

## Influence of Financial Management Practices On Service Delivery in the Public Health Facilities in Nakuru East Sub-County, Kenya

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**Abstract:** The study was necessitated by financial challenges facing public health facilities under the purview of devolved governments in Kenya. The study precisely, examined the effect of financial accountability on service delivery in public health facilities in Nakuru East Sub-County. A descriptive survey design was adopted. The 211 finance and management staff working with the aforesaid facilities constituted the study population. A sample of 68 respondents was obtained by use of both purposeful and stratified random sampling technique. A structured questionnaire was employed to aid in data collection. The questionnaire was pilot tested in order to determine its validity and reliability. The collected data were subjected to both descriptive and inferential analyses with the facilitation of the Statistical Package for Social Sciences Version 24 analytical tool. The null hypothesis was tested at 95% confidence level. The results of the analysis were presented in form of tables. The study found that there existed a positive, moderately strong and statistically significant relationship between financial accountability and service delivery ( $r = 0.471$ ;  $p < 0.05$ ). The study established that the studied financial management practice was able to explain 39.9% of service delivery. It was also found that there ought to be 0.613 unit change in financial accountability while holding other factors, not addressed by this study, constant as represented by ( $\beta_0 = 1.372$ ) to realize 1 unit change in service delivery. The null hypothesis was rejected. The study concluded that financial accountability was significantly important in the delivery of health services. The public health facilities are advised to put in place effective, sound and reliable accountability mechanisms, financial controls, internal controls, and audit trails.

**Keywords:** financial accountability, financial management practices, Nakuru East Sub-County, public health facilities, service delivery,

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Date of Submission: 09-04-2018

Date of acceptance: 23-04-2018

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### I. Introduction

Financial management in the public sector include various facets, important ones touching on accounting, budgets and budgeting, and auditing [1]. Involvement of stakeholders such as the community and employees in planning process are bound to result in increased accountability, financial sustainability and also both effectiveness and efficiency in financial management [2]. The effectiveness of financial management is largely hinged on requisite reforms. There are various influencers of reforms in the public sector which include but not limited to timely allocation of resources, training of employees, and also improved public awareness and civic education in setting of the reform agenda. Financial system at the firm level, which centres on financial transactions and money exchanges between investors, lenders and borrowers, is another factor that presumptively impacts on financial management among firms in the public sector including public health.

In a guide to public financial management (PFM) particularly focusing on practitioners in developing countries, it is posited that public financial management underlines all activities of the government [3]. PFM is said to constitute mobilization of resources (revenue), allocation of the mobilized funds to various vote heads. It also involves expenditure, and being accountable to the utilization of the disbursed funds.

There has been mounting pressure on governments across countries in Africa to deliver basic services including education and health and also to improve the living conditions of the populace. According to Ernst and Young, the public financial management reform has been an enabling factor for African governments to address the aforesaid demands [4]. In the same breadth, it is reported that these governments are appreciating the broader importance of enhancing the management of their finances. The improvement on the PFM is carried out differently in different countries on the continent depending on the level of individual country’s maturity level. Essentially, therefore, different countries are presently at various stages of the reforming their PFM. It is exemplified that a country like South Africa has a fully automated public accounting system which, however, is yet to be fully integrated across all tiers and departments of the government. On the other hand, countries like

Ghana and Uganda though having achieved a greater level of integration of the PFM reforms than South Africa, they lack fully automated public financial accounting systems [4].

The promulgation of the Constitution of Kenya, 2010 resulted in devolution that is associated with decentralization of many government functions hitherto under the purview of the central government. According to the Society for International Development (SID), devolution has obliged policy changes to provide for fiscal decentralization and public financial management [5]. In tandem, the Public Financial Management Act 2012 was enacted into law with the primary object of promoting both transparency and accountability in the management of public finances at both central and county government levels. It is further asserted that the changes in the public financial management was necessitated by hitherto challenges faced in the local public sector and also the gaps identified which had resulted in embezzlement of public funds, inequities in resource distribution, among others [5]. Granted that healthcare is one of the core functions decentralized and hitherto under the purview of the county governments except for selected referral hospitals, it was imperative to investigate the various financial management practices that influence service delivery in this sector. The overall objective is to come up with recommendations that if and when implemented can promote provision of better healthcare in Kenya.

## **II. Statement of the Problem**

The public health sector in Kenya is one of the crucial functions that have been devolved to the County Governments in tandem with the Constitution of Kenya 2010. Indeed all the public health facilities in Kenya, apart from Kenyatta National Referral Hospital (KNRH), Moi Teaching and Referral Hospital (MTRH), The Spinal Centre, and the Mathari Mental Hospital which are autonomous State corporations, are hitherto under the purview of the devolved governments. However, the level of preparedness of these devolved units in managing this all-important function is below par. Most of the complaints emanating from the staff working with public health facilities in Counties and also members of the public directly and/or indirectly touch on finances. It is in the public domain that the employees working with the aforementioned health facilities have been complaining of poor remuneration terms. The epitome of these complaints is manifested in strikes by medical practitioners constituting of doctors, clinical officers, pharmacists, nurses and other related staff on the payroll of County Governments. The foregoing points out to challenges in the management of finances by the county governments. This could probably be due to poor resource mobilization, misplaced budgetary allocations, weak financial systems, lack of accountability, among other inhibitions. Financial management in the public sector including health facilities constitute various facets which touch on accounting, budgeting, and auditing [1]. In the wake of these challenges, crucial health services provided by public health utilities have intermittently been compromised and in some cases and at some times ceased altogether. Granted that financial management is a prerequisite for success of the health sector among other functions, it was imperative to evaluate the influence of financial management practices on service delivery in the public health sector.

## **III. Objective of the Study**

To examine the effect of financial accountability on service delivery in the public health facilities in Nakuru East Sub-County

## **IV. Research Hypothesis**

**H<sub>0</sub>:** There is no significant relationship between financial accountability and service delivery in the public health facilities in Nakuru East Sub-County.

**H<sub>A</sub>:** There is no significant relationship between financial accountability and service delivery in the public health facilities in Nakuru East Sub-County.

## **V. Theoretical Review**

In this section, theories that explain financial management practices and service delivery are reviewed. The theories reviewed include the stakeholder theory and the agency theory. The foregoing theories are further discussed in the context of financial management practices and service delivery in the public health sector in Kenya.

### **5.1 Resource-Based Theory**

Resource-based theory (RBT) was proposed by Grant (n 1991). The theory states that a firm comprises a bundle of productive resources and capabilities, and that heterogeneity in performance across entities is founded on underlying heterogeneity in their resources and capabilities. It is postulated that the theory is premised on the concept of economic rent, and the view of an organization as a collection of resources and capabilities. Resources are defined as inputs into an entity's production process and/or service provision and include capital (finances), equipment, skills and expertise of individual employees, patents, and talented or

experienced management. The basic five categories of resources are financial, physical, human, technological, reputational, and organizational resources. Resources may be either tangible or intangible.

It is further stated that as the effectiveness of the resources increases, the resources have a tendency of becoming larger. In the same vein, it is held that individual resources are likely to be unable to yield a competitive edge. In this regard, the synergistic combination and integration of a set of resources can result in a firm getting a competitive advantage over rivals. In order for resources to be optimally utilized and effective, they must be integrated with requisite capabilities.

A capability is defined as the capacity for a given set of resources to perform a certain task synergistically. Capabilities closely centre on the vision and core values of an entity. As such, it is essential in value creation, is a corporate property, and is broadly based across the value chain. It is stated that in reference to competitive advantage, capabilities ought not to be too simple to be imitable or too complex to defy internal steering and control. In respect of the public health sector, the resources available include the staff hired by the national and county governments, the finances collected and/or disbursed to them, and also the facilities including the infrastructure and medicine to facilitate the execution of various tasks that the said health outlets are required to dispense to the public. Relative to resource-based theory, the bundle of productive resources include staff, finances and infrastructure among others. On the other hand, capabilities include the expertise possessed by the medical staff. Therefore, the theory is relevant to this study in that it is cognizant of the aforementioned resources and capabilities in public health facilities in Kenya.

## **5.2 Agency Theory**

The pioneers of the agency theory were Jensen and Meckling in 1976 [6]. The theory states that there exists conflict in an agency relationship when the agents pursue objectives contrary to the interests of the principals. The theory analyzes the conflict between shareholders and managers. The shareholders are the principals who contract the managers as agents to run their businesses on their behalf. Due to the agents' vested interests in the shareholders' firms, there arises agency problem between the two parties. Further, the two parties may have different appetite towards risk and thus have different objectives. The agency problem is further fuelled by the agents' interest to maximize its own utility. Since it's costly to observe and monitor the agents' activities, the principals assume that the managers will act in the best interest of the shareholders [7]. In the same light, it is exemplified [8] that, the agency theory as a result of the explored risk sharing among individuals and groups in the 1960s and 1970s.

The agency theory is usually associated with information asymmetry [9]. The information asymmetry creates the risk of adverse selection and moral hazard [10]. Adverse selection is correlated with pre-contractual asymmetric information and one party, say the entities entrusted with reforming the financial management systems in the public health sector, conceals certain crucial information regarding the reforms thereby leading to interested parties (mainly the public) receiving a raw deal in relation to the end-results of the financial management reforms. It is stated that agency problem generates agency costs [11]. The costs include the monitoring costs, bonding costs by the agent and the residual loss of economic welfare [7]. It is further noted that having reward schemes and making changes in the organizational structure that compels the agents to act in the best interest of the shareholders would deter the agency costs [11].

In the context of public health facilities, the agency theory is applicable in that the public through the county government act as the principal while the management of these health institutions act as the agents. The facilities' management is charged with the responsibility of delivering services in the best interest of the public. However, this at times, fails to be the case when the agents (managers and staff) fail to perpetuate the public interests and start executing their personal interests. A case in point, is the failure by doctors to be at the health facilities where they work and, instead, operate from their private clinics offering the very services they were employed to dispense to the public that hire them at exorbitant rates. To address this standoff of principal-agent conflict, it is advisable for the interests of both the agents (staff of the health facilities) and the principals (the public) to be harmonized. One way is to adequately remunerate the foregoing staff while the staff, on the other hand, expedite their services by presenting themselves to the patients whenever the call of duty beckons.

## **VI. Empirical Review**

In this section, past studies in relation to financial management practices and service delivery are reviewed. Specifically hitherto empirical studies on financial accountability and service delivery are reviewed.

### **6.1 Financial Accountability and Service Delivery**

An empirical study conducted in the United States sought to analyze the effectiveness of audit committee in the largest public hospitals in the country [15]. In particular, the study examined the role and quality of audit committees in public hospitals in addressing challenges associated with financial reporting. The study findings indicated that audit committees with financial expertise and increased activity positively



**VIII. Research Methodology**

The research methodology centres on the step-by-step procedure that the study followed in addressing the statement of the problem and study objectives. In this regard, therefore, the chapter constitutes of the research design, target population, sampling procedure, research instrument, pilot testing, and data collection procedure. Others include data analysis and how the results of the analysis were presented.

**8.1 Research Design**

A research design is a blueprint for carrying out a research study [23]. In essence, it spells out the procedure and the methods of defining and collecting the data requisite to address the research problem and study objectives. There are various research designs, but in the context of this study, a descriptive survey design was adopted. The choice of this design is founded on the fact that descriptive studies explain a phenomenon in terms of attempting to answer “what?” kind of questions. The phenomenon in this study was public financial management reforms, and the general research question was: What is the influence of financial management practices on service delivery in the public health facilities in Nakuru East Sub-County, Kenya? The survey aspect was premised on the fact that the study was conducted at a specific point in time which is contrary to longitudinal studies that essentially take an extended duration of time.

**8.2 Target Population**

Target population is defined as a group of subjects, say individuals, sharing similar or related characteristics [22]. Essentially, therefore, the findings of the study are generalized to this population [23]. In the context of the present study, all the management and finance staff working in the public health sector in Kenya constituted the target population. These two categories of employees were preferred to others because they were believed to be closely concerned with financial management practices and service delivery in their respective workstations and jurisdictions. Given that the target population was relatively large as it cut across various public health facilities in the country ranging from dispensaries to referral hospitals at the national level, the focus of this study was narrowed down to a manageable and accessible population. In tandem, therefore, the study opted to centre on public health facilities in Nakuru East Sub-County. This implies that the 211 finance and management staff as further broken down (Table 3.1), working with these health facilities comprised the study population.

**8.3 Sampling Frame, Sample Size and Sampling Technique**

In this section, the sampling frame, the sample size and sampling technique respectively are put into perspective.

**8.3.1 Sampling frame**

A sampling frame refers to an exhaustive list of subjects from which the sample is obtained [21]. Essentially, the sampling frame is equivalent to the constituents of the study population as outlined in Table 1.

**Table 1: Sampling frame**

<b>Employees’ Category</b>	<b>Number</b>
Management-HMB & HMT	48
Finance	69
Budget Officers	2
Accountants	15
Revenue clerks	46
Internal Auditors	7
Health Administrators	24
<b>Total</b>	<b>211</b>

**8.3.2 Sample size determination**

A sample is a subset of the study population and is derived scientifically and subsequently drawn from the sampling frame [21]. In this study, the researcher used the Nassiuma’s formula [24] to calculate the size of the sample as shown below.

$$n = \frac{NC^2}{C^2 + (N - 1) e^2}$$

Where:

- n represents ‘Sample Size’
- N represents ‘Target Population’
- C represents ‘Coefficient of Variation (21% ≤ C ≤ 30%)’
- e represents ‘Precision Level (2% ≤ e ≤ 5%)’

Therefore;

$$n = \frac{211 \times 0.25^2}{0.25^2 + (211 - 1) 0.025^2}$$

$$n = 68.06$$

$$n = 68 \text{ respondents}$$

The sample size as outlined in the above calculations was found to be 68 respondents.

### 8.3.3 Sampling technique

Alter calculating the size of the sample, the next step was to determine how the calculated sampled respondents were to be obtained from the study population (sampling frame). The study adopted purposeful and stratified random sampling techniques to obtain the sampled respondents from the study population. Purposeful in that not all employees working with the county government were targeted. The stratified random sampling technique was chosen based on the fact that the distribution of staff across the various sections as shown in Table 1 was not even. This method ensured fair and equitable distribution of respondents [21] as shown in Table 2.

**Table 2: Sample distribution**

Employees' Category	N	Sampling Ratio (%)	n
Management	48	23	16
Budget officers	69	33	22
Accountants	15	7	5
Revenue clerks	46	22	15
Internal auditors	7	3	2
Health administrators	24	11	8
<b>Total</b>	<b>211</b>	<b>100</b>	<b>68</b>

### 8.4 Research Instrument

A research instrument is a tool that aids in collection of data from respondents. In survey studies (as it was the case with the present study), questionnaires are the most preferred and appropriate data collection tools [25]. This justified the choice of a structured questionnaire to facilitate collection of requisite data for the study. A structured questionnaire is that which consists of close-ended questions [23]. It was ensured that the research questionnaire was structured in a manner that effectively and objectively addressed all the study constructs, which included revenue mobilization, budgeting, financial accountability, and service delivery.

### 8.5 Pilot Testing

A pilot study is a minor study that is essentially conducted prior to the main study with the primary objective of determining the feasibility of the actual study and also in facilitating detection of probable weakness in the data collection tool. In reference to this study, the object of pilot testing the research questionnaire was to assess its validity and reliability in the collection of data for the main study. The pilot study in this context was conducted in public health facilities in Nakuru West Sub-County, in the same Nakuru County as the scope for the main study (Nakuru East Sub-County). Simple randomly selected management and finance employees working with the former health facilities took part in the pilot study. The choice of these facilities ensured that the participants in the pilot study were excluded from the main study. Pilot study was based on 10% of the sample size (that is 7 respondents) who were effectively excluded from main study.

#### 8.5.1 Validity Testing

Validity test is a means of assessing whether or not the data collection tool is able to facilitate collection of the requisite data as it purports [26]. The validity of the research questionnaire was determined by consulting the assigned university supervisor regarding the content of the instrument. The suggestions and/or amendments of the supervisor, were duly incorporated in the research questionnaire.

#### 8.5.2 Reliability Testing

Reliability is a test of internal consistency of the data collection tool (research questionnaire). The data collected during the pilot study were subjected to reliability testing through the use of the Cronbach alpha coefficient ( $\alpha$ ). It is postulated that this method is the most widely recommended particularly when dealing with Likert scale data [26]. The study constructs that managed to return alpha values equal to 0.7 ( $\alpha = 0.7$ ) or greater than 0.7 ( $\alpha > 0.7$ ) were considered reliable. The results of the pilot test are as shown in Table 3. According to the reliability results, all the four study variables namely revenue mobilization, budgeting, financial accountability, and service delivery returned alpha coefficients greater than the reliability threshold of 0.7. Effectively, therefore, the research instrument (questionnaire) was found to be reliable.

**Table 3:** Results of the reliability test

Study Variable	Items Tested	Alpha Coefficient
Financial accountability	8	0.781
Service delivery	7	0.805

**8.6 Data Collection Procedure**

The data collection procedure started by seeking the approval of the university to commence with the data collection. Armed with the University official letter, the researcher then sought the consent of the health administrators in Nakuru County, and senior management of all the participating health facilities in Nakuru East Sub-County to be allowed to solicit information from the targeted staff. The research instrument was issued to the management staff by the researcher in person, while the questionnaires were administered on the finance staff through the concerned heads of departments and sections. The filled questionnaires were collected by the researcher immediately they were filled and in a few instances, after a period of less than a week.

**8.7 Data Analysis and Result Presentation**

The collected data were first screened by going through all the collected questionnaires to ensure that only the ones that were completely filled and where respondents answered according to given instructions were considered for analysis. The essence of data screening was to address the challenges brought about by outliers. Screened data were subjected to both descriptive and inferential analyses with the facilitation of the Statistical Package for Social Sciences (SPSS) Version 24 analytical tool. The descriptive statistics that were used in this study included measures of distribution, measures of central tendencies, and measures of variation. More so, inferential statistics included Pearson’s correlation coefficient, and multiple regression. The null hypotheses were tested at 95% confidence level, that is, 0.05 probability (*p*) value. The results of the analysis were presented in form of tables. The following simple linear regression model guided the inferential analysis.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \epsilon$$

Where:

- Y** represents ‘service delivery
- $\beta_0$**  represents ‘constant’
- $X_1$**  represents ‘financial accountability’
- $\epsilon$**  represents ‘error term’
- $\beta_1$**  represents ‘regression coefficient of independent variable’

**IX. Findings and Discussions**

This section presents the results of data analysis in respect of financial management practices and service delivery in the public health sector with a special focus on public health facilities operating in Nakuru East Sub-County. The first part presents the response rate. The second part covers the results of descriptive analysis and associated interpretations and discussions. The third and last part presents inferential statistical results, interpretations and discussions.

**9.1 Response Rate**

The proportion of the number of questionnaires effectively filled and collected vis-à-vis the total number of questionnaires initially administered on the respondents constitute the response rate [27]. The recommended response rate in survey studies is 75%. In the present study a set of 55 questionnaires was issued to the sampled respondents. The number of filled questionnaires that were collected totaled 51. This translated to 92.73 per cent response rate which was way above the recommended threshold in survey studies.

**9.2 Descriptive Results, Interpretations and Discussions**

The results of the descriptive analysis in respect of all the study variables (financial accountability, and service delivery) are outlined. The results are interpreted and discussed in relation to findings made by previous empirical studies. It is imperative to remember that the data collected were on a 5-point Likert scale where various degrees of agreement/disagreement from strongly disagree to strongly agree are represented by 1 to 5 respectively.

**9.2.1 Financial accountability**

In line with the third objective, the study analyzed the views of management and finance staff working with public health facilities in Nakuru East Sub-County in respect of financial accountability in the sector. The descriptive results to this effect are as shown in Table 4.

**Table 4:** Descriptive statistics for financial accountability

	n	SA	A	N	D	SD	Mean	Std. Dev.
Our hospital conducts financial audit of all financial transactions	51	15	5	20	11	0	3.47	1.138
Financial reporting is done at the end of every financial year	51	8	17	17	9	0	3.47	.966
Our hospital has effective accountability mechanisms	51	2	15	24	7	3	3.12	.909
Our hospital has sound and reliable financial controls	51	2	7	32	10	0	3.02	.707
Our hospital has a sound accounting system	51	0	14	26	8	3	3.00	.825
Our hospital makes full disclosures of all its financial transactions	51	4	9	20	18	0	2.98	.927
Our hospital has well-kept financial database	51	2	9	24	14	2	2.90	.878
Our hospital is transparent in all its financial transactions	51	2	11	18	17	3	2.84	.967

According to the results indicated in Table 4, it was evident that the sampled management and finance staff were largely neutral in respect of all issues touching on financial accountability. Most of the respondents (20 out of 51) were uncertain whether or not public health facilities in the area conduct financial audit of all financial transactions. Though, 17 respondents were in agreement that financial reporting is done at the end of every financial year, a similar number of staff (17) were not sure regarding this proposition. Twenty-four respondents held neutral opinion regarding public health facilities in the Sub-County having effective accountability mechanisms. These results mirror previous findings in a study carried in Malaysia [16]. The latter study had noted that though the public sector generally implemented accountability practices, accountability in medical and health services was below the overall average.

Moreover, 32 out of the 51 sampled staff were not certain if or not the aforesated facilities have sound and reliable financial controls, while 26 respondents did not know whether they had a sound accounting system or not. Albeit the fact that 18 respondents disputed that the health facilities made full disclosures of all their financial transactions, a larger number (20) of the respondents were not sure. Twenty-four respondents were found to be uncertain regarding the proposition that the public health facilities have well-kept financial database. The health institutions were believed by 17 of the respondents not to be transparent in all their financial transactions while 18 additional staff remained indifferent. The foregoing results could have been linked to the findings of a past local study [18] that there are certain accountability mechanisms which simply remain on paper and are never implemented.

The study also revealed that, the sampled staff were generally uncertain in respect to the assertion that public health facilities in Nakuru East Sub-County conduct financial audit of all financial transactions (mean = 3.47). There was, however, significant variation of the respondents' views in respect of this assertion (std dev = 1.138). It was further established that the respondents were indifferent regarding the propositions that financial reporting is done at the end of every financial year (mean = 3.47); the studied health facilities have effective accountability mechanisms (mean = 3.12), sound and reliable financial controls (mean = 3.02), and sound accounting systems (mean = 3.00). In respect of the foregoing propositions, there was insignificant variation in the staff's opinions (std dev < 1.000). In the same vein, the study found that the respondents were not sure whether or not the health facilities make full disclosures of all its financial transactions (mean = 2.98); had well-kept financial databases (mean = 2.90); and that they are transparent in all its financial transactions (mean = 2.84). In spite of the indifference among the sampled staff, the variation in their opinions was not significant (std dev < 1.000).

**9.2.2 Service delivery**

The study sought the views of the finance and management staff working with public health facilities in Nakuru East Sub-County in relation to service delivery. The descriptive results in form of frequencies, means and standard deviations to this effect are as shown in Table 5.

**Table 5:** Descriptive statistics for service delivery

	n	SA	A	N	D	SD	Mean	Std. Dev.
The costs of health services in public hospitals are relatively affordable	51	19	29	3	0	0	4.31	.583
Our hospital offers quality health services to the public	51	9	10	23	9	0	3.37	.979
The services rendered by public health facilities are reliable	51	11	2	23	12	3	3.29	1.064
Our health facility is transparent in its service delivery	51	4	9	26	12	0	3.10	.855
There is prompt delivery of health services by public health facilities	51	2	10	28	11	0	3.06	.759
Our health facility is highly efficient in its service delivery	51	2	7	33	7	2	3.00	.775
Our hospital is very concerned about customer satisfaction	51	4	2	24	21	4	2.78	.856

It was apparent that majority of the sampled finance and management staff as shown in Table 5, concurred that the costs of health services in public hospitals are relatively affordable (strongly agree = 19/51; agree = 29/51; mean = 4.31). This was contrary to the results of a study conducted by Robertson et al (2011) on the attitudes of different stakeholders within the healthcare system. The latter study observed that there were increasing medical costs which were attributed to a number of factors. However most of the respondents were uncertain regarding the propositions that public health facilities in Nakuru East Sub-County offer quality health services to the public (neutral = 23/51; mean = 3.37); the services rendered by public health facilities are reliable (neutral = 23/51; mean = 3.29); the health facilities are transparent in their service delivery (neutral = 26/51; mean = 3.10); there is prompt delivery of health services by public health facilities (neutral = 28/51; mean = 3.06); the facilities are highly efficient in their service delivery (neutral = 33/51; mean = 3.00); and that these institutions are very concerned about customer satisfaction (24/51; mean = 2.78).

There was significant variation in the views of the sampled staff regarding the reliability of services rendered by public health facilities (std dev = 1.064). In respect of all the other assertions regarding service delivery by public health facilities in Nakuru East Sub-County, the views of the sampled employees had insignificant variation (std dev > 1.000).

**9.2 Inferential Results, Interpretations and Discussions**

The study analyzed the relationship between financial accountability and service delivery. Moreover, the study examined the influence of the stated financial management practice on service delivery. The Pearson’s rank correlation coefficient was employed to analyze the relationship between the stated study constructs. The coefficient of determination ( $R^2$ ) was used to determine the proportion of the service delivery that was explained by the studied financial management practice. The analysis of variance (ANOVA) was used to test the significance of the regression model. Moreover, the regression coefficient was employed to determine the extent to which the aforesaid financial accountability influence service delivery amongst the public health facilities in Nakuru East Sub-County.

**9.2.1 Relationship between financial accountability and service delivery**

The study evaluated the relationship between financial accountability and service delivery using the Pearson’s correlation coefficient (r). The results of the correlation analysis are as illustrated in Table 6.

**Table 6:** Correlation between financial accountability and service delivery

		Service delivery
Financial accountability	Pearson Correlation	.631**
	Sig. (2-tailed)	.000
	n	51

\*\* Correlation is significant at the 0.01 level (2-tailed).

It was established as shown in Table 6, that there existed a positive, strong and statistically significant relationship between financial accountability and service delivery ( $r = 0.631$ ;  $p < 0.05$ ) among public health utilities in the aforementioned Sub-County. The results meant that greater emphasis on financial accountability was likely to occasion improved service delivery. In the same light, reduced accountability of financial resources was likely to result in substantive decline in service delivery amongst public health facilities. According to the findings and in the context of service delivery amongst public health facilities in Nakuru East Sub-County, financial accountability was the most important financial factor. The importance of financial accountability in relation to service delivery in the health sector was earlier been emphasized in a study conducted in Malaysia [16].

**9.2.2 Influence of financial accountability on service delivery**

The study further analyzed the influence of the financial management practices, specifically financial accountability, on delivery of services amongst public health facilities in Nakuru East Sub-County. The results shown in Table 7 indicate the extent to which financial accountability explains service delivery.

**Table 7:** Model summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.631 <sup>a</sup>	.399	.386	.53056

a. Predictors: (Constant), Financial accountability

According to the results of the coefficient of determination ( $R^2 = 0.399$ ) as shown in Table 7, the study established that the studied financial accountability was able to explain 39.9% of service delivery in the

forementioned health facilities. The findings implied that the practice contributed considerably to service delivery across public health facilities in Nakuru East Sub-County. The remaining proportion (60.1%) of service delivery could be attributed to other factors that were not part of this study which can warrant further empirical research. The study further examined the significance of the following empirical (regression) model and the results to this effect are as shown in Table 8.

$$Y = \beta_0 + \beta_1 X_1 + \varepsilon$$

**Table 8:** Analysis of variance

Model	Sum of Squares	df	Mean Square	F	Sig.
1 Regression	9.139	1	19.139	32.466	.000 <sup>a</sup>
Residual	13.793	49	.281		
Total	22.932	50			

a. Predictors: (Constant), Financial accountability

b. Dependent Variable: Service delivery

The study established as shown in Table 8 that the model linking the financial accountability to service delivery in public health facilities in Nakuru East Sub-County was significant (F = 32.466; p < 0.05). This meant the model was suitable for further analysis and interpretation.

The results shown in Table 9 outlines the regression coefficient ( $\beta_1$ ) that illustrate the extent to which the analyzed financial management practice influence service delivery among public health facilities in Nakuru East Sub-County.

**Table 9:** Regression coefficients

Model	Unstandardized Coefficients		Standardized Coefficients		t	Sig.
	B	Std. Error	Beta			
1 (Constant)	.1.372	.342			4.013	.000
Financial accountability	.613	.108	.631		5.698	.000

a. Dependent Variable: Service delivery

The regression model is interpreted using the results indicated in Table 8.

$$Y = \beta_0 + \beta_1 X_1 + \varepsilon$$

$$Y = 1.372 + 0.613 X_1$$

The model indicates that in order for 1 unit change in service delivery to be effected, there ought to be 0.613 unit change in financial accountability while holding other factors, not addressed by this study, constant as represented by ( $\beta_0 = 1.372$ ). The findings underscored the importance of financial accountability in relation to service delivery in public health facilities. This was in support of an earlier study which centred on the public accountability system [16].

### 9.3 Hypothesis Testing

The null hypothesis was tested at 95% confidence level which is equivalent to 0.05 significance level (p = 0.05). The results of the T-statistics as shown in Table 9 were employed to test the research hypotheses.

**H<sub>01</sub>:** There is no significant effect of financial accountability on service delivery in public health facilities in Nakuru East Sub-County.

**H<sub>0A</sub>:** There is significant effect of financial accountability on service delivery in public health facilities in Nakuru East Sub-County.

Results of the T-statistics (t = 5.698; p < 0.05)

**Interpretation:** There is significant effect of financial accountability on service delivery in public health facilities in Nakuru East Sub-County.

**Verdict:** The null hypothesis was rejected.

**Discussion:** It was revealed that financial accountability was of significant importance in the provision of healthcare by public health facilities in Nakuru East Sub-County.

## X. Conclusions

The study concluded that it was unclear regarding public health facilities in Nakuru East Sub-County conducting financial audit of all their financial transactions. Moreover, the study indicated that it was not certain that financial reporting is done at the end of every financial year by the concerned health institutions. It was also deduced that there was ambiguity in reference to the public health facilities having effective accountability mechanisms, sound and reliable financial controls, and sound accounting systems. The study further concluded

that financial accountability was significantly important in the delivery of health services by public health facilities in Nakuru East Sub-County.

The study concluded that, in relation to the private sector, the costs of health services in public hospitals are affordable. This implies that unlike the former institutions that charge exorbitant fees, public health facilities are quite often considerate in their charges. However, it was concluded that the quality of healthcare offered by the public health facilities could not absolutely be guaranteed. The study also concluded that there was considerable uncertainty regarding the reliability, transparency, promptness, efficiency, and satisfaction of the services offered by the aforementioned health facilities. It was further concluded that financial management practices. Particularly financial accountability, are very important in improving the delivery of healthcare services by public health facilities in Nakuru East Sub-County.

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IOSR Journal of Business and Management (IOSR-JBM) is UGC approved Journal with SI. No. 4481, Journal no. 46879.

M’NyiriJane “Influence Of Financial Management Practices On Service Delivery In The Public Health Facilities In Nakuru East Sub-County, Kenya." *IOSR Journal of Business and Management (IOSR-JBM)* 20.4 (2018): 64-74.