entail a composite score of ethical stewardship, strategic direction and equitable advocacy in resource management.

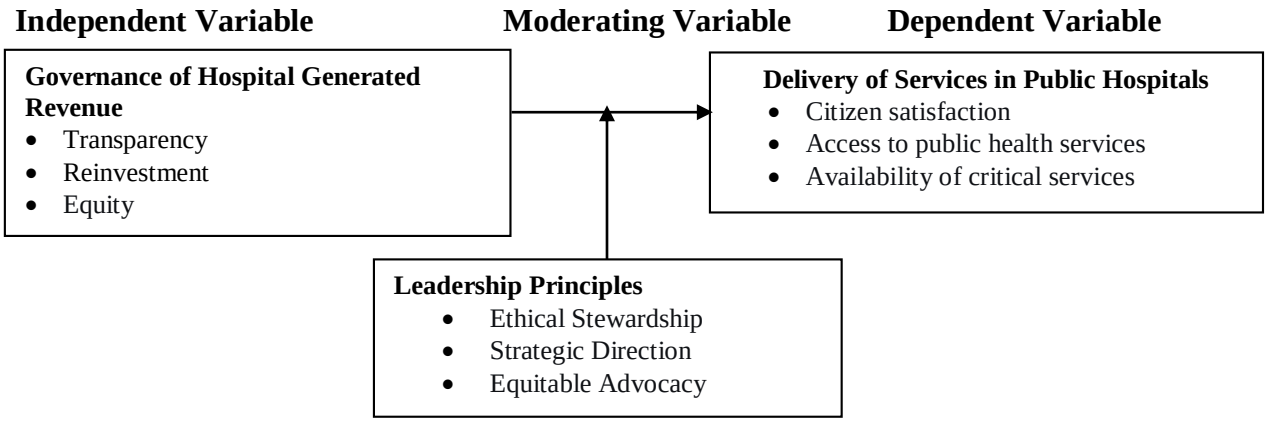

Figure 1: Conceptual Framework

3.0 MATERIALS AND METHODS

This study employed a descriptive cross-sectional research design. This is an optimal approach for generating a "snapshot" of a population or phenomenon at a single point in time. Its primary purpose is to describe what is happening (e.g., prevalence, patterns, associations) rather than to explain why (Johnson & Christensen, 2017). Quantitative data were collected through structured questionnaires administered to healthcare personnel, including physicians, nurse practitioners, pharmacists, dietitians, physical therapists, and medical technologists, across 13 Level 5 public referral hospitals in 10 counties. A total of 372 questionnaires were distributed, and 252 were completed and returned, resulting in a response rate of 67.74%.

To ensure representativeness, healthcare personnel were selected using stratified random sampling, with strata defined by key hospital departments, including outpatient, maternity, inpatient, and administration. This approach ensured balanced representation across diverse functional units within the hospitals. Counties were purposively selected based on their health sector budget absorption performance, assessed using average recurrent and development expenditure data from 2015 to 2020.

4.0 FINDINGS AND DISCUSSION

4.1 Reliability and Validity Tests

Before analysis, the data was subjected to reliability and validity tests. The reliability analysis, assessed via Cronbach's alpha, indicated good internal consistency for all scales. The governance of county revenue scale demonstrated acceptable reliability ($\alpha = .721$, k=7), as did the leadership principles scale ($\alpha = .765$, k=7) and the delivery of services in public hospitals scale ($\alpha = .757$, k=3). All values exceeded the predetermined threshold of .70 (Lund, 2023). Validity was established through multiple assessments. Content validity was confirmed via expert review. Convergent validity was evidenced by factor loadings above .50; Average Variance Extracted (AVE) values exceeding .50 (Governance of Hospital Generated Revenue AVE = .51; Leadership Principles AVE = .66; Delivery of Healthcare Services AVE=.711); and strong Composite Reliability (CR) scores (Governance of Hospital Generated Revenue CR = .870; Leadership Principles CR = .93; Delivery of Healthcare Services CR = .876). Discriminant validity, tested using the Fornell-Larcker criterion, was established, as the square root of each construct's AVE was greater than its correlation with any other construct.

4.2 Descriptive Statistics

A 5-point Likert scale was used to assess the governance and leadership principle's construct. The scale ranged for 1-5 where 1-1.8 (Strongly disagree); 1.811-2.6 (disagree); 2.61-3.4 (Neutral); 3.41-4.2 (Agree); 4.21-5 (Strongly agree). These scores were then aggregated into cumulative composite scores. The construct of service delivery was based on dichotomous score of Yes/No.

4.2.1 Governance of Hospital Generated Revenue

The descriptive findings on governance of hospital-generated revenue revealed distinct perceptions across the sub-constructs of transparency, re-investment, and equity. On transparency, responses indicated significant room for improvement, with the availability of information on hospital-generated revenue and expenditure to the public receiving only a moderate level of agreement (mean = 3.12, SD = 0.911). A substantial 29% of respondents expressed disagreement, suggesting potential transparency issues that could undermine public trust and accountability, a

concern highlighted by Kairu et al. (2021), who identify trust in financial management as a key factor in healthcare settings. While mechanisms to ensure effective allocation of fee revenue were viewed more positively (mean = 3.63, SD = 0.829) with 70.6% agreement, the significant number of neutral or dissenting opinions pointed to the need for continuous monitoring and refinement of these processes to enhance effectiveness and accountability, aligning with suggestions from the Ministry of Health (2016).

In contrast, perceptions of re-investment were overwhelmingly positive. Respondents strongly believed that revenue from hospital fees directly improves the quality of medical services (mean = 3.85, SD = 0.514) with 86.5% agreement, underscoring its role as a critical determinant for enhancing care. This observation is supported by Barasa et al. (2021), who noted the importance of such revenue for financing and improving service quality. Furthermore, this financial input was seen as significantly influencing patient satisfaction and healthcare outcomes (mean = 4.01, SD = 0.423) with 94% agreement, reinforcing the link between financial systems and care delivery quality. Crucially, hospital-generated revenue was also perceived to positively impact the retention of healthcare personnel (mean = 3.76, SD = 0.753) with 82.2% agreement, confirming that financial resources are vital for maintaining a competent workforce, a necessity also indicated by Kairu et al. (2021).

The sub-construct of equity received the most emphatically positive assessment. Voluntary health schemes were widely seen as contributing to financial sustainability and improved service delivery (mean = 3.94, SD = 0.373) with 90.5% agreement, emphasising their role in supplementing hospital income and improving access. Korir et al. (2021) stress that such systems can help address cost barriers, though they may also risk exacerbating inequities if not carefully managed. Most strikingly, the Social Health Insurance Fund (SHIF) was perceived as a transformative tool for equity, with an overwhelming 95.3% of respondents agreeing that SHIF revenue has improved healthcare access for vulnerable populations, yielding a very high mean score of 4.49 (SD = 0.602). This positions SHIF as a cornerstone for advancing universal health coverage by increasing access and reducing out-of-pocket costs, fitting into the broader healthcare financing architecture as discussed by Moses et al. (2021).

Supporting qualitative data from patients, chief officers, and health committee chairs provided deeper context. On transparency, respondents reported that clearer SHIF subscription processes and benefit information have improved affordability and patient confidence, though challenges like high out-of-pocket costs and delayed reimbursements persist, indicating benefits are not evenly realised. Regarding re-investment, participants acknowledged that effective reinvestment of hospital revenue into staffing and services enhances care quality. However, they also noted that high fees remain a significant barrier for the uninsured, underscoring the need to balance revenue generation with affordability to ensure improved services benefit all patients. On equity, voluntary health schemes and insurance were credited with improving service delivery, specialist access, and chronic disease management. Yet some respondents felt these schemes alone are insufficient to address deeper systemic issues in public healthcare, highlighting that their positive impact on equity in service quality depends on adequate integration and consistent implementation across the health system.

In summary, the governance of hospital-generated finance in Kenya's level 5 public hospitals is characterised by highly effective reinvestment and strong equity outcomes, but is hampered by transparency deficits. Internally, the system functions well, with revenue from fees

overwhelmingly perceived to be effectively reinvested into improving service quality, patient outcomes, and staff retention. However, this operational effectiveness is undercut by a lack of public transparency, as information on revenue and expenditure is not readily available, risking public trust and accountability. In essence, the hospitals are good at using the money they generate to improve care, but the process is not seen as open or accountable to the citizens they serve.

Table 1: Governance of Hospital-Generated Revenue and the Delivery of Health Services in Level 5 Public Hospitals

Statement	SD (1)	D (2)	N (3)	A (4)	SA (5)	Mean	Std Dev
Transparency							
Q1. Information about hospital-generated revenue & expenditure is readily available to the public.	3.20%	25.80%	27.80%	42.50%	0.80%	3.12	0.911
Q7. Mechanisms are in place to ensure revenue from hospital fees are effectively allocated to improve healthcare service delivery.	1.60%	11.10%	16.70%	63.90%	6.70%	3.63	0.829
Sub-Aggregate	2.40%	18.50%	22.30%	53.20%	3.80%	3.38	0.87
Re-Investment							
Q2. Revenue from hospital fees has improved the quality of medical services in public hospitals.	0.40%	3.20%	9.90%	84.10%	2.40%	3.85	0.514
Q5. Hospital fees influence patient satisfaction & healthcare outcomes in public hospitals.	0.00%	1.20%	4.80%	85.70%	8.30%	4.01	0.423
Q6. Hospital-generated revenue positively impacts the retention of healthcare personnel in public hospitals.	0.80%	10.70%	6.30%	76.20%	6.00%	3.76	0.753
Sub-Aggregate	0.40%	5.00%	7.00%	82.00%	5.60%	3.87	0.563
Equity							
Q3. Voluntary health schemes contribute to the financial sustainability for improved service delivery in public hospitals.	0.00%	0.40%	9.10%	86.90%	3.60%	3.94	0.373
Q4. Revenue from the Social Health Insurance Fund (SHIF) has improved access to healthcare services for vulnerable populations in public hospitals.	0.00%	0.40%	4.40%	40.90%	54.40%	4.49	0.602
Sub-Aggregate	0.00%	0.40%	6.80%	63.90%	29.00%	4.22	0.488
Overall Aggregate	0.90%	7.60%	11.30%	67.40%	12.90%	3.83	0.637

4.2.2 Leadership Principles

The survey data on leadership principles revealed distinct perceptions across the sub-constructs of ethical stewardship, strategic direction, and equitable advocacy in the management of public hospitals, based on the same 5-point Likert scale interpretation. On the sub construct of ethical stewardship, perceptions were strong regarding leadership's personal commitment to transparency and accountability in resource management, with a mean of 4.19 (SD = 0.484) falling within the agree range and 97.6% agreement. This aligns with the World Bank's (1998) assertion that good governance is essential for sustainable development. However, perceptions of the systemic mechanisms for transparency and accountability were more moderate and varied. The statements on clear transparency mechanisms (mean = 3.54, SD = 0.954) and strong accountability structures (mean = 3.54, SD = 0.946) both fell within the agree range but with significant standard deviations, indicating a diversity of opinion. This suggests that while leadership intent is trusted, the institutional frameworks guiding fund allocation and use are seen as less robust or consistently applied, highlighting a need for better communication and stronger systems, as emphasised by Balabanova et al. (2013). Despite these mechanistic concerns, there was broad consensus that county leadership advocates for fairness and equity in service delivery (mean = 3.67, SD = 0.642) with 72.2% agreement, suggesting a foundational commitment to ethical principles, though challenges in fully institutionalising them persist, as noted by Atisa, Zemrani, and Weiss (2021).

In the area of strategic direction, leadership was perceived very positively. The influence of leadership decisions on the quality and responsiveness of service delivery received a mean of 4.03 (SD = 0.388) falling within the agree range, with 96.4% agreement. This reinforces the link between effective leadership and meaningful community engagement, a cornerstone of Kenya's participatory governance model. Furthermore, policies promoting equitable access were also viewed favourably, with a mean of 3.96 (SD = 0.487) within the agree range and 88.5% agreement. This indicates that the strategic vision set by leadership is widely seen as positively influencing both service quality and fairness, supporting the argument by McCollum et al. (2018) that strong political stewardship enhances the efficiency and equity of health system financing.

The sub-construct of equitable advocacy, however, revealed a significant tension. While leadership's decisions were seen as positively influencing service quality (mean = 4.03, as also captured in strategic direction), there was marked skepticism about whether transparency and accountability are upheld regardless of political interests. This statement received a mean of 3.18 (SD = 1.052), falling within the neutral range, indicating uncertain perceptions. This inconsistency points to a critical governance challenge. The potential for political influence to undermine the impartial application of accountability mechanisms. This variability underscores that perceived political interference can erode trust and create disparities in service delivery experiences across different facilities or regions.

The broader literature contextualises these findings. Effective governance, marked by transparency and stakeholder engagement, is empirically linked to better health system performance, as noted by Huffstetler et al. (2022). However, the success of such interventions is highly context-dependent, as George et al. (2023) found, requiring faithful implementation. The persistent governance challenges and inconclusive results of public-sector reforms in Kenya, as discussed by M'Mugambi, Okeyo, and Muthoka (2020), further explain the gap between the high trust in leadership's intent and the more moderate trust in the systems they oversee.

Supporting qualitative data from patients provided deeper context. On ethical stewardship and transparency, respondents affirmed its importance but noted inconsistencies in practice. One patient captured the ideal, stating: *"Transparency in the healthcare sector is crucial because it fosters trust, accountability, and quality care."* Yet, others observed a gap between policy and experience, suggesting the full benefits of ethical stewardship are not uniformly felt. Regarding strategic direction, views on its effectiveness were mixed. Some were optimistic about its potential, with one participant sharing: *"I am optimistic that level 5 public hospitals have the potential to enhance their service delivery through creating awareness and responsiveness."* Others, however, found strategic frameworks to be slow or theoretical, indicating a variable translation of plans into practical improvements. On equity, reflections were divided. While some acknowledged visible efforts to provide fair care, many highlighted persistent disparities. Respondents pointed to uneven resource allocation and socio-economic barriers, indicating that substantial gaps remain in ensuring consistent, equitable care for all community members, particularly the marginalised and economically disadvantaged.

Generally, from the findings, the application of leadership principles in Kenya's level 5 public hospitals presents a landscape of strong strategic intent undermined by operational and ethical inconsistencies. The overall aggregate mean of 3.73 falls within the agree range, indicating generally positive perceptions of leadership. However, the execution of ethical stewardship is mixed. While personal leadership commitment to transparency and fairness is highly rated (mean 4.19), the institutional systems for ensuring accountability and transparent fund allocation are viewed with moderate trust and high variability (mean 3.54), revealing a gap between principle and practice. Most critically, the domain of equitable advocacy exposes a fundamental tension, as confidence falls to the neutral range (mean 3.18) when assessing whether accountability is upheld regardless of political interests, suggesting perceived political interference is a corrosive force. In summary, leadership is effective at setting goals and commanding trust in its intent, but the system is perceived as failing to institutionalise those principles impartially and consistently, creating a vulnerability where strategic gains could be eroded by compromised governance and inequitable application.

Table 2: Leadership Principles

Statement	SD (1)	D (2)	N (3)	A (4)	SA (5)	Mean	Std Dev
Ethical Stewardship							
Q1. Leadership upholds transparency and accountability in managing resources for public hospital services.	0.00%	0.80%	1.60%	75.40%	22.20%	4.19	0.484
Q2. Clear transparency mechanisms guide the allocation and utilisation of hospital funds.	2.40%	13.10%	25.00%	46.80%	12.70%	3.54	0.954
Q3. Strong accountability structures ensure that health funds are used appropriately and responsibly.	2.40%	13.50%	23.80%	48.80%	11.50%	3.54	0.946
Q7. County leadership advocates for fairness and equity in the delivery of healthcare services in public hospitals.	0.80%	5.20%	21.80%	70.20%	2.00%	3.67	0.642
Sub-Aggregate	1.40%	8.20%	18.10%	60.30%	12.10%	3.74	0.757
Strategic Direction							
Q4. Leadership decisions positively influence the quality and responsiveness of public hospital service delivery.	0.00%	1.20%	2.40%	88.50%	7.90%	4.03	0.388
Q6. Policies and practices within public hospitals promote equitable access to health services for all populations.	0.00%	1.20%	10.30%	79.80%	8.70%	3.96	0.487
Sub-Aggregate	0.00%	1.20%	6.40%	84.20%	8.30%	4	0.438
Equitable Advocacy							
Q4. Leadership decisions positively influence the quality and responsiveness of public hospital service delivery.	0.00%	1.20%	2.40%	88.50%	7.90%	4.03	0.388
Q5. Leadership ensures transparency and accountability in health service management regardless of political interests.	3.20%	32.10%	13.90%	44.80%	6.00%	3.18	1.052
Sub-Aggregate	1.60%	16.70%	8.20%	66.70%	7.00%	3.61	0.72
Overall Aggregate	1.30%	9.60%	14.10%	64.90%	10.10%	3.73	0.708

4.2.3 Delivery of Health Services in Level 5 Public Hospitals in Kenya

The data provided citizen perspectives on three key domains of satisfaction, access, and the availability of critical services within level 5 public hospitals, based on dichotomous Yes/No responses. On the domain of citizen satisfaction, perceptions were strongly positive. An overwhelming 87.3% of respondents expressed satisfaction with the delivery of health services, supported by a mean score of 2.75 and a low standard deviation of 0.667, indicating a high degree of consensus. This aligns with Chumba's (2019) assertion that public hospitals prioritising high-quality, low-cost service provision can successfully attract clients and generate revenue, suggesting the existing fiscal approach is meeting core expectations for many.

In contrast, perceptions of access to public health services were more divided and less favourable. While a majority (57.1%) believed the fiscal structure leads to easy access, a substantial 42.9% responded negatively, pointing to persistent barriers. The mean score of 2.14 with a high standard deviation of 0.992 reflects this significant variability in experiences. This mixed sentiment underscores the point that effective service delivery hinges not just on accessibility but also on quality and affordability, indicating these elements may be inconsistently realised within the current system.

Similarly, perceptions of the availability of critical services, such as essential medical equipment and supplies, were modest and varied. A slim majority of 55.6% viewed availability positively, while 44.4% expressed dissatisfaction, yielding a mean of 2.11 with a high standard deviation of 0.996. This reflects considerable disagreement and uncertainty, consistent with Liwanag's (2019) findings on fiscal decentralisation, where impacts vary significantly across different subpopulations. The nearly equal split between satisfaction and dissatisfaction highlights a critical vulnerability in the health system's operational capacity, emphasising the need for targeted investigation into the determinants of these varying perceptions.

Table 3: Delivery of Health Services in Level 5 Public Hospitals

Statement	Yes	No	Mean	Std Deviation
Citizen Satisfaction: Do you feel that there is citizen satisfaction with the delivery of health services in level 5 public hospitals as a result of the existing fiscal structure?	87.3%	12.7%	2.75	0.667
Access to public health services: Does the existing fiscal structure lead to easy access to public health services in level 5 public hospitals?	57.1%	42.9%	2.14	0.992
Availability critical services: Does the availability of essential medical equipment and supplies sufficient for diagnostic and treatment purposes?	55.6%	44.4%	2.11	0.996

Supporting qualitative data from patients provided a deeper context for these statistical trends. On satisfaction, respondents expressed a mix of appreciation and pointed criticism. While many valued knowledgeable staff and specialist care, they identified specific deficits. One respondent's suggestion for improvement captured widespread concerns: *"increasing staff numbers, providing modern medical technology, enhancing cleanliness, and better communication between healthcare providers and patients."* Others highlighted outdated equipment, rushed consultations, and

medication shortages, indicating that core services are valued but require meaningful enhancement to sustain high satisfaction.

Regarding access, respondents confirmed that services are generally available but identified significant, practical barriers. One participant detailed common obstacles, stating: *"common challenges include transportation issues, long wait times, limited availability of specialty services, and physical infrastructure that is not inclusive, particularly for individuals with disabilities."* Additional barriers like language differences and stigma were noted, with recommendations focusing on community outreach, improved transport, inclusive infrastructure, bilingual staff, and better mental health support.

On the availability of critical services, patients acknowledged that essential services like emergency care and diagnostics are present but questioned their consistency and reliability. Concerns were raised about outdated machinery, medication shortages, and long queues for procedures. These qualitative insights directly explain the statistical variability, revealing that the experience of "availability" is fragile and dependent on consistent equipment functionality and supply chain stability, underscoring the need for sustained investment in modern infrastructure and robust logistics.

In summary, the findings reveal mixed results on the state of healthcare delivery in Kenya's level 5 public hospitals. While overall citizen satisfaction is high (87.3%), this approval coexists with severe systemic weaknesses. Critical operational areas show deep divides. Access to services and the availability of essential equipment and supplies are only perceived as adequate by a slim majority (approximately 55-57%), with nearly half the population reporting deficiencies. This reveals a system that earns public trust for its core intent and specialist care, but is critically undermined by inconsistent execution, unreliable resources, and inequitable access, making its current positive standing fragile and unsustainable without targeted investment and reform.

4.3 Inferential Analysis

4.3.1 Correlation Results

To test the relationships between the study variables, a simple linear regression analysis was conducted. Pearson correlation analysis was conducted to examine the bivariate relationships among all study variables. Governance of hospital generated revenue and leadership principles exhibited statistically significant correlations with delivery of services. The correlation matrix also confirms that multicollinearity is not a concern between governance of hospital generated revenue score and leadership principles, as the correlations between the two is not excessively high (<0.8).

Table 4: Correlation Matrix

Variable	Measure (N-252)	Delivery of Services	Hospital Generated Revenue	Leadership Principles
Delivery of Services	Pearson Correlation	1		
Hospital Generated Revenue	Pearson Correlation	.252**	1	
Leadership Principles	Pearson Correlation	.921**	.622**	1

4.3.2 Regression Results

The results of the regression indicated that governance of hospital generated revenue explained a significant proportion of variance in delivery of health services. That is, 23.2% (Adjusted R^2 =.232) of the variance in delivery of health services was predicted by governance of hospital generated revenue (F (1,250) =12.905, p< .001). To contextualize the practical significance of this relationship, the effect size was calculated using Cohen's $f^2 = \frac{(R^2)}{(1-R^2)}$. The value of f^2 was 0.391, which indicates a large effect size effect size according to conventional benchmarks (Cohen, 1988), suggesting that the observed effect of quality of governance of hospital generated revenue, while statistically significant, explained a substantial and meaningful proportion of variance in the delivery of health services.

Table 5: Model Summary

Source	**SS**	**Df**	**MS**	**Number of obs**	**251**
Model	7.069	1	7.069	F (1, 250)	12.905
Residual	136.931	250	0.548	Prob > F	.000[b]
Total	144	251		R-squared	0.253
				Adj R-squared	0.232
				Std. Error of the Estimate	0.74008
				Cohen's f^2	0.391

Service Delivery	**Coef.**	**Std. Err.**	**Beta**	**T**	**P> t**
Constant	0.464	0.522		0.888	0.375
Governance of Hospital-Generated Revenue	0.488	0.136	0.222	3.592	0

4.3.3 Moderation Effect of Leadership Principles

A moderated regression analysis was conducted to examine whether leadership principles moderate the relationship between the governance of hospital generated revenue and the delivery of health care services. To reduce multicollinearity and facilitate interpretation of the conditional effects (Aiken & West, 1991), the predictor variables (leadership principles and governance of hospital-generated revenue) were mean-centered prior to analysis. The following regression equation was estimated:

$$\widehat{Y}_i = b_0 + b_1 X_i + b_2 W_i + b_3 (X_i W_i) + \varepsilon_i$$

where $\widehat{Y}_i$ represents the predicted delivery of health care services for the *i*th case, X_i represents mean-centered governance of hospital-generated revenue, W_i represents mean-centered leadership principles, and $X_i W_i$ represents the product term capturing the interaction between the two centered predictors.

The overall model was significant, F (3, 248) =40.13, p<.001, explaining 32.7% of the variance in service delivery **(**R^2=.327**)**. A significant main effect was observed for leadership principles (b=0.114, p=.040). However, this effect was qualified by a significant interaction between governance of hospital generated revenue and leadership principles (b=0.353, p <.001), which explained an additional 2.7% of the variance (ΔR^2=.027, p <.001). This significant interaction indicates that the effect of financial governance practices on health service delivery is not uniform but rather depends on the leadership context in which they are implemented. The analysis yielded the following unstandardized regression coefficients:

$$\hat{Y}_i = 1.321 + 0.131X + 0.114W + 0.353(XW) + \varepsilon_i$$

As shown in the equation, the interaction between governance of hospital-generated revenue and leadership principles was significant, confirming that the relationship between revenue governance and service delivery is contingent upon the level of leadership principles. To probe this interaction, simple slope analysis was conducted to examine the conditional effects of hospital revenue governance at different levels of leadership. The simple slopes were computed using the following equation:

$$\text{Effect X on Y} = b_1 + b_3W = 0.131 + 0.353W$$

where W represents the specific value of leadership principles. This equation demonstrates that the slope of governance on service delivery increases by 0.353 units for every one-unit increase in leadership principles, shifting the nature of the relationship as leadership strengthens. At low levels of leadership principles (one standard deviation below the mean), the relationship between governance and health service delivery was negative and significant (b=−.227, p<.001). This suggests that where leadership is weak or poor, efforts to tightly govern hospital generated funds may not bear positive outcomes, potentially being perceived as bureaucratic obstruction rather than effective oversight, thereby hindering service outcomes. At mean levels of leadership, the relationship was positive but not statistically significant (b=.131, p=.105), indicating that average leadership is insufficient to translate fiscal governance into improved outcomes.

However, at high levels of public service-oriented leadership principles (one standard deviation above the mean), the effect of revenue governance became positive and significant (b=.313, p=.008). Here, strong leadership appears to provide the necessary vision, communication, and trust to ensure that financial governance translates into effective resource allocation and improved patient care. This pattern indicates that effective governance of hospital generated revenue is positively associated with the delivery of health services only when it is coupled with strong leadership principles. That is, leadership acts as a facilitator, strengthening the link between fiscal governance and service outcomes, while its absence can render such governance efforts counterproductive.

Table 6: Moderating Effect of Leadership Principles

Outcome: Delivery of Health Services						
	R	**R-sq**	**MSE**	**F**	**df1**	**df2**	**p**
	.572	.327	.485	40.18	3	248.	.000
Model 1		**coeff**	**se**	**t**	**p**	**LLCI**	**ULCI**
constant		1.321	.024	55.158	.00	1.274	1.368
Leadership Principles		.114	.055	2.067	.040	.005	. 223
Governance of Hospital Generated Revenue		.131	.081	1.625	.105	-.028	.290
int_1		.353	.100	3.537	.000	.156	.550
Test (s) for unconditional interaction			**R2-change**	**F**	**df1**	**df2**	**p**
int_1 : GHG Revenue x Leadership			.027	12.509	1	248	.000
Conditional Effect of X on Y at values of the moderator							
	Mod (Leadership)	**Effect**	**se**	**t**	**p**	**LLCI**	**ULCI**
	Low: -.413	-.227	.068	-4.097	.000	-.360	-.094
	Mean: .000	.131	.081	1.625	.105	-.028	. 290
	High: .413	.313	.109	2.875	.008	.099	.527

5.0 CONCLUSION

The study demonstrates that governance of hospital-generated revenue plays a crucial role in improving health service delivery in level 5 public hospitals. Hospital generated revenue, including hospital fees, voluntary health schemes, and the Social Health Insurance Fund (SHIF), when properly governed (with transparency, strategic re-investment, equitable distribution), enhances healthcare service delivery exemplified through citizen satisfaction, access to public health services, and availability of critical services. These positive outcomes are further enhanced where leadership principles are public service oriented (with ethical stewardship, strategic direction and equitable advocacy). Despite these benefits, gaps in transparency and resource allocation were identified, indicating the need for stronger accountability mechanisms. The study concludes that effective governance of hospital-generated revenue, combined with public service-oriented leadership, is essential for strengthening healthcare delivery in public hospitals in Kenya.

6.0 RECOMMENDATIONS

The study recommends:

- Institutionalisation of transparent and accountable financial systems, requiring county governments and public hospitals to implement robust budgeting and expenditure-tracking mechanisms.
- That hospitals develop strategic revenue allocation frameworks as well as adopting performance-based budgeting and cost-effective planning tools that prioritize essential services aligned with community health needs.
- The strengthening of leadership capacity and oversight mechanism, promotion of leadership training and introduction of precise accountability mechanisms within hospital management structure.
- Enhanced integration of Social Health Insurance Fund (SHIF) and voluntary health schemes as well as addressing operational challenges such as delayed reimbursements and addressing inconsistent implementation of SHIF
- Investments in health infrastructure and resource equity and targeting investments toward upgrading medical equipment, improving hospital environments and reducing regional disparities in the delivery of health services

REFERENCES

Atisa, G., Zemrani, A., & Weiss, M. (2021). Decentralised governments: Local empowerment and sustainable development challenges in Africa. *Environment, Development and Sustainability*, *23*(3), 3349-3367.

Balabanova, D., McKee, M., Mills, A., Walt, G., & Haines, A. (2013). What can global health institutions do to help strengthen health systems in low-income countries? *Health Research Policy and Systems, 11*(1), 1–8. https://doi.org/10.1186/1478-4505-11-4

Barasa, E., Rogo, K., & Maina, T. (2021). *Health Financing in Kenya: Fiscal Constraints and Opportunities*. BMC Health Services Research.

Bateman, T. S., & Crant, J. M. (1993). The proactive component of organizational behavior: A measure and correlates. Journal of Organizational Behaviour, 14(2), 103–118.

BMJ Global Health. (2025). Stewardship and governance in public health systems. BMJ Global Health, 10(1), e015678.

Busse, R., Geissler, A., Quentin, W., & Wiley, M. (2020). Healthcare financing in Germany: Challenges and opportunities. *Health Policy, 124*(3), 234–247. https://doi.org/10.1016/j.healthpol.2020.01.003

Chumba, P. K. (2019). *Influence of competitive strategies on firm performance in the telecommunication industry: A case study of Telkom Kenya in Nakuru East Sub County* (Doctoral dissertation, KABARAK UNIVERSITY).

Crant, J. M. (2000). Proactive behavior in organizations. Journal of Management, 26 (3), 435–462

Davis, J. H., Schoorman, F. D., & Donaldson, L. (1997). Toward a stewardship theory of management. Academy of Management Review, 22(1), 20–47.

Frese, M., Fay, D., Hilburger, T., Leng, K., & Tag, A. (1997). The concept of personal initiative: Operationalization, reliability and validity in two German samples. Journal of Occupational and Organizational Psychology, 70(2), 139–161. Fjeldstad, O.-H., & Heggstad, K. (2012). *Local Government Revenue Mobilisation in Anglophone Africa*. ICTD Working Paper 7. Institute of Development Studies. Retrieved from https://www.ictd.ac/publication/local-government-revenue-mobilisation-in-anglophone-africa/

Government of Kenya. (2014). *Kenya Health Policy 2014–2030 and Kenya Health Sector Strategic and Investment Plan*. Nairobi: Government of Kenya

Jordaan, J., & Fourie, D. (2013). Stewardship theory in public administration. Journal of Public Administration, 48(4), 567–582.

Johnson, B., & Christensen, L. (2017). *Educational research: Quantitative, qualitative, and mixed approaches.* Los Angeles: SAGE.

Kairu, A., Nyamongo, D., Nyagero, J., Wangia, E., & Mbugua, J. (2021). Financial management systems and practices in public health facilities: A case study of Nairobi and Machakos Counties in Kenya. *BMC Health Services Research, 21*, 1086. https://doi.org/10.1186/s12913-021-07123-7

Liwanag, H. J. (2019). *Analyzing the effectiveness of decentralization in improving the health sector with a focus on the Philippines.* University of Basel.

McCollum, R., Limato, R., Otiso, L., Theobald, S., & Taegtmeyer, M. (2018). Health system governance following devolution: comparing experiences of decentralization in Kenya and Indonesia. *BMJ Global Health, 3*(5), e000939.

Moses, M. W., Korir, J., Zeng, W., & others. (2021). Performance assessment of the county healthcare systems in Kenya: A mixed-methods analysis. *BMJ Global Health, 6*, e004707. https://doi.org/10.1136/bmjgh-2020-004707

Parker, A. N. (1995). Decentralization: The Way Forward for Rural Development. *Policy Research Working Paper 1475, Washington D.C: World Bank*.

Seibert, S. E., Crant, J. M., & Kraimer, M. L. (2001). Proactive personality and career success. Journal of Applied Psychology, 86(3), 416–427.

Wagana, D M; Iravo, M A; Nzulwa, J D. (2015). Analysis of the relationship between devolved Governance, political decentralization, and service delivery: a critical review of the literature. *European Scientific Journal, November 2015 edition, vol.11, No.31 ISSN: 1857 – 7881 (Print) e ISSN 1857- 7431*.

World Bank. (2022**).** *Kenya Public Expenditure Review for the Health Sector: FY2014/15–FY2019/20*. World Bank Group.

Barasa, E., Mbau, R., & Gilson, L. (2022). The autonomy of public health facilities in decentralised health systems: Evidence from Kenya. *BMJ Global Health, 7*(11), e010260. https://doi.org/10.1136/bmjgh-2022-e010260

García-Subirats, I., Vargas, I., Mogollón-Pérez, A. S., de Paepe, P., da Silva, M. R. F., & Vázquez, M. L. (2020). Decentralization and equity of healthcare services in Colombia. *International Journal for Equity in Health, 19*, 1–13. https://doi.org/10.1186/s12939-020-1135-y

Kaplan, R. S., Norton, D. P., & Mazur, G. (2021). Hospital revenue cycle governance and quality improvement. *Health Care Management Review, 46*(3), 198–210. https://doi.org/10.1097/HMR.0000000000000261

McIntyre, D., Naledi, T., & Govender, V. (2018). Equity in public hospital financing in South Africa: The role of decentralization and hospital autonomy. *Health Policy and Planning, 33*(7), 749–760. https://doi.org/10.1093/heapol/czy046

Mwaisengela, S. M., et al. (2025). Direct health facility financing and quality compliance in Tanzania. *Health Research Policy and Systems*. [Forthcoming]

Ndayishimiye, C., Nduwayezu, R., Sowada, C., & Dubas-Jakóbczyk, K. (2025). Performance-based financing in Rwanda: a qualitative analysis of healthcare provider perspectives. *BMC Health Services Research, 25*(1), 418.

Ruhago, G. M., et al. (2023). Implications of direct facility financing on commodity availability in Tanzania. *PLOS Global Public Health, 2*(5), e0001867. https://doi.org/10.1371/journal.pgph.0001867

Sriram, V., Khan, M. S., & Jesse, M. (2021). Exploring facility-level financial autonomy in India. *International Journal of Health Policy and Management, 10*(11), 815–826. https://doi.org/10.34172/ijhpm.2020.211

Tani, K., et al. (2025). Managers' perspectives on direct health facility financing in Tanzania. *[Forthcoming]*

Tsofa, B., Gilson, L., Mbau, R., & Barasa, E. (2023). *Political economy analysis of subnational health sector governance in Kenya. BMJ Global Health, 8*(3), e010076. https://doi.org/10.1136/bmjgh-2022-010076

Zhang, X., Lei, J., & Chen, L. (2019). Public hospital autonomy and transparency reforms in China. *Health Economics, Policy and Law, 14*(2), 131–149. https://doi.org/10.1017/S1744133118000167.

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